Care Home Assessment and Review Service:

coordinated, proactive care home primary care delivery

INTRODUCTION

Many care home primary care schemes are aimed at improving care and reducing unplanned care episodes. They include using community geriatricians, community matrons, pharmacists and therapists, dedicated care home GPs, and whole care homes aligned to single GPs.[1,2] Most utilise a paternalistic approach whereby non-care home staff advise and direct health care while not utilising the skill mix of the staff or encouraging them to proactively manage their residents' health care.

There is an increasing demand on GP time with the complexity and healthcare needs of care home residents significantly pressurising the primary care team. The reactive care that is largely practised is well documented.[3]

OBSERVATIONS OF A CARE HOME GP

The quality of nursing and residential home care varies, evidenced by reported safeguarding concerns and unwarranted variation in rates of unplanned care episodes. Staff, sometimes temporary or inexperienced, can be isolated or pressurised by demanding residents and families. Staff can worry about decision making, meaning decisions are not made or made inappropriately, sometimes leading to unplanned hospitalisation.

Care homes are required to train staff in many matters, for example, infection control and safeguarding, yet there is no requirement to have any training on medical/healthcare subjects. One of our most vulnerable patient populations, with diverse medical problems, at great expense to the public sector, is looked after by a group of staff with little ongoing support for their professional development in the healthcare problems they are expected to manage.

CARE HOME ASSESSMENT AND REVIEW SERVICE

Care Home Assessment and Review Service (CHARS) engaged seven general practices and nine care homes (roughly evenly spread between nursing and residential homes). It aimed to generate a cultural shift in how care homes are viewed by primary care and social services, and how care home staff view their role within the healthcare team. It promoted proactive two-way communication and data transfer between care homes and GPs. It engaged and supported care staff to systematically review and monitor their residents and it engendered the concept of a 'care home' team within general practice.

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This two-way communication pre-empted potential problems and reduced the usual reactive, 'firefighting' approach. It consisted of three key parts:

1. A standard monthly structured review of residents by care home staff, engaging staff in the continuous review and management of their residents. The information helped identify trends that may signify deteriorating health (for example, weight loss, blood pressure, medicines compliance). It also collected information related to advanced care planning. It was faxed to the GPs monthly where the GP care home team analysed the data and made a care plan accordingly. The GP care home team consisted of a lead GP, lead nurse, and/or healthcare worker and administrator.
2. A programme of tutorials for care home staff, delivered in working hours in care homes, approximately fortnightly by a GP or various local consultants on such topics as Parkinson's disease, dementia, palliative care, and urinary infections.
3. Weekly stakeholder meetings attended by various agencies including social services, the clinical commissioning group (CCG), acute hospital trust, and the community trust. The care homes were private but had a mixture of social services and privately funded residents.

CHARS RESULTS

The pilot was funded to last a year and an independent evaluation report was commissioned, which can be provided on request. Qualitative data were gathered using semi-structured interviews with stakeholders and observation of the monthly stakeholder meetings and education sessions. The CCG was devolved into a larger CCG and the project was not recommissioned, although a new iteration of the concept has just been commissioned that involves funding care homes to take part.

A selection of quotes show the key themes and suggest that the process was well received and beneficial (Box 1).

Quantitative data for the largest nursing home (60 beds), compared with the same period the year before, showed that in the 12 months of CHARS there was a 20% reduction in emergency department attendances and a 23% reduction in hospital admissions. Although direct cause and effect cannot be shown, the trend is encouraging.

Cross-agency collaboration generated dialogue on better managing care home residents as the core contract is held by social services, the health care delivered by GPs and the community trust, and the patients monitored and managed by the care homes. This dialogue helped bring the expectations of CHARS into line with that of the Care Certificate[4] introduced

Box 1. Key themes

'We feel listened to now.'

'... we don't bother the GPs as much with silly things that can wait until the month's end ...'

'... closer links with practice staff ...'

'... it gives us a common platform on which to base discussions about residents ...'

'... allowed me to network with other professionals from health, social care, voluntary and private sector ...'

"Care home staff led the observation of residents and recorded key healthcare information."

by health and social care, setting out 15 standards that outline what health and social care workers should know and deliver in their jobs. The Care Certificate impresses the need to standardise quality in care but CHARS has gone a step further by educating and reinforcing knowledge on the medical issues faced by care workers. A significant barrier to education was releasing care staff for the tutorials, and session attendance varied from three to 15 delegates.

DISCUSSION

How often should you review a resident to ensure their care is proactive and pre-emptive rather than ticking boxes, leading to a reactive, 'firefighting' approach?

Although recording an annual blood pressure may satisfy the Quality and Outcomes Framework (QOF), it does little to establish a pattern of health or flag up decompensation.

High demands on GPs' time mean that routine clinical reviews get postponed and a Direct Enhanced Service (DES) or incentive scheme is relied on to raise the profile of care home care in the interest of reducing unplanned care.

The value of the CHARS process is in its frequency of holistic observation and the fact it was delivered and managed by the care home staff. A monthly review highlighted trends that could signify a decline in health, thus triggering management. This was done alongside any other patient reviews, whether it was an acute visit request or a planned weekly ward round visit and did not detract from any other ongoing care needs.

Care home staff led the observation of residents and recorded key healthcare information. This reduced demand on the GP; it promoted the idea of data collection and inter-agency data sharing; it could help to improve morale among care home staff by demonstrating their value to the residents' health care. The programme of education helped staff understand the rationale for doing observations and learning more about the clinical conditions they see.

The result is better patient care due to the systematic production of an up-to-date healthcare record, collated by a motivated, knowledgeable, and valued staff, and shared regularly with the primary care team, which is better coordinated and structured to manage the patient group.

The CHARS process has a standard approach. There is huge variety between care homes in how they manage medical problems and record data. Some residential homes have trained staff who are happy to perform blood sugar monitoring and carry out post-head-injury observations, whereas others (even nursing homes) are hesitant for staff to take a temperature and have a falls policy consisting of 'call 999'! This variety in skill mix and behaviour is not adequately managed by health or social care and is an oversight in the care home contract and schemes created to better manage care home residents.

A coordinated, proactive, and standard method of managing care home residents is long overdue. To achieve this, meaningful dialogue between the public sector health and social services and the private sector care homes is needed. CHARS, while trying to develop the relations between these stakeholders, also maintained its focus on supporting care homes and GPs to better manage their patients. It is this engaged, multifaceted approach that is essential.

Eddie Roche,
GP Partner, Marine Lake Medical Practice, West Kirby, Wirral.

Thomas Wyatt,
GP Partner, The Orchard Surgery, Bromborough, Wirral.

Provenance
Freely submitted; externally peer reviewed.

Competing interests
The authors have declared no competing interests.

DOI: https://doi.org/10.3399/bjgp17X689821

ADDRESS FOR CORRESPONDENCE

Eddie Roche
GP Partner, Marine Lake Medical Practice, West Kirby, Wirral CH48 4HZ, UK.

E-mail: edwardroche@nhs.net

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