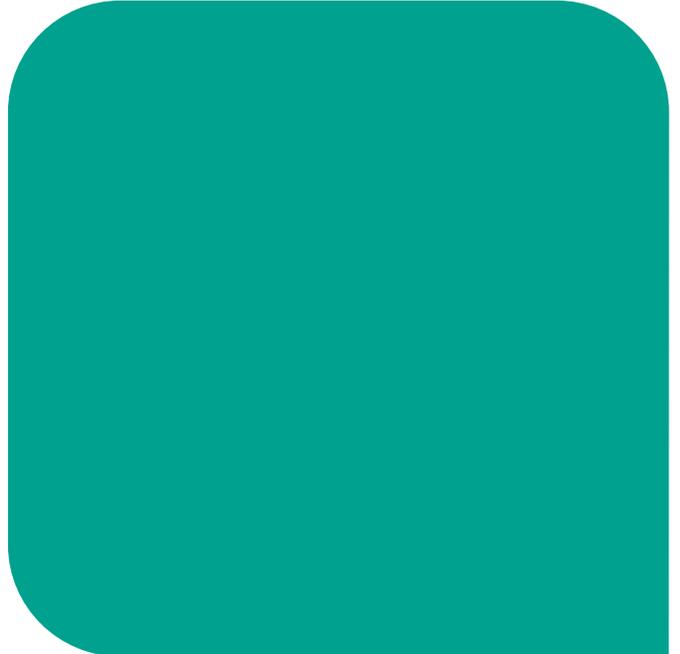


GP services for older people: a guide for care home managers



The health and wellbeing of older people in care homes depends on them accessing GP services in a timely way. This guide is for managers and senior staff of care homes, and also for GPs, members of clinical commissioning groups and joint health and wellbeing boards.

The Social Care Institute for Excellence (SCIE) was established by Government in 2001 to improve social care services for adults and children in the United Kingdom.

We achieve this by identifying good practice and helping to embed it in everyday social care provision.

SCIE works to:

- disseminate knowledge-based good practice guidance
- involve people who use services, carers, practitioners, providers and policy makers in advancing and promoting good practice in social care
- enhance the skills and professionalism of social care workers through our tailored, targeted and user-friendly resources.

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Foreword

I thoroughly welcome this guide. Care homes have a frontline role and operate in often demanding circumstances. The guidance offered here will be immensely helpful for their staff.

The health and care needs of older people present a particular challenge. Two-thirds of over-75s have a long-term condition. I know from my own visits that the best care homes do an extraordinary job, and make a massive difference to people's lives.

Establishing better links between GPs and care homes will help address problems at an earlier stage, reduce pressure on A&E and provide enormous reassurance to residents and their families. So SCIE is absolutely right to promote a joined-up relationship between care homes, GPs and other primary care services, and to say that we must 'place the resident at the centre of the picture'.

SCIE is also right to outline what care homes can do in terms of record-keeping and medications management. And I particularly welcome the stress on resident feedback and involving individuals in decisions about their care.

This Guide shows how care home managers can work with GPs, primary care services and others to ensure that residents can expect to receive the same access to NHS care as any of us. This is why we have recently announced the changes to next year's GP contract to promote personalised care and provide a named GP for all patients aged 75 and over, including those in care homes. The contract will also help to ensure that providers such as care homes can easily contact the GP practice by telephone to support decisions relating to hospital transfers or admissions.

It is time to raise our expectations of primary care for people in care homes. This timely and useful SCIE Guide helps us do just that.

A handwritten signature in black ink, reading "Jeremy". The signature is written in a cursive style with a long horizontal stroke at the end.

The Rt Hon Jeremy Hunt MP, Secretary of State for Health

About this guide

The health and wellbeing of older people in care homes depends on them accessing GP services in a timely way. Effective joint working between GP and care home management, the involvement of residents and their relatives and the engagement of care staff are factors that can affect the outcome and lead to quality improvements.

This guide is primarily written for managers and senior staff of care homes but it has also been written with GPs in mind, as well as members of clinical commissioning groups and joint health and wellbeing boards.

Acknowledgements

SCIE would like to thank all the care homes, staff, residents and relatives who agreed to take part in the practice survey (2013) as well as the project advisory group, in particular:

- Clive Bowman (Residential Forum)
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- Rebecca Goldman (Research Consultant)
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- Joanne Kallevik (Personal Assistant)
- Mary Larkin (De Montfort University)

Recommendations

Residents' entitlements and requirements

- **Care home managers should ensure that residents are registered with a general practitioner (GP) of their choice.** In order to make an informed decision, residents and their relatives may want help to consider the pros and cons of retaining their existing GP, if possible, or registering with a GP already providing services to other residents in the home. Residents lacking mental capacity to make decisions about particular matters, including health care, must be protected under the Mental Capacity Act 2005.
- Providers and managers of care homes should take the necessary steps to ensure residents have appropriate, high-quality GP and primary care services readily available to them. These include daytime and out-of-hours general medical services (GMS) commissioned by NHS England area teams, and enhanced medical services commissioned by their local clinical commissioning group (CCG). Current variable standards need to be identified and harmonised by primary care leads in area teams. Quality of life and good end of life care are of particular importance to residents and relatives.
- **All professionals should treat each resident as a person with experiences, aspirations and opinions, and not make assumptions about their capacity based on their age.** People should be involved as fully as they wish in discussions about their health care and treatment. Provision of health services should be responsive to the needs of individual care home residents and reflect their wishes and preferences.
- **Care homes should ensure that residents understand why information about their health is shared with other professionals and their consent should be sought.** Health and care professionals should listen, explain and discuss health and care matters with residents, and their relatives and carers. Information-sharing between professionals should contribute to improved health outcomes for individual residents.
- **Managers should make sure that residents have their human, civil and statutory rights protected in relation to their ongoing health care needs.** They should have fair access to scarce resources and services, active involvement in their care plans and protection from discrimination on the grounds of age, gender and/or disability. Residents lacking mental capacity for decisions about particular matters, including health care, must be protected under the Mental Capacity Act 2005.

Managers' responsibilities and the NHS reforms

- **Care home managers should establish ways of listening to and regularly checking the views and experience of residents and relatives regarding their medical care.** Managers and care staff can take leadership and advocacy roles in relation to the health care needs and preferences of residents, relatives and carers. Managers and GPs should ensure that local pharmacists, dentists, opticians and hearing services, CCGs and NHS England area teams understand the needs of their residents.
- **Care home managers should ensure that accurate, up-to-date, consistent records are kept on medical conditions, health care and medications.** Residents who wish to have access to their health records have a right in law to do so, with assistance if their capacity requires it, and may wish to make their own entries in the record.
- **Care homes should work with GPs and pharmacists to develop a strategy for medicines management, including regular (e.g. six-monthly) medication reviews conducted by GPs and/or pharmacists.** Managers should consider with GPs how to address medication issues in order to reduce high levels of prescribing error, and have a plan to obtain medication out of hours through liaison with GPs and pharmacies.
- **Care homes should ensure that they and their care staff are familiar with the new NHS structure and integration arrangements, especially in relation to what has been agreed locally.** They should know how complaints and challenges are handled. Networking, joining local forums and service development groups could all be seen as part of their advocacy role at a strategic level.

GPs' role in relation to the resident, the home and the wider NHS

- **A GP's primary relationship should be with the resident who is their patient, rather than with a care home.** Working in partnership with the home is, however, essential to providing a good-quality service to residents. Practice suggests that good relationships between GPs and residents are built up through regular contact and respectful, interpersonal communication which builds trust and confidence.
- **GPs should be proactive in offering residents the wide range of diagnostic and therapeutic services in primary care, and full access through referral to acute and specialist hospital-based physical and mental health services.** These can all contribute to maintaining each resident's health, wellbeing and independence. GPs should be aware that access to secondary services (e.g. mental health services) may be a problem for older people in care homes.
- **Care home managers and GPs should agree how to handle relationships, communications and joint working between the home and the practice, to deliver what works best for residents.** Issues to be considered include GP availability and interest; alignment of practices and homes; continuity, joint

protocols and role clarity; and development of shared understanding through, for example, the use of end-of-life frameworks and pathways.

- **Care homes and primary care providers should recognise and support the role that nurses in care homes and GP practices can play in facilitating communication between homes and GPs.** This includes practice nurses undertaking initial assessment visits and nurses in homes raising professional concerns. Nurse practitioners and other senior nursing staff can share up-to-date knowledge and skills with nursing and care staff in homes, and with residents and relatives.

Workforce development, standards and regulation

- **Managers and proprietors should ensure that care staff are trained and supported to be aware of and understand the medical and health needs of residents, and respond appropriately.** This has implications for leadership and culture in the care home; raising staff awareness of residents' health needs; and provision of training and staff development opportunities.
- **Managers and owners should be aware, and inform their staff, of the Care Quality Commission's (CQC) requirements on care home providers.** This applies in relation to the health care of residents and requirements of NHS England and the CQC on GPs in relation to the care of older people.

Introduction

Why this guide?

The health and wellbeing of older people in care homes depends on them accessing GP services in a timely way. Joint working between GP and care home management, the involvement of residents and their relatives and the engagement of care staff are factors that will affect the outcome and lead to quality improvements. The purpose of this guide is to support managers and staff of care homes to work in partnership with GPs and primary care teams, with a view to improving access for residents to good medical services. It seeks to place the resident at the centre of the picture, viewing from their perspective the need for, and benefits of, effective joint working between the home manager and the GP.

Nearly half a million adults, mostly older people, live in care homes in England. Alongside their requirements for care and support, the majority of older residents have significant health conditions and health care needs. Many experience long-term, chronic and fluctuating conditions, often including multiple impairments and co-morbidities affecting their health, intellectual capacity and psychological wellbeing.

Care home and nursing home residents have the same rights as the rest of the population to access the full range of general medical services (GMS) The GP is their route to referral for assessment and treatment by primary and secondary NHS services. The relationship between the home and the residents' GPs is therefore critical to their health and wellbeing.

