Improving care home residents' health through collaboration between geriatricians and GPs

This Future Hospital Programme case study comes from Dr Katie Athorn, a consultant geriatrician for the Hull and East Yorkshire Hospitals NHS Trust. It describes how specialist geriatric support in care homes can improve the care of residents and support effective working between primary and secondary care clinicians.

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Key recommendations

- Delivering specialist geriatric support to care home residents can reduce admissions to hospital and ensure more effective use of medicines and secondary care interventions.

- Community-based specialist support can help to improve the confidence, skills and knowledge of GPs and care home staff.

- Sharing knowledge and good practice between geriatricians, GPs and care home staff can help to develop effective relationships between primary and secondary care clinicians.

- Taking time to review patients' notes before care home visits can help clinicians to better understand all of their likely issues and look to address them in the one instance, as a whole.

- Careful review of medicines and treatments can lead to significant cost savings for the NHS.

The challenge

In 2012 I was appointed as a community geriatrician and tasked with looking at how we could improve the overall care of the residents situated within the catchment's 114 care homes, supporting the GPs in doing so.

We identified a need to reduce non-elective admissions to hospital among care home residents, and rationalise other secondary care appointments and diagnostics that were not appropriate or necessary. In addition, it was felt that a more effective medicines review and optimisation could help to ensure that patients were not prescribed unnecessary medications.

We also wanted to develop a stronger relationship between primary and secondary care to support the sharing of good practice and knowledge across traditional boundaries.

Local context

Hull and East Yorkshire Hospitals NHS Trust provides healthcare for a large, rural catchment with a population of 340,000. Of this population, 80,000 are of pensionable age and over 7,000 live in care homes.

Our solution

I used one session a week to visit each care home within the locality in turn. In this I was accompanied by the care home's designated GP and either the care home manager or a senior member of staff. Patients were seen one-by-one, reviewed, treated and cared for as required.
During every visit, I sought to:

- provide a medical review for every patient and carry out a comprehensive geriatric assessment for the more complex and frailer cohort
- carry out a medicines review and optimisation
- promote and support GPs and carers in an advance care planning approach. This involved:

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    - joining some conversations, when required
    - formulating a draft version of a generic advance care planning document. This could then be used to capture and/or share the information being discussed
- rationalise secondary care appointments and diagnostics where deemed not appropriate or necessary
- support the patient to stay well in the care home, in order to reduce inappropriate non-elective admissions
- engage in difficult or sensitive communication with patients and relatives at the request of and in the presence of the GP and/or carers, eg around end-of-life care
- share knowledge and good practice with GPs and care home managers.

I returned to each care home 12 months later, with the same GPs and care home staff, so that we could review previous discussions, see any new patients or look at any new issues.

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> Dr Katie Athorn, Hull and East Yorkshire Hospitals NHS Trust

Outcomes

For the first round of visits, we reviewed 450 patients across 16 different care homes over 8 months. Non-elective admissions from the care homes included in the project reduced by 8% (from 316 in the 12 months before the scheme to 290 during the scheme). This is compared with a 24% increase from care homes that were within the catchment but were not included in this project (from 38 to 47). A total of 440 medications were stopped and 88 started. Both the medication reviews and the reduction in admissions resulted in a total cost saving of £79,000.

In the second round of visits there was a further 3% reduction in non-elective admissions and a further 298 medications stopped and 41 started. The cost saving attached to the medication changes, and the reduction in admissions equated to a saving of £61,000.

Secondary care interventions, appointments and scans were also rationalised if deemed no longer appropriate or necessary after review. This freed up resources for those in need and attributed a further attached cost saving. For example, in the first round of visits, we were able to cancel three secondary care appointments after undertaking the necessary reviews in the care home, and we rationalised and cancelled three CT scans and an MRI scan.

As well as these cost savings the confidence, skills, knowledge and relationships garnered by the involved GPs and care home staff are notable. Amongst the 23 GPs involved, 83% were more confident in reviewing care home patients at the end of the first round, and 44% of GPs were more confident in reviewing medications. 100% of the care homes reported a better working relationship with their assigned GPs at the end of the project. These figures were collected after discussions with all of the GPs involved and a selection of the 16 different care homes involved, both approached on an individual level and at locality meetings.

The first round of results for this pilot were presented as a poster presentation at the British Geriatrics Society, Brighton, 15-17 October 2014. The abstract can be found here.

Barriers and levers

We faced barriers regarding the accessibility of patient information. For this pilot we were supported with a laptop that could link remotely to the GP's patient management system, but this IT solution was temperamental. The biggest issue was being able to access a secure link from the laptop to the GP's

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system. This was due in the most part to issues with the laptop itself or not being able to log on to the system, as well as ineffective internet access (no Wi-Fi) in a small selection of care homes we visited.

Practice points

1. Begin visits at GP practice, to go through the patient's notes, before seeing them at the care home. For us this did mean time delays and some duplicated work.
2. Review patient with GP and member of care home staff.
3. Follow up with patients after interval, to review decisions and new issues.
4. Anticipate and address issues with Wi-Fi in advance of visit. Practice point one was our solution to the issue.

Patient feedback

One particular patient was on a complex regime of medications, mostly initiated by secondary care. He had painful intractable leg ulcers affecting his mobility, physical and mental wellbeing and requiring costly dressings. This made the patient reluctant to interact with his doctors. By carefully reviewing his notes and having this opportunity to review the patient and his active symptoms, via this project, we were able to rationalise his medications. This ultimately included stopping one particular medication that was the cause of his leg ulcers. They healed up within weeks, the patient regained his mobility and 'had never felt better'.

It was reported back to me that he asked every week when he was having another visit.

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