Yet evidence suggests that many residents are unable to access the GP services they are entitled to and the following obstacles have been identified:

- failure to acknowledge and implement residents' equal rights to appropriate and effective health care
- lack of interest in and commitment to the health care of older people on the part of some GPs
- the effects of excessive GP workloads, and demands on primary care nurses
- an assumption that residents in care homes are at lower risk than those in their own homes, and so should receive lower priority
- acceptance by some residents and care homes of less than optimal standards and expectations for NHS care.

In addition to these barriers, the role of care staff, their lack of status, confidence and competence in working at the interface between health and social care is something that needs to be addressed. As they are part of the context in which older people are able to access services that will affect their health and wellbeing.

Leadership from the care home manager facilitates training, according to a systematic review of international evidence. [1] Dedicated time and resources from managers are needed to enable care home staff to access training which can be facilitated by learning contracts between managers and care staff. Moreover, evidence from the work on

effective supervision in a variety of settings [2] suggests that supervision and organisational culture can also play a part in improving practice.

This guide sets out steps the care home manager should take, in areas such as record-keeping, medications management and monitoring resident feedback on their experience of medical care, to complement the work of GPs and nurses. This enables prompt action to prevent ill-health and deterioration in long-term and chronic conditions, and more integrated approaches to assessment and monitoring of related health, support and care needs. It also helps to avoid unnecessary hospital admission and delayed discharge. Residents and relatives should participate as fully as possible in identifying and reporting health needs, and in contributing to decision-making and the discussion of options.

Who will find this guide useful?

- The guide is primarily written for managers and senior staff of care homes.
- It has also been written with GPs in mind, as well as members of CCGs and joint health and wellbeing boards, and should promote improved understanding of joint working.
- The issues addressed in the guide are of considerable importance to current and prospective residents in care homes and nursing homes, to their relatives and advocates, and to social workers, care managers and others helping them find their way through complex social and health care structures.
- Inspectors and other staff, regulating standards in the provision of NHS and adult social care services, may find it useful to reflect on the guide's approach to joint working between GPs and care homes.

The policy context

Although care homes provide care and support for nearly half a million disabled and older people, there is little in the way of positive government policy about what the adult residential care sector is for. It is 25 years since publication of 'the Wagner review - Residential care: a positive choice', which was published in 1988. [3] This review sought to shift the emphasis away from the view that residential care is the 'last resort' and to value its role as a vital part of community care. Government statements and responses to publicity about serious lapses in standards of residential care have until recently tended to regard such care as a regrettable hangover from a past age. Local authorities have for some years been exhorted by government to reduce the usage of, and spending on, care and nursing home placements to meet cost reduction targets.

Purposes of residential care for older people

Residential care meets a variety of positive purposes. As the Residential Forum has consistently reported, [4] this is best seen, not in isolation, but as part of the broad and diverse spectrum of care and support for disabled and older people. Residents vary greatly in their care and support needs, and in the kinds of programmes from which they are likely to benefit. Some examples are:

- people who move into care home settings after trauma and/or hospital admission, who may, with active reablement, be able to regain sufficient capacity and confidence to return to independent living
- people with problems of physical, mental and/or psychological frailty, including some degenerative and neurological conditions and functional mental health problems, who are seeking a positive, stimulating, supportive and caring environment which will help them to maintain and maximise their capability and capacity
- people with Alzheimer's and other forms of dementia, at various stages and levels of severity, whose care and safeguarding require particular forms of skill in communicating and understanding, and expertise in sustaining their personhood, dignity, choice and quality of life
- people who are close to the end of their lives and require good-quality end of life care, catering for their physical, psychological, intellectual and spiritual needs, supporting the active and sensitive involvement of family members and aiming to deliver some of the qualities of good hospice care.

These groups are not self-contained. Individual residents can have the characteristics of more than one group, and can move from one group to another over time. The crucial factor is that the home and its staff, the resident and any relatives, consider and plan for outcomes from the individual resident's stay that are as clear and well defined as possible. Maximising each resident's health, functioning, wellbeing and independence is a purposeful target for staff and residents alike.

Commissioning residential care

As commissioners, local authorities play a large and influential role in the residential care market. This has been changing as larger numbers of older people with housing equity have been in a position to fund their own residential care themselves. Across the UK in 2012, on average, 57 per cent of older residents paid the costs of their own long-term care, in whole or in part. The remaining 43 per cent were funded either by local authorities, or by the NHS under the continuing health care programme. [6] There is wide regional variation with a much higher proportion of 'pure' private payers in more affluent areas of the country, including the South East, South West and East of England. Any effects from government pressure to reduce dependence on residential care have tended to be countered by rising demand as a result of demographic change and increasing levels of need for care and support.

General and enhanced medical services

Primary health care is provided to people in care homes free at the point of contact through GMS delivered by GPs and their teams as well as community health services. In some areas GPs can seek additional NHS funding to provide a range of enhanced medical services, and residents of care homes may be among those to benefit from such arrangements.

Local enhanced service agreements

Typically, a local enhanced service agreement for residents of a care home or nursing home requires the general practice to provide a named lead clinician, a set number of sessions a week, and commitment to:

- a weekly visit (for an expected minimum of three hours)
- a weekly follow-up session (for an expected minimum of one hour)
- appropriate clinical administrative work.

Not all the residents users in a care home will need to be seen weekly. Following a comprehensive initial medical assessment, some will require only routine medical monitoring while others may require a more intense period of medical review. However, some people who are admitted with minimal medical needs may develop complications of existing medical conditions or new medical problems that require increased medical input from that initially thought appropriate. This increase may be temporary or permanent, the latter including the possibility that a resident may become terminally ill during their stay.

Some schemes identify three categories of resident to recognise the medical workload of any residential/nursing home population at any one time, and so that a clinician will prioritise who needs to be seen, based on sound clinical judgement:

- **Level 1** residents may have chronic physical or mental health conditions (e.g. dementia, diabetes, hypertension) but are stable and only require follow-up as per national or local guidelines. The person will need to be seen for an initial assessment and annual review as a minimum. Their records will be updated promptly following inpatient episodes, and drug sensitivities and allergies recorded.
- **Level 2** residents are likely to have an unstable chronic disease or medical problem, or to have been subject to an emergency admission that requires assessment, possible changes to management and close monitoring. Examples include service users with acute confusional states, urinary tract infections, gastroenteritis, unstable diabetes and respiratory infections. It is expected that these individuals will need an assessment of the acute problem weekly, or more frequent reviews as the condition dictates, until they are stable. The majority of residents who are assessed as Level 2 will return to Level 1 status once the acute episode is resolved. However, some residents will develop life-threatening deteriorations and/or complications of existing conditions or new conditions that may prove terminal. Where the person prefers to stay in the residential/nursing home, and this is deemed clinically appropriate, they will be treated at Level 3.
- **Level 3** residents are those with a terminal illness. It is likely that these residents will need a multidisciplinary review prior to any definite decision to manage the final stages of their illness in the residential/nursing home, and weekly, or more frequent, multidisciplinary reviews as their condition dictates. The palliative care team may become involved at this point, to support the person, their family, clinicians and staff.

For residents of nursing homes, the direct costs of services to be provided by a registered nurse are underwritten by the NHS, but not services provided by non-nursing staff under the direction and guidance of the nurse. There are no specialist services for care home medicine nor are specialised geriatric services routinely provided.

Policies and legislation

A number of policy initiatives intended to promote and secure more integrated working between NHS and adult social care services are part of the context for cooperation between care homes and GPs, although this is not explicitly named as their target.

Examples include:

- National Service Framework (NSF) for Older People's Services (2001)
- NSF for long-term conditions (including long-term neurological conditions) (2005)
- National Dementia Strategy, 'Living well with dementia' (2009), including provision to increase early diagnosis of dementia, and reduced use of anti-psychotic medication
- National Mental Health Strategy 'No health without mental health' (2011).

The 'UN Convention on the Rights of Persons with Disabilities', to which the UK is a signatory, applies to virtually all those resident in care and nursing homes. Its provisions include Article 19, the right of disabled people to live independently and be included in the community, and Article 25, entitling disabled people to the same health service support, on the same terms, as non-disabled people.

Key relevant legislation in this area includes:

- The Equality Act 2010, outlawing unfair discrimination on a number of grounds including gender, disability and age.
- The NHS and Social Care Act 2012. This contains major NHS reforms including the creation of NHS England and GP-led CCGs; the establishment of local joint health and wellbeing boards to oversee production of joint strategic needs assessments and health and wellbeing strategies; transfer of responsibilities for public health to local authorities; setting up national and local HealthWatch as the vehicle for service user and carer monitoring of health and care services; and changes to service and workforce regulation.
- The Care Bill introduced into Parliament in 2013. This consolidates existing adult social care legislation, setting up new arrangements for care and support needs assessment and eligibility criteria, placing duties on local authorities to promote integrated working with the health service and to work in partnership with a number of local bodies, as well as addressing issues of service regulation in the NHS and social care.

The 2013 NHS reforms provides more details of the legislative changes affecting the NHS and social care, and some of their implications for residents, care homes and GP services.

Care and support workers in health and social care

For more than 10 years, the government has recognised the growing significance of the care and support worker workforce in the NHS as well as in social care. In the wake of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) [5] on conditions in Staffordshire hospitals, the government commissioned Camilla Cavendish [7] to conduct an independent review into health care assistants and support workers in the NHS and social care settings.

There are over 1.3 million front-line staff who are not registered nurses but who now deliver the bulk of hands-on care in hospitals, care homes and the homes of individuals. The review's terms of reference included recruitment, training, supervision, support and public confidence. It did not include statutory registration, which the government felt would not add sufficiently to the general assurance provided by the CQC.

The report observes that:

'The phrase 'basic care' dramatically understates the work of this group. Helping an elderly person to eat and swallow, bathing someone with dignity and without hurting them, communicating with someone with early onset dementia; doing these things with intelligent kindness, dignity, care and respect requires skill. ... Like healthcare assistants, social care support workers are increasingly taking on more challenging tasks, having to look after more frail elderly people. Yet their training is hugely variable.'

Cavendish Review [7]

The increasing reliance upon care staff, and the urgent need to integrate health and social care, makes it even more important to boost public understanding and respect.

Residents' entitlements and requirements

Care home managers should ensure that residents are registered with a general practitioner (GP) of their choice. In order to make an informed decision, residents and their relatives may want help to consider the pros and cons of retaining their existing GP, if possible, or registering with a GP already providing services to other residents in the home. Residents lacking mental capacity to make decisions about particular matters, including health care, must be protected under the Mental Capacity Act 2005.

Registration with a GP

For a resident to receive good quality general medical services, primary health care and access to the rest of the NHS, it is essential for them to be registered with a GP.

The revised NHS Constitution [8] guarantees everyone the right to receive NHS services, free at the point of need and to access NHS services without being refused on unreasonable grounds. People are not excluded from these guarantees because they live in a care home. GPs can undertake to provide enhanced services to the residents of a care home, but this provision is arranged and funded through the NHS.

Under the NHS Constitution, individuals also have the right to choose their GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse. There are reports in the literature of individual GPs resisting or refusing to register a care home resident. Home managers taking part in the **SCIE's Practice Survey** confirmed that this remains a problem with some practices.

'I have to fight every time I go to register a resident. Basically, GPs don't want to take an older resident on because they cost too much in time, in resources, in medication, supplements, whatever, so it's very difficult to get to register an older person with a GP.'

Care Home Manager [46]

Resident choice

A new resident should be involved, with their relatives where appropriate, in the decision about whether to remain registered with their current GP practice, or transfer to the list of a GP practice with which the care home has arrangements for cooperation, joint working and/or enhanced services. The option to stay with a GP the person knows partly depends on whether the care home is still within their practice boundaries. In some instances, though, the GP will choose to continue providing medical care to a patient they know well, despite the greater distance.

The home manager, together with the social worker or care manager, if one is involved, should take steps to help the resident and relatives make an informed decision. They can provide information and advice on the pros and cons of maintaining an established doctor-patient relationship, or benefiting from a care home's liaison arrangements with one or more local practices, which may include an enhanced services agreement.

The care home and general practice can both provide information for residents and relatives to clarify:

- roles of primary care and other health professionals
- how residents register with a GP (and who is responsible for doing this), entitlements to basic services, any enhanced services and how residents can exercise choice
- how the care home makes the decision to contact a GP, and how they obtain feedback on the outcome of GP visits.

Some care homes have found, and residents have confirmed, that a GP who visits regularly and is familiar with the residents has a beneficial impact. The GP may have a better understanding of any current medical needs within the context of previous and future health needs.

Access to quality GP services

Providers and managers of care homes should take necessary steps to ensure residents have appropriate, high-quality general practitioner (GP) and primary care services readily available to them. These include daytime and out-of-hours general medical services (GMS) commissioned by NHS England area teams, and enhanced medical services commissioned by their local clinical commissioning group (CCG). Current variable standards need to be identified and harmonised by primary care leads in area teams. Quality of life and good end of life care are of particular importance to residents and relatives.

Free care

'One GP asked for £3,000 a quarter to look after the home's residents. I said it is your duty. They are registered to your surgery, why should I pay you extra? It is your duty to care for the residents registered to you, so why should I pay you a retainer?'

Care Home Manager [46]

'Personally I do not think any care homes should pay a retainer, service users have a right to basic medical care and it's not right that care homes should pay for this. They would get this care free of charge in their own homes and frankly a care home is their home.'

Care Home Manager [9]

Policy is very clear that NHS services are provided on the basis of need and free at the point of delivery. In spite of this, there is evidence of variations in the provision and funding of key elements of NHS services for care home residents. The variations can result in unfair access and even discrimination. In its review report 'Health care in care homes', [10] the the Care Quality Commission (CQC) found surprising variations

between care homes in the services provided by GPs and who pays for them: 33 per cent of homes said that GPs did not provide post-admission assessments for residents; 53 per cent said they were provided and paid for by the primary care trust (PCT); and 7 per cent said that they were provided but paid for by the care home. In the last case, the costs were presumably reflected in the home's fees to residents. More than half of homes (54 per cent) did not provide residents with information about which health care services were included in the home's basic fees in their care contract and agreement.

Expectations of GPs

What is expected of GPs was set out by NHS England in the document 'Securing excellence in commissioning primary care'. [11] Home managers should know the key principles underpinning the commissioning of GP and primary care services, including:

- **Quality will be the overriding principle.** Everyone in the system must focus on clinical effectiveness, safety and patient experience, although their role will differ depending on their job and the area in which they work.
- **Patients' experiences are the main driver** of the primary care commissioning arrangements.
- **The system will be clinically led** through a range of mechanisms, including central and local clinical leadership teams and explicit partnership arrangements with CCGs and local professional networks for dental, pharmaceutical and optical services, which will include relevant public health clinicians.

NHS England's area teams are responsible for commissioning standard GMS. These take the form of a daytime service Monday to Friday and an out of hours service. In some cases, the same practice provides daytime and out of hours cover, but this has become the exception in most areas. The result is that homes often have to rely on independent out of hours services, where a significant proportion of medical staff are locums who are unlikely to have prior knowledge of the resident or the home. When CCGs consider commissioning enhanced services they should include the benefits of continuity of service that could be provided by the existing GP practice.

Proactive health care

It is important for the care home to be confident its GP service will respond if asked to examine a patient, or in an emergency, but good GP care also needs to be proactive. This involves the clinician reviewing a resident's health condition on a regular basis; monitoring progress, taking steps to prevent decline and identifying scope for health improvement; and working closely with other agencies to maximise the individual's wellbeing

Practice examples:

In Sheffield, a pilot of a local enhanced GP service was evaluated (2008-09) through feedback from residents, relatives and care home staff, and before/after comparison of outcomes after one year. The scheme was based on a service level agreement, and

residents had the choice whether or not to register. GPs provided annual medical reviews, medical care plans, end of life planning, weekly surgeries in care homes, six-monthly medication reviews, access to a community geriatrician, and shared learning and review following emergency hospital admissions. It is reported that almost all residents agreed that the GP service gave them the help they wanted and needed, and that they understood more about their health. Eighty-four per cent of relatives agreed that the resident received better care. [12]

One scheme paid particular attention to the resident's voice. The service provided advance care plans which incorporated the wishes of residents. It asked residents and families about their preferences, recorded these in care plans, made sure they were carried out, and then audited the care given to check whether this had happened. They carried out a 'gap analysis' where the outcome did not follow the plan. GPs saw relatives as requested during their routine visits. The scheme also offered a GP available on the telephone out of hours (nights and weekends) to advise care homes on the care plans that had been written. Usual out of hours GP services were still available if a resident needed a GP visit. [13]

Multiple and complex health needs

An increasing proportion of residents, in care and nursing homes, are coping with multiple and complex physical and mental health problems. A recent cohort study of the health status of residents in UK care homes, with and without nursing, observed that:

The mean number of diagnoses per participant (6.2) and the prevalence of stroke, dementia, Parkinson's disease and osteoporosis were higher than previously reported for similarly aged UK community-dwelling cohorts, confirming the hypothesis that multi-morbidity is a defining feature of the care home population, and implying a requirement for expertise in geriatric medicine that may be beyond that of some GPs. [14]

Moreover, this study found that while there might be an increased need to access services due to cognitive impairment, behavior disturbance or malnourishment, residents had contact with the NHS on average once per month.

End of life care

Providing good end of life care has become a core function of many care and nursing homes, as recognition has grown that moving into hospital simply to die is neither necessary nor desirable for many residents. In 2006-08, among people aged 75 and over, 12 per cent of deaths took place in nursing homes and 10 per cent in care homes. The proportion of deaths in care homes increased with increasing age. It was 6.8 per cent in 75 to 79-year-olds compared with 17.9 per cent of the 90 and over group. The proportions in 'old people's homes' were 3.7 per cent and 18.8 per cent for the same age groups. In people aged 90 and over, 36.7 per cent of deaths were in nursing homes or 'old people's homes'. [15]

Homes have worked with GPs and palliative care teams to increase their knowledge and skill in this field. There is evidence from qualitative studies and reports that the use of end of life pathways and frameworks can facilitate positive relationships and joint or partnership working between GPs and care homes, but using these tools is not

essential: the relationship between GPs and care homes is more important than the tools themselves. [16, 17, 18, 19]

Practice examples

Care home staff attended multidisciplinary end of life and palliative strategy meetings in the PCT which took place in local GP surgeries. The staff reported that they had developed support from a wider network than before which reduced their reliance on GPs. [16]

A GP was involved in initiating a local palliative care in dementia group of a range of health professionals from primary and secondary care, including GPs and care home managers, which (among other initiatives) has created protocols for use by care homes. [20]

Many local initiatives to improve end of life care have used the Gold Standard Framework associated with the Liverpool Care Pathway. Use of the Pathway has been discontinued in the NHS, in the light of the 'Neuberger report' [21] which raised serious questions about failings in aspects of its design and implementation. The Department of Health (DH) intends to issue revised guidance.

Being seen as an individual

All professionals should treat each resident as a person with experiences, aspirations and opinions, and not make assumptions about their capacity based on their age. People should be involved as fully as they wish in discussions about their health care and treatment. Provision of health services should be responsive to the needs of individual care home residents and reflect their wishes and preferences.

'The home manager recently contacted a GP to discuss one resident who had suddenly stopped eating. Rather than considering whether this might be the effect of the resident's dementia, or the impact of new medication, the GP's response was to say, 'Oh well, she's 96, what do you expect?' The manager sees this as discrimination. 'If you went to your GP and she said, "Oh well, you're 54, what do you expect?", I don't think you would be happy with that or tolerate it. What difference does your age have to do with it?'

Care home manager [46]

Personalisation and personal budgets

Personalisation was initiated by people who use services and the disability rights movement. The core values of social work and social care that refer to dignity, respect and social justice reflect wider values of how we as individuals would like to be treated irrespective of age, disability and all the categories defined in the Equality Act 2007. While many professionals working with older people would agree with these values, in practice older people are still treated differently.

For disabled and older people receiving care and support at home, policies for personalisation have led to an emphasis on shaping support to the individual's strengths

as well as their social and health care needs. The aim is to respond to their preferences and aspirations, take account of help from family, carers and community networks, and design a care package to fit.

Using direct payments and personal budgets, people have been able to create varied and flexible arrangements for securing care and support in ways that are tailored to their particular circumstances. The government has yet to provide residents with access to direct payments or personal budgets but increased choice, flexibility and involvement are now becoming more widely recognised in many homes as part of good practice. Choice and flexibility are reflected in two of the core standards defined by the CQC:

'You should expect to be respected, involved in your care and support, and told what's happening at every stage – for example, you will be involved in discussions about your care, treatment and support. You will get support to help you make decisions and staff will respect your privacy and dignity. You should expect care, treatment and support that meet your needs – for instance, you can expect your care home to meet your needs relating to your cultural background, language, gender, disability, age, sexuality, religion or beliefs.'

GPs and care homes should find ways to make the voice of the resident integral to care planning, as happens in the **Thames Valley enhanced service scheme**. There are benefits all round if relatives are also involved in care planning as much as they wish to and are able to. The Health Foundation suggests 'care partnership' groups, in which relatives are given a more structured role in care planning. The care partnership would include the resident, the care home manager, staff, an appropriate carer or relative, the GP and other health and social care professionals such as the community pharmacist. [22]

Ageism and other forms of discrimination

Ageism is deeply rooted in society as a whole, and influences attitudes and behaviour towards older people in a variety of ways. The Equality Act 2010 outlawed discrimination in the delivery of goods and services on the grounds of age, alongside other factors such as race, sex and disability, already covered in anti-discrimination law. It also put a general requirement on public bodies to promote equality. For care home residents, ageism in service provision can be guarded against if GPs and staff are proactive in identifying and treating long-term physical and mental health conditions.

The National Dementia Strategy confirmed that only a minority of people with dementia receive a formal diagnosis; but depression also often goes undiagnosed and untreated among older people in residential care, primary care and hospital settings. Depression, and the loss of confidence and competence that go with it, are not an inevitable feature of growing old. They are often a predictable response to the range of known factors commonly experienced by older people, including bereavement, disability and sensory impairment, incontinence, loss of independence, social isolation and lack of opportunities for meaningful activity.

'Older people with mental health problems can be among the most socially excluded in society. The stigma of old age is amplified by the stigma of having a mental health problem, and may be further compounded by physical health problems and disabilities. Older people in residential and nursing homes are in many ways society's most excluded group. Up to 50% of older people in residential care have clinically severe depression, yet only between 10-15% receive any active treatment. [23]'

Although less often referred to, care homes also reflect significant aspects of sexism and sex discrimination. More than 80 per cent of residents are women, and women make up the overwhelming majority of care staff and shift leaders. The persistent problems of inadequate funding and staffing levels, low pay, high vacancy and turnover rates, frequent use of agency staff and lack of access to training, are characteristic of sectors with a mainly female workforce. The consequences for residents include having to rely on unfamiliar staff for intimate personal care; limited staff knowledge and understanding of complex health and care conditions; loss of continuity of care and support; and less chance to form friendships with staff who know them well.

You may find the following resources useful:

Implementing a ban on age discrimination in the NHS – making effective, appropriate decisions (DH, 2012)

Social CareTV: What is personalisation? (SCIE video, 2010)

Co-production and participation: Older people with high support needs (SCIE, 2012)

Age equality and age discrimination in social care (SCIE, 2013)

Individualised care and co-production

Practice examples

Having lived alone since her husband's death over 20 years before, Alice moved into a care home aged 91 with a range of chronic physical and mental health problems. These included after-effects of a major heart attack 12 years earlier; proneness to falls; almost complete hearing loss; urinary incontinence; long-standing depression; some degree of dementia; confusion associated with urinary infections; suspicious feelings akin to paranoia; and periods of hearing and vocalising tormenting voices. For some time, because of Alice's deafness, her family had been communicating by writing information and questions on a pad for her to read and respond to, and the care home staff used the same method.

A few months after entering the home, Alice was refusing to take any of her medication, and was spending a good deal of time in a distressed, tearful state. Younger care staff were troubled that whatever they said or did, they could not find effective ways to

comfort and console her. On the advice of the GP, the home manager involved a community psychiatric nurse (CPN) from the older people's mental health team, who in turn arranged for the consultant psycho-geriatrician to undertake an assessment visit, at which Alice's family were also present. He talked to the staff and relatives, and to involve Alice, despite her hearing loss, he too wrote his questions on a pad for her to read and answer.

On this basis, he was able to separate out the impacts of the different factors affecting Alice's mental health; prioritise the one principally associated with her experience of delusions, delirium and persecutory voices; and write a note explaining why it was particularly important for her to take the medication for that condition. He also discussed with her family and the staff, in terms of Alice's 'best interests' under the Mental Capacity Act, how far it was appropriate for staff to administer that particular medication concealed in food or drink

Information shared appropriately

Care homes should ensure that residents understand why information about their health is shared with other professionals and their consent should be sought.

Health and care professionals should listen, explain and discuss health and care matters with residents, and their relatives and carers. Information-sharing between professionals should contribute to improved health outcomes for individual residents.

'Dr Andrews is absolutely brilliant. He may not be able to solve all the problems but I am intelligent and I understand him. Only a month ago he discovered why I got paralysed and he was able to discuss it all with me and I now know what it means.'

Resident [24]

'Emergency call-out doctors do not know residents, so play safe and order them to be admitted to hospital for many conditions which could perhaps be resolved differently.'

Resident [25]

Good practice in information-sharing

In its report on 'Health care in care homes', [10] the CQC found that three-quarters of homes included in the review provided staff with training on the sharing of personal information. However, interviews with residents suggested that although most felt that their information was kept private, many did not feel that staff asked them for their permission before sharing information more widely.

Among residents in care homes, medical interventions and hospital admissions often arise at short notice or in emergency conditions, perhaps following a fall and/or injury. In the urgency of dealing with the immediate situation, it is not always easy to make sure information about a resident's wishes and intentions is known and conveyed. It may not

even be formally recorded, but is only part of the informal discussion among staff, or shared at shift handover meetings. A clear record can make a difference to residents, particularly if they are distressed, injured or unwell, so that key professionals are aware and take notice of their wishes.

These problems can be reduced by following the British Geriatric Society's advice to:

'arrange a holistic review for any individual within a set period from their move into a care home, leading to healthcare plans with clear goals. This will guide medication reviews and modifications, and clinical interventions both in and out-of-hours.'

British Geriatrics Society [45]

The Society also recommends that:

'Care home residents should be at the centre of decisions about their care. An integrated social and clinical approach should support anticipatory care planning, encompassing preferred place of care and end of life plans.'

British Geriatrics Society [62]

If a resident relates to or communicates well with particular staff, they may share conversations about important personal concerns, like worries about relatives, admissions to hospital, or wishes about end of life care. Staff should know how to respond to this information, which may at first be communicated on a private or confidential basis. The manager should support and guide staff, perhaps with a general procedure as well as advice about individuals. An appropriate response may be for the staff member to ask the resident's permission to record the information securely, so that it is available and can be referred to in the event of an emergency.

Care plans

Care home managers can play a leading role in identifying residents' health care needs, acting as advocates for residents, and discussing residents' preferences with family members where appropriate, as well as with GPs. [26] They or a designated senior can act as an advocate for residents, and in a leadership role for implementing medical plans.

Care home managers and senior staff need to ensure access to care plans by all involved, including out of hours services and locum GPs. The residents' records should be well organised, making it easy both to assess their ongoing personal care and support, health care and treatment, and to identify recent changes in demeanour, behaviour or capacity which may help the GP's understanding and assist diagnosis.

Protection of residents' rights

Managers should make sure that residents have their human, civil and statutory rights and entitlements protected in relation to their ongoing health care needs. They should have fair access to scarce resources and services, active involvement in their care plans and protection from discrimination on the grounds of age, gender and/or disability. Residents lacking mental capacity for decisions about particular matters, including health care, must be protected under the Mental Capacity Act 2005. (For a better understanding of how to apply the principles, see the [Mental Capacity Act resource](#).)

Rights under the NHS Constitution

The NHS Constitution [8] states that:

'You have the right to be involved in discussions and decisions about your health and care, including your end of life care, and to be given information to enable you to do this. Where appropriate this right includes your family and carers.'

This right extends to residents in residential and nursing homes. It also promises:

'To offer you easily accessible, reliable and relevant information in a form you can understand, and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the range and quality of clinical services where there is robust and accurate information available (pledge).'

Many residents have multiple long-term conditions relating to their physical, mental and psychological health, and require proactive care and active protection from age discrimination. Participants in the SCIE Practice Survey, 2013 raised the issue of age discrimination within the NHS: they felt professionals could be reluctant to put themselves out for an older person, either because they lacked the expertise or they felt it was a waste of their time. Proactive GP involvement benefits not only medical and medication reviews, but also clinical planning and assessments to facilitate proactive and preventative medical care and end of life care.

'In our study, there were significant differences between dependency, cognitive function, behaviour, nutrition, medication and use of services between nursing and residential care homes. However, residents of both types of homes had profound dependency and frailty. There seems no evidence-based rationale for rationing access to healthcare resources on the basis of residence in one type of home or the other, as has been reported by other researchers to occur commonly in clinical practice. [14]'

Reluctant clinicians and poor-quality medical services

In surveys and some qualitative studies, care home staff often express satisfaction with the services and support provided by GPs, and report that most GPs do visit when asked to. However, in several qualitative studies, care home staff and relatives report individual GPs' refusals or reluctance to visit on request; a lack of interest in the medical care of care home residents; a lack of interest in participation in end of life planning; and/or a lack of interest in providing anticipatory care and medication, medical equipment (e.g. syringe drivers and venepuncture kits), and other services to care homes, or in working in partnership with care homes.

Care home managers can facilitate continuity of care where there is high turnover and shift working, such as a change of GP or other health care professional. Difficulties reported with GP or medical out of hours services for care homes include a lack of communication; a lack of out of hours visits to the care home; a lack of knowledge of residents; difficulties in obtaining medication, linked to a lack of anticipatory prescribing by GPs; and having no access to adequate medical records. Qualitative studies report inappropriate hospital admissions, and harm caused by prescribing errors, as a result of the actions of out of hours services and other doctors who do not know residents' medical histories.

Health inequalities

'I think we should have specialist GPs that have an interest in older people. That are paid maybe to just look after older people. Who would be clinical specialists, I mean and community matrons. We don't have any tissue viability specialists coming into nursing homes, we don't have any dieticians. We have people who are on complete bed rest who have to be transferred to hospital once a year to do their PEG; it doesn't make sense. These services should be in the community, we don't have access to them of any kind. We have no diabetic nurse.'

Care home manager [46]

Care home managers can ask for GPs to lead medical reviews, medication reviews, clinical planning and assessments, which facilitate proactive medical care. They should also be aware of other services available locally to which GPs can refer residents. Twenty-five per cent of NHS trusts surveyed in 2008 reported inequality of access to physiotherapy and occupational therapy, and 35 per cent to district nursing. Fifty-seven per cent of residents in a 2009 CQC survey were unable to access all health care services required. [27]

Managers' responsibilities

Actions as a result of listening to residents and relatives

Care homes managers should establish ways of listening to and regularly checking the views and experience of residents and relatives regarding their medical care. Managers and care staff can take leadership and advocacy roles in relation to the health care needs and preferences of residents, relatives and carers. Managers and GPs should ensure that local pharmacists, dentists, opticians and hearing services, CCGs and NHS England area teams understand the needs of their residents.

Co-production and participation

Sharif et al. [37] consider the factors that older people say are fundamental to participation. These are:

- a proactive approach
- timely involvement
- clarity of purpose
- willingness to work in partnership
- a devolution of power.

These authors also consider the barriers to participation such as negative and ageist attitudes from staff, practical support such as transport, lack of support for older people to develop personal skills and inappropriate forms of communication. Their report suggests senior management involvement, sustained training and supervision in order to make participation a reality in practice.

It is worth noting that in satisfying CQC essential standards, forms of evidence around the quality of care can be found in supervision notes and in talking to staff about what training they have undertaken.

Hearing from residents and relatives on medical matters

Many homes arrange regular residents' meetings, sometimes but not always inviting relatives to attend. If the meetings are well conducted, residents should be free to place items on the agenda and able to air and share common concerns. These meetings offer one way for managers to hear residents' experiences and views of the GP services and medical care they receive. Managers in the SCIE survey of practice also mentioned periodic resident satisfaction surveys as another source of information. They thought it would be straightforward to include questions about accessing GP services, and the quality as experienced by residents.

Alongside these more formal processes, care staff in their day-to-day contact with residents are well placed to pick up and respond to informal accounts of their experiences with GPs and the NHS, both positive and more critical. This kind of feedback can help to improve service quality and working relationships between homes and GPs. Although it is harder to gather feedback from residents with the more serious

degrees of dementia, staff are often able to pick up non-verbal indications of increased anxiety or distress, and may be able to guide the GP or nurse towards ways of acting and communicating which will cause the resident the least upset.

Studies and reports [13, 22, 24, 38] emphasise the importance of the 'voice' of residents and relatives, and their advocates, in determining medical and end of life care. An enhanced service scheme [13] had the aim of incorporating residents' wishes in care plans. No evidence was found in the research literature of studies which evaluated the participation of residents and relatives in shared decision-making.

The contributions and requirement of relatives

Homes should enable relatives to be present during GP visits if they wish, and the resident agrees, so that they can talk to a GP directly. Alternatively, they should update relatives afterwards on outcomes from a GP consultation, including any medication changes. Relatives in two studies [22, 29] reported feeling frustrated that they weren't told by care home staff or GPs about important developments in their relatives' care such as changed medication. They weren't involved in shared decision-making, nor invited to attend or updated about GP visits. They said GPs tended to visit care homes when family or carers were not there. [22] Sometimes a GP would be happy to share information with a relative, for example when they took the care home resident to an appointment, treating them as an advocate, and such information-sharing was appreciated by relatives. [24]

Residential/nursing home staff, patients and their families/carers should be aware that they can raise concerns with the visiting clinician at the weekly visit and a mechanism should be in place to ensure the visiting clinician is made aware of any new problems. An agreed standard and system for referral should be documented and available to all.

Accurate, up-to-date recording

Care home managers should ensure that accurate, up-to-date, consistent records are kept on medical conditions, health care and medications. Residents who wish to have access to their health records have a right in law to do so, with assistance if their capacity requires it, and may wish to make their own entries in the record.

'The GP lists changes to medication on a professional log, and fills it in each time she visits. Then we issue prescriptions and then we would transfer them to service user administration records, and update the process. If she comes with the computer she can generate the prescription right after her visit – sent straight to the home. She has her own laptop and all the information is on there. It is pretty good.'

Care home manager [24]

Person-focused record-keeping

Although the NHS publication 'Benchmarks for record keeping' [39] was developed to apply to NHS records, its person-focused approach and main principles are equally applicable to record-keeping in care home settings. In pursuit of the overall outcome that 'People benefit from records that promote communication and high quality care', three of the principles are:

- people are able to access their care records in a format that meets their needs
- people's care records demonstrate that their care follows evidence-based guidance
- people's care records are safeguarded and their confidentiality is respected.

Record-keeping problems

Problems with record-keeping and sharing information reported by research participants, which can be associated with medication errors and other harm, include:

- hospital input (e.g. outpatient and discharge letters; changed medication) not recorded in care home or GP records, or inconsistent with such records) [24, 40]
- residents' records not available to GPs, hospital doctors or out of hours doctors when they visit care homes
- a lack of prescribing technology in care homes, meaning GPs have to return to the surgery to prescribe [24]
- residents entering hospital without an accurate record of their medications and preferences, such as their care plan. [22]

Quality improvement in record-keeping

Relatives in another study [22] suggested that homes should have a protocol for making sure residents never enter hospital without an accurate record of medications and care preferences, in line with any mandatory regulation. Managers in the SCIE Practice Survey, 2013 said they found that some professionals did not take the time to read basic information provided. There also needs to be a handover of resident information if a resident changes GP on entering a home.

Practice suggests that care homes should:

- keep records securely, while making them accessible to individual residents
- make sure that records are clear, complete, well written, up to date and consistent, with good visibility of key care plans, do not attempt resuscitation (DNAR) agreements and medication issues
- record hospital input – obtain discharge letters, etc., send on to GP to follow-up with post-diagnosis support and ongoing treatment/care
- make records available to hospital and out of hours doctors when they visit care homes, especially if the resident has recently moved into the home, has changed GP or been discharged from hospital

- investigate with GPs whether prescribing technology (e.g. mobile prescription tools – 'pods' – laptops and printers) could be provided for use in the care home, so that GPs do not have to return to the surgery to prescribe
- ensure that residents enter hospital with their care and medical plans, which should include their medications and preferences.

Participants in the SCIE Practice Survey, 2013 said that in some homes, GPs and nurses (including CPNs) regularly wrote medical information in the residents' notes or care plan. One participant described how, in her home, the GP made weekly visits and made notes of any consultation on a record system the home's nurses could access.

Other participants said they had learned to fax requests to GPs for referrals for secondary services, so as to have a paper trail if referral did not take place or was unduly delayed.

Internal and external information-sharing

It is recognised that some of the issues concerning external information-sharing, including with GPs and relatives, relate to the culture and behaviours of professionals in other agencies. However, accurate, up-to-date recording of information, and ensuring that the resident carries with them key significant information relating to their conditions and medications, are the responsibility of the care home and its manager.

Managers are best able to decide the most appropriate ways of sharing and updating information with staff. Care staff spend the majority of their time with residents and their observations, coupled with knowledge about a person's health needs and any resulting plan, are important. It is recommended that information about medical care, and medication in general, is made available, together with information about a resident's needs as they affect the person's health. This should be supported by training, supervision and role clarity.

Development of a medicines strategy

Care homes should work with their GPs and pharmacists to develop a strategy for medicine management, including regular (e.g. six-monthly) medication reviews conducted by GPs and/or pharmacists. Managers should consider with GP practices how to address medication issues in order to reduce high levels of serious prescribing error, and have a plan to obtain medication out of hours through liaison with GPs and pharmacies.

The home manager's role in developing a medicines strategy

The care home manager can take a lead role in identifying the health care needs of residents, and discussing preferences with residents and/or family members and GPs. [26] The manager acts as an advocate for residents and takes a leadership role in relation to medical plans.

Various studies [16, 22, 26] and one report [12] note the importance of leadership or 'persistence' from the care home manager and other care home staff in their

relationship with GPs and other health professionals in the multidisciplinary context, and in supporting health care regimes and decisions made by health care professionals.

In two examples, a care home manager prepared medication forms for each resident at her own initiative, to be used in joint medication reviews involving the GP and community pharmacist. [26] The SCIE Practice Survey [46] carries an example of a care home that had been involved in designing the pre-admission assessment form, 'so it had the information we need to provide proper care'.

Relatives and carers in one study [22] suggested that care home managers and staff should take the role of 'medication champions' in the context of managing medication and reducing prescribing and dispensing errors in care homes. In homes having a key worker for each resident, the key worker can be formerly responsible for medication issues and for updating family and carers about any changes.

Two major studies found that about 40 per cent of residents had a prescribing error, linked to harm in some cases, compared to 11 per cent having a monitoring error, 22 per cent having an administration error and 37 per cent having a dispensing error. The prescribing errors were 'incomplete information' in 38 per cent of cases, 'unnecessary drug' (24 per cent of cases), 'dose/ strength error' (15 per cent) and 'omission' (12 per cent). [40, 41]

Practice examples

In one GP practice, [26] the care home manager, staff and GP decided that the staff, rather than the GP, were best placed to facilitate decisions about health care and end of life care for residents. One care home manager had a lead role in identifying residents' health care needs, discussing preferences with residents and/or family members, and liaising with health care services.

One study [24] gives an example of GPs, local pharmacies and care homes working together to establish delivery systems to ensure that in cases where GPs cannot prescribe in the care home, medication is received by homes on the day of prescribing without staff having to collect prescriptions and medication.

Medication and broader health reviews

The evidence indicates that the practice of GPs in relation to medication reviews for residents, and broader reviews of their health status, advance care plans and end of life plans, is very variable:

- There are examples in the literature of regular reviews and assessments being part of enhanced service agreements, related to additional payments to GPs, and facilitated by regular GP visits and scheduled surgeries.
- Additionally, individual GPs may regularly assess the health, medical care and treatment of specific residents in response to requests from care home staff on an ad hoc basis, for example in end of life care. [17]
- A study of hospital admissions from care which had a high mortality rate within 24 hours, and were therefore likely to be inappropriate, found the reasons

included a lack of advance care plans and a lack of regular medical reviews by GPs. [32]

- In a recent survey of GPs, [12] 37 per cent did not know whether new residents would have a medical and nursing care plan within one month of admission and 67 per cent did not carry out a medication review on each resident every six months.
- Other studies also report a lack of advance care and medical plans, medication reviews, initial assessments, end of life plans, decisions and regular medical reviews involving or carried out by GPs. [10, 12, 26, 29, 42]
- There can be a lack of GP follow-up visits after hospital discharge.

Reported beneficial outcomes from medication reviews include:

- stopping potentially hazardous drugs [26]
- streamlined medication and prescribing procedures [24]
- adjusting medication [26]
- reduced dosages of antipsychotic drugs [13]
- reduction in medication costs (by over 17 per cent in Thames Valley). [13]

NHS structures and integration arrangements

Care homes should ensure that they and their care staff are familiar with the new NHS structure and integration arrangements, especially in relation to what has been agreed locally. They should know how complaints and challenges are handled. Networking, joining local forums and service development groups could all be seen as part of their advocacy role at a strategic level.

The 2013 NHS reforms

Major changes to NHS structures and responsibilities came into force in April 2013 and will inevitably take time to bed in and work smoothly. The new structures are intended to help health and care agencies to work together in more integrated ways and to ensure people who use services and their relatives are central. The changes include abolition of the former PCTs and strategic health authorities, and transfer of responsibilities for commissioning health services to new bodies. For home managers and provider organisations, the reforms will involve changes in key NHS personnel, a need to build up working relationships with new commissioners and the likelihood of transformation over time in the behaviours of provider bodies.

[Read more about the NHS reforms and the complaints procedure.](#)

Complaints about NHS services

Since April 2009, the NHS has run a simple two-stage complaints process:

- A GP, hospital or trust complaints procedure sets out how to proceed. The first step for a service user would normally be to raise the complaint (in writing or face to face) with the practitioner (e.g. the nurse or doctor concerned), or with their organisation, which will have a complaints manager. Alternatively, the matter can be raised with the relevant commissioning body (e.g. NHS England or a local CCG). Most cases are resolved at this stage.
- If the person is still unhappy, they can refer the matter to the Parliamentary and Health Service Ombudsman, who is independent of the NHS and government.
- Help is available from the Patient Advice and Liaison Service (PALS) based at hospitals, or the

Independent NHS advisory service.

GPs' role in relation to the resident

GP relationships with their patients in care homes

A GP's primary relationship should be with the resident who is their patient rather than with a care home. Working in partnership with the home is, however, essential to providing a good-quality service to residents. Practice suggests that good relationships between GPs and residents are built up through regular contact and respectful, interpersonal communication which builds trust and confidence.

'because really the contract's between you and the patient, not you and the home.'

GP [28]

'I'm 92 you know. Before I came here (to the nursing home) I used to see Dr B. He knew me for 30 years and saw me through all my traumas. He used to phone me up to have a chat and I liked that. When I moved here, I didn't want to drag Dr B. here so I'm registered with the one from here... I'm happy with my medicines. They work. If I wanted to see a GP I could because I've got a mouth and I know how to make myself heard.'

Resident [46]

The concept of the 'assertive patient' emerged from listening to residents taking part in the SCIE Practice Survey. [46] They were clear that they received services they were entitled to if they, or the people advocating on their behalf, were assertive or persistent.

Care home managers and their staff can help residents to be more confident in relating to visiting GPs. Positive relationships between GPs and individual residents and family members (GPs 'getting to know' them) are reported by residents, GPs and care home staff to be associated with positive outcomes. These include residents feeling reassured and listened to, understanding their medical issues and being encouraged to take medication or cooperate with treatment; GPs following residents' wishes for treatment and care; and reductions in hospital admissions. [12, 24]

Fostering good relationships

Views differ among care home managers about how to foster good relationships between GPs and residents. A qualitative evaluation found that an enhanced service scheme and preferred practice arrangement with regular scheduled visits by GPs encouraged positive relationships between GPs and individual residents and family members. [24] However, in the SCIE focus groups and questionnaires, arrangements where some residents continued using their own GP were also reported to lead to good relationships between the GPs, 'their residents' and the care home staff. The manager of one care home in an urban setting felt there were benefits in several GP practices visiting and caring for residents in the home, rather than being dependent on one practice. Another reported that, of the five practices local to the home, two were better to work with than the others. New residents who did not wish to remain with their own GP were encouraged to register with one of the more supportive practices.

Research studies indicate that residents, relatives and care home staff notice and appreciate it when GPs and other professionals are respectful, sensitive, friendly, understanding and kind in their relationships with residents. [22, 24, 29] Conversely, they find it distressing when GPs are dismissive, aloof or disrespectful. [22] GPs' lack of knowledge of individual residents is raised as an issue in studies, and is associated by research participants with outcomes such as inappropriate hospital admission and medication errors.

The GP as point of access to primary and secondary care

GPs should be proactive in offering residents the wide range of diagnostic and therapeutic services in primary care, and full access through referral to acute and specialist hospital-based physical and mental health services. These can all contribute to maintaining each resident's health, wellbeing and independence. GPs should be aware that access to secondary services (e.g. mental health services) may be a problem for older people in care homes.

The GP's role

The Royal College of General Practitioners defines the GP's role as follows:

'GPs assess, diagnose, treat and manage illness. They carry out screening for some cancers and promote general health and wellbeing. GPs act as a patient's advocate, supporting and

representing a patient's best interests to ensure they receive the best and most appropriate health and/or social care. GPs also provide the link to further health services and work closely with other healthcare colleagues to help develop those services.'

The practice team includes other staff, and other professionals may be based in the practice premises. The team can include practice nurses, nurse practitioners, practice managers, health care assistants, physician assistants, receptionists and clerical staff. Pharmacists, occupational therapists, physiotherapists, midwives, district nurses, health visitors and other health professionals may be based in the same building as the GP practice, although they are generally employed by the NHS.

'Excellent, we are lucky to have somebody who is aggressive in the good sense of the word. She (the GP) covers the bases and tells us what we need to do if we need direction, there are rarely gaps.'

Care home manager [24]

Proactive medical care

Home managers and senior staff should be aware of the importance of proactive anticipatory medical care. Many residents have multiple health and care needs on residential admission, and others may experience declining health and capacity as part of the ageing process. Care homes should consider what measures they can put in place to maintain residents' independence and mobility, and prevent or delay deterioration and loss of function. Prompt responses to events like a stroke are known to have a major impact on residents' chance of recovery. Early identification of the onset of dementia can enable residents to access suitable medication, and allow the individual and their family to prepare and make plans for coping with the impact of the condition.

Managing relationships

Care home managers and GPs should agree how to handle relationships, communications and joint working between the home and the practice, to deliver what works best for residents.

'We don't actually have a retained GP here as such, so they would, I mean, there are a couple of surgeries that are quite local so they're sort of like the surgeries probably of choice. But you know what I mean, at the end of the day it would be down to the resident to choose, wherever they wanted to have a GP, wherever they wanted to register.'

Care home manager/owner/matron [28]

'Well, I think if they've known the resident for twenty, thirty years, they should continue that. I don't see any point in changing, because they know them best. They've dealt with all their illnesses for the last X number of years. So, we wouldn't, you know, we wouldn't change, unless we were forced to for some reason.'

Care home manager/owner/matron [28]

Effective working relationships

No single model for relationships and communication between care homes and GPs has received universal endorsement. Practice varies across England and even within a given locality.

A number of different models appear capable of working effectively. As with other aspects of joint and integrated working, structures and systems for improved cooperation will fail without the will to cooperate. If the parties share a commitment to working together, and preferably a shared value base, they can make most structural arrangements work.

Home managers taking part in the SCIE's Practice Survey, 2013 said that, whatever the arrangement was in practice, it should be designed to meet the health care needs of the residents, rather than being chosen primarily to suit the GP or the home. Issues to be considered include GP availability and interest; alignment of practices and homes; continuity, joint protocols and role clarity; and development of shared understanding through, for example, use of end of life frameworks and pathways.

Close, effective working relationships between care homes and GPs are reported by care home staff, GPs and other stakeholders. These are associated with several positive outcomes including:

- better access to services such as regular visits, prescriptions and out of hours contact, greater continuity of care and higher service efficiency
- better partnership working between care homes and GPs
- better end of life care (reported to be more important than the use of end of life tools) [30]
- reducing care homes' isolation and supporting them in their caring responsibilities [17]
- care home staff feeling more confident about their judgement to refer residents to the GP and other health services [12, 31]
- professional advice from GPs to care homes. [24]

Factors aiding or hindering relationships

Enhanced service agreements, preferred practice arrangements, having just a few GP practices per home, regular visits and meetings, and other forms of contact are reported

by residents, relatives, care home staff and GPs to contribute to and sustain positive relationships. However, in the SCIE focus groups and managers' questionnaires, the system of residents using their own GP was also reported by care homes to facilitate good relationships between the GPs, 'their residents' and the care home staff.

Research identifies a number of factors likely to enhance or detract from the quality of relationships between homes and GPs:

- Lead roles and responsibilities. It is important to agree roles and responsibilities. Inappropriate and harmful prescribing is linked by care home staff and relatives in qualitative studies to a lack of clarity around lead responsibilities. Studies suggest a leadership role. For example, a 'medication liaison officer' for GPs, pharmacists, care home staff, nurses and relatives. This person would be responsible for ensuring medication reviews are carried out regularly, would oversee and attend medication reviews and take responsibility for medicines in individual care homes. [22]
- Trust and mutual respect. Several studies report that relationships between care homes and GPs need to be trusting and supportive, and to involve sensitivity, recognition and mutual respect to have the most impact on partnership working and the medical care of residents. At best, in the SCIE survey, this relationship was 'friendly, relaxed and informal while remaining professional'.
- Tackling negative attitudes. Several studies and reports refer to the need for GPs to respect the knowledge of care home staff about individual residents, and their skills and decisions. Some care home staff describe health professionals generally, and GPs specifically, as sometimes patronising, condescending and even 'discriminatory'. Care home managers in the SCIE focus groups spoke about some health professionals being preoccupied with identifying and reporting safeguarding concerns.
- Different professional values and priorities. Communication and understanding may be hampered by different professional values, priorities and working cultures among health service practitioners, including GPs and care home staff. There are also reports of a power imbalance, with health professionals (not only GPs) feeling more powerful, professional and higher in status than care home staff, and expecting to set the agenda and priorities, which can make equal partnership working difficult.

Communication

Several studies and reports mention the importance of effective communication in promoting better joint working between GPs and care homes; reducing hospital admissions; reducing medication errors; and resolving difficulties obtaining medication. Care home staff and GPs say that they value their contact out of hours, using a variety of media (email, fax, mobile phone), as well as having regular meetings.

- Greater clarity. In one study, nursing home staff used collaborative learning groups and action learning sets to look at how they worded requests to GPs, assumptions they were making about the GPs, and ways that they could make

options more explicit when making decisions about end of life care. This approach was effective in building up trust and getting some GPs to collaborate with nursing home staff in using end of life documentation. [18]

- Use of telephone. Studies report how GPs and care homes use the telephone – for example for advice, and for requests for prescriptions, equipment and medical tests, especially where a GP feels they know enough about a particular resident and their medical conditions, and/or trusts the care home staff and has a good relationship with them, and/or has regularly scheduled visits to the home. The telephone may be used by GPs specifically as a strategy to reduce the workload created by face-to-face visits to the home. [12, 24, 26, 28]
- Telephone problems. In some cases (SCIE focus groups and questionnaires), 'over-enthusiastic gatekeeping' by other practice staff could hinder communication between care homes and GPs, and there could be 'lots of waiting on the phone and then not being able to get through to the right person'. One study reports that the telephone replacing visits out of hours may be a factor in increasing hospital admissions. [32] Two studies [9, 28] and the SCIE focus groups report concern by care home staff or relatives about telephone prescribing and consultations.

Practice examples

One care home developed positive working relationships with health practitioners and staff other than the GP, such as the receptionist at the practice, which facilitated quick and effective handling of their calls about a resident. [17]

A scheme in Leicester [12] piloted shared management of care home residents between GP practices and community geriatricians. The pilot involved access for GP practices to comprehensive geriatric assessments, care planning, rapid written feedback and a telephone advisory service. It is reported that, after the first six months, out of hours consultations reduced by 16 per cent, and requests for visits by 37 per cent. Hospital admissions fell by more than 50 per cent. The total cost of hospital admissions fell by 60 per cent.

Role of nursing staff in facilitating joint working

Care homes and primary care providers should recognise and support the role that nurses in care homes and GP practices can play in facilitating communication between homes and GPs. This includes practice nurses undertaking initial assessment visits and nurses in homes raising professional concerns. Nurse practitioners and other senior nursing staff can share up-to-date knowledge and skills with nursing and care staff in homes, and with residents and relatives.

Changing roles of nursing staff

A change has been taking place over a number of years in the relationship between the roles and remits of medical practitioners and nurses. Some professional tasks which were once the preserve of doctors are now shared with designated categories of

nursing staff. Several different types of nurse may now be part of the practice team based with the GP, and in registered nursing homes, nurses will undertake nursing tasks and oversee some aspects of the work of care staff. Care home managers need some understanding of the different nursing roles, and skills in dealing with the more complex links with general practice which are now required.

Registered nurses may occupy a variety of roles, including:

- **Registered nurses** in care homes for older people. They bring to their work two fundamental elements of expertise: [33] caring, empathy, understanding patients as individuals, communication, building therapeutic relationships and working with families; and the use of clinical nursing knowledge, skills, experiences and clinical judgement to support health, identify ill health and ill being, and manage medical aspects of care including medicines and therapies.
- **General practice nurses**, trained to be part of the practice team undertaking a range of general nursing tasks.
- **Advanced nurse practitioners**, often with an advanced nursing qualification, who can make an assessment of people's health care needs, carry out physical examinations, screen people for disease risk factors and early signs of illness, make differential diagnoses, develop an ongoing nursing care plan, order necessary investigations, provide treatment and help people to manage and live with illness.
- **Nurse independent prescribers**, who are experienced nurses specially trained and allowed to prescribe any licensed and unlicensed drugs within their clinical competence. In 2006, they were given full access to the British National Formulary (BNF), putting them on a par with doctors in relation to prescribing capabilities.
- **Community matrons**, who provide expert case management for people with long-term conditions with deteriorating health that may result in declining quality of life or potential hospital admission.

Nurses employed in nursing homes may be the natural staff group to liaise with nurses based in the practice, and with GPs when they consider a matter requires the attention of a medical practitioner. For care home managers without nurses on their staff, the challenge is to establish appropriate working relationships with the various nursing staff based at the practice, some of whom may now be carrying out tasks that would formerly have been undertaken by the GP.

Nurse-led liaison and support services

There are examples in the literature of nurses and nurse-led teams, in particular nurse clinicians, advanced nurse practitioners, Macmillan nurses and community matrons:

- working to mediate the relationship between care homes and GPs, pharmacists and specialist services – for example, operating a 'nurse triage system' to regulate GPs' workload, [28] or taking on a liaison role [34]

- acting as an informal advocate for the care home in their communications with GPs [16]
- taking on some of the work of GPs (e.g. reviews and assessments which may be signed by GPs) [20, 26, 35]
- taking a lead role in individual care homes or local service development, working in partnership with GPs to different degrees – for example: working with other health practitioners to lead intermediate care units [36] or care home support teams; [35] leading on chronic disease management and proactive weekly visits in GP local enhanced service schemes; [13, 34] and implementing end of life frameworks.

Nurse-qualified home managers participating in the SCIE focus groups said that their status as registered nurses meant that GPs listened to them if they said there was clinical need. Their clinical knowledge also helped to make them better advocates.

Participants in the SCIE Practice Survey said that it was often district nurses who provided the main link between homes and GP practices. This could work well, but barriers included varying capacity, availability and quality of district nurses; frequent reorganisations; and district nurses giving higher priority to people in the community.

Research and practice literature stresses the need to ensure the right level of skills if nurses substitute for GPs in medical care. There was no robust evaluation found in the literature that gave evidence on outcomes when nurses partially replace GPs. However, one evaluated model of a care home support service run by a nurse and a pharmacist, with the nurse liaising with GPs, reported resident, family and GP satisfaction, reductions in GP callouts, positive outcomes and cost savings (in a before-after evaluation.) [35]

Workforce development, standards and regulation

Managers and proprietors should ensure that care staff are trained and supported to be aware of and understand the medical and health needs of residents, and respond appropriately. This has implications for leadership and culture in the care home; raising staff awareness of residents' health needs; and provision of training and staff development opportunities. Staff need the confidence, communication skills and knowledge to initiate and handle the relationship with GPs. Nurses in care homes should be offered joint training with their counterparts employed in the NHS, and the opportunity to obtain practice hours in order to validate specific training. GPs and health care professionals can play a valuable role in training and updating staff, and homes can also contribute to the training of doctors and nursing staff.

Leadership and culture

The provision of good residential or nursing home care is a challenging, demanding and highly skilled job. Yet the staff providing that care are generally undervalued, lacking public recognition, subject to poor pay and conditions and denied the training and development opportunities the job requires. Staff turnover rates are high, although the commitment and motivation of the great majority of care staff are beyond question.

In those homes that offer a good quality of life, support and care to residents, despite the obstacles, the leadership offered by the home manager is crucial. Good managers are able to create a culture and ethos in which staff, residents and relatives are supported, nurtured, motivated and able to maximise their potential. They also tend to be skilled at maintaining good relationships with outside professionals, services and local communities, so that the home has roots in its neighbourhood, is open to contact and influence and avoids becoming isolated.

Increasing staff confidence in relating to GPs

Staff need the confidence, communication skills and knowledge to initiate and handle relationships with GPs. Nurses in care homes should be offered joint training with their counterparts employed in the NHS, and the opportunity to obtain practice hours in order to validate specific training. GPs and health care professionals can play a valuable role in training and updating staff, and homes can also contribute to the training of doctors and nursing staff. Relatives in one study [22] thought that more information and support could be provided by health specialists already working with the home, including the community pharmacist and GP.

GPs, nurses and relatives report a low level of confidence, knowledge and skills among care home staff, associated with a lack of access to training. This can affect their interactions with GPs, and GPs' or relatives' perceptions of care home staff, as well as being a barrier to partnership working. This can be exacerbated by high turnover among staff. [1] It has been found that some nurses and other care home workers do not have the confidence, or the knowledge, to influence a GP's decision, and 'go along' with what

has been suggested, even if it is to the detriment of the resident and causes harm (such as a medication error). [12, 18, 22] Two studies [18, 22] report that care staff can be reluctant to contact a doctor, especially if there is a poor working relationship with them, or an apparent lack of interest from the GP in visiting the home, so compromising medical care.

Care staff, who provide most of the personal care and have direct day-to-day contact with residents, require a range of skills and knowledge, but their character, values and personal qualities are also critical. Patience, tolerance, empathy, emotional intelligence, curiosity, ingenuity, imagination, flexibility: these are some of the character traits that enrich relationships between staff and residents, and enhance their quality of life. Skills for Care have a number of resources that help to develop these qualities.

Raising staff awareness and expertise

The essential task of improving staff awareness of key issues and maintaining and increasing their professional expertise can be achieved through

- formal training sessions, off-site or on
- the use by staff groups or individuals of relevant elearning and Social Care TV materials produced by SCIE and other organisations
- formal and informal supervision and team meetings in the home
- making use of clinician visits to the home to arrange instruction and updating sessions for staff on particular topics.

The CQC's review report 'Health care in care homes' [10] found that training in a variety of topic areas was provided in care homes. This was both general and specialist, with some variation in the subject areas covered. When looking specifically at nursing and residential homes, most homes (93 per cent) provided training on dementia, but only half (52 per cent) trained staff about stroke. Staff interviews about training attendance during the past 12 months in a range of areas showed, across all care homes, that medicines was the health care area with the highest attendance (59 per cent of all staff interviewed), while a much smaller proportion (36 per cent) had attended training about continence care.

With experience and support, care staff and shift leaders in homes become skilled at picking up the signs that a resident is becoming unwell, or that there has been a worsening of their physical or mental health.

'Very rarely have we called a GP out and it's not been needed. We do, particularly our permanent people, we do know them, we do recognise changes, although we're not medically trained, so we're very quick on picking up urine infections. (So we) phone up and say, 'Can we send up a urine sample?' and nine times out of ten it is an infection. So we never get refused or have any problems having a GP out.'

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Numerous studies and reports note the importance of health care decisions by care home staff because they are with residents all the time. GPs and staff feel that high levels of confidence and skill, along with appropriate judgements in relation to residents, can facilitate relationships with GPs, and increase GP confidence and trust in care staff's work.

Practice examples

In its 'Care Update' (Issue 2: March 2013), the CQC describes a special study it undertook of care home residents with dementia being admitted to hospital. In more than half (78 out of 151) of PCT areas, such people were admitted with 'avoidable conditions' significantly more than people without dementia. The avoidable conditions include urinary infections, dehydration, pressure ulcers, pneumonia and other lower respiratory tract infections, severe malnutrition and fractures. Reviewing the findings, the Alzheimer's Society commented: 'This could firstly be an issue of training. Many care home staff are not adequately trained to work with people with dementia, yet we know that 80 per cent of care home residents have the condition. Without the right training staff are not equipped to support people with dementia, and so they may deteriorate and need hospital care (for example, if they don't have enough to eat or drink). This could also highlight a lack of integrated care. The right services need to be commissioned to provide treatment for avoidable conditions outside of the hospital environment and support care homes in their work.'

Training and other tools for staff development

In an evaluation of the impact of improving the skills of care home staff in 'new roles', [25] one home thought that 'new role working' had moderately decreased GP workloads. The report discusses whether 'new role' care staff have greater confidence, knowledge and skills, and whether this can benefit the relationship between GPs and staff. One potential downside identified is that if GPs engage less with care home residents as a result of staff taking on 'new roles', ironically staff may end up taking on responsibilities beyond their expertise.

A systematic review [1] concluded that a facilitator for integrated working between care homes and health services would represent an effective 'bottom-up' approach for health care practitioners (not specifically GPs) to train and support all levels of staff.

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Staff in a nursing home considered, in collaborative learning groups and action learning sets, ways they could overcome a lack of partnership working by GPs to implement an end of life pathway. The staff considered how they worded requests to GPs, what assumptions they were making about the GPs, and ways in which they could communicate more explicit options when making decisions about end of life care. The authors of an article written about the study report that this kind of facilitation can make a greater difference than traditional education. [18]

Code of conduct for care staff

The 'Code of conduct for healthcare support workers and adult social care workers in England' [43] is another measure designed to improve practice, performance and sensitivity in response to older and disabled residents. It describes the standards of conduct, behaviour and attitude that the public, people who use health and care services and employers should expect. The care worker is responsible for, and has a duty of care to ensure that his or her conduct does not fall below the standards detailed in the 'Code'. If there are people who do not meet these standards, the 'Code' will help to identify them and their support and training needs. Nothing that they do, or omit to do, should harm the safety and wellbeing of people who use health and care services, and the public.

The seven principal elements of the 'Code'

As a healthcare support worker or adult social care worker in England you must:

1. Be accountable by making sure you can answer for your actions or omissions.
2. Promote and uphold the privacy, dignity, rights, health and wellbeing of people who use health and care services and their carers at all times.
3. Work in collaboration with your colleagues to ensure the delivery of high-quality, safe and compassionate health care, care and support.
4. Communicate in an open and effective way to promote the health, safety and wellbeing of people who use health and care services and their carers.
5. Respect a person's right to confidentiality.
6. Strive to improve the quality of health care, care and support through continuing professional development.
7. Uphold and promote equality, diversity and inclusion.

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Practice examples

- A GP surgery arranged for all their GP trainees to spend time in a care home learning about the care of residents. [46]

A multidisciplinary GP and secondary care team held regular meetings with care home management teams to develop partnership and pursue opportunities for training. [34]

In one enhanced service scheme, audit interviews helped the provider of GP local enhanced services and the nursing home manager to identify improvements made in working practices. [44]

Developing trained, confident care workers

Managers and proprietors should ensure that care staff are trained and supported to be aware of and understand the medical and health needs of residents, and respond appropriately. This has implications for leadership and culture in the care home; raising staff awareness of residents' health needs; and provision of training and staff development opportunities. Staff need the confidence, communication skills and knowledge to initiate and handle the relationship with GPs. Nurses in care homes should be offered joint training with their counterparts employed in the NHS, and the opportunity to obtain practice hours in order to validate specific training. GPs and health care professionals can play a valuable role in training and updating staff, and homes can also contribute to the training of doctors and nursing staff.

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In one enhanced service scheme, audit interviews helped the provider of GP local enhanced services and the nursing home manager to identify improvements made in working practices. [44]

Requirements of the regulator

Managers and owners should be aware, and inform their staff, of the Care Quality Commission's (CQC) requirements on care home providers. This applies in relation to the health care of residents and requirements of NHS England and the CQC on GPs in relation to the care of older people.

CQC's regulatory standards

The CQC is the national body that regulates health and social care services. In adult social care, it registers services, managers and proprietors, conducts inspections, and publishes reports on how well services meet its standards. Some of its standards, such as respect for people's dignity and privacy, are common across different kinds of services, from small home care agencies to teaching hospitals. Others relate to one particular type of service, such as a care home. CQC standards are one benchmark of good practice.

CQC's standards for residents of care and nursing homes are summarised, with examples, below.

1. You should expect to be respected, involved in your care and support, and told what's happening at every stage – for example, you will be involved in discussions about your care, treatment and support. You will get support to help you make decisions and staff will respect your privacy and dignity.
2. You should expect care, treatment and support that meets your needs – for instance, you can expect your care home to meet your needs relating to your cultural background, language, gender, disability, age, sexuality, religion or beliefs.
3. You should expect to be safe – you will be protected from abuse or the risk of abuse and staff will respect your human rights.
4. You should expect to be cared for by staff with the right skills to do their jobs properly – for example, there will always be enough members of staff available to keep you safe and meet your needs.
5. You should expect your care provider to routinely check the quality of their services – for instance, your personal records, including medical records, will be accurate and kept safe and confidential.

Findings from the CQC's 2012 report 'Health care in care homes' [10]

The following were found to promote a culture of putting patients' needs first:

- Staff clearly understood the preferences and needs of their residents.
- Care home providers made sure the ways staff talked to and cared for people were respectful and appropriate.
- Staff saw residents as individuals and supported them to live as independently as possible.

- Care home providers made sure that interactions between staff and residents were just as important as providing practical care needs.
- Homes that recorded people's choices and decisions about their care were more likely to be involving people (91 per cent) than those that had not (41 per cent).
- Additionally, homes that had recorded people's individual food and drink preferences were more likely to be giving people a choice of food and drink (88 per cent) than those that had not (41 per cent).

Homes caring for people with dementia, including those with a dedicated dementia unit, were less likely to respect people's dignity and protect them from abuse. This may be because some of the staff did not have the appropriate skills, knowledge and experience in the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005.

Practice survey

SCIE's Practice survey, 'Older People living in care homes access to and experience of GP services' was carried out between February and May 2013. Three focus groups of care home managers from the voluntary, not for profit and private sector were formed. In addition, there were visits to a number of sites to talk to residents, relatives, managers and care staff.

Summary of key points:

- Care home residents reported that they were happy with the service they received from GPs, feeling that GPs took the time to listen to them and understand the specifics of their situation. Nevertheless, few residents reported regular contact with their GPs.
- The home managers described a wide range of practice in the ways in which older people in care were able to access GP services, and often in the standard of service received. Managers spoke of a postcode lottery, but it is also clear that services can vary widely even within one area.
- Managers of homes that use local enhanced GP services (an arrangement funded by the primary health care trusts) mostly reported that this system was working well, with the closeness between the home and a given practice seen as beneficial. However, there were also arguments put forward for why older people in care should continue with their existing GP, particularly because the GP has a longer-term knowledge of the person and their wider family. Some people noted how upsetting it could be to have to break off a long-standing relationship with a GP on being admitted to a home, and would have liked to keep their existing GP.
- The key factors seen as promoting joint working between care homes and GPs were establishing good communication and building a close working relationship. The majority of home managers reported that they had a good, very good or excellent relationship with the individual GPs they worked with. Regular meetings and reviews with GPs were felt to be important in achieving this, although not all GPs were willing to do this. Care home residents or relatives rarely reported any kind of fixed or regular GP reviews.
- Although home managers emphasised their close relationship with some GPs, this could cause difficulties when that GP was not available. One major problem reported was working with locums or out of hours GP services, where knowledge about individual residents was lacking, often leading to unnecessary hospitalisation.
- There was a wider problem reported by home managers regarding record-keeping and the way information was shared between the home and other

health professionals. It was felt that there could be a greater role for technology in ensuring better practice in this area.

- Home managers reported that district nurse teams often provided the main link between care homes and GP surgeries. This could work well and provide a level of continuity of care, particularly if direct contact with GPs was difficult. Nevertheless, as with GPs, the quality and cooperation of district nurse services could vary widely, causing some difficulties.
- There was a sense among home managers, particularly those within the private sector, that some health service providers saw care home residents as already receiving a level of care within the home, and therefore viewed them as a lower priority compared with those in the wider community. This was particularly the case with mental health services.
- Homes often did not have specific mechanisms in place for collecting the perspectives of residents and their relatives on access to and experience of GP services, although this subject was often covered in broader quality assurance forms and CQC surveys. Residents mostly reported a very positive experience of GP services, although home managers did note that this was a growing cause of complaint for some relatives of residents.
- Managers of homes reported that they would like a clearer protocol or agreed definition, at national or local level, of what services should be on offer from every general practice, and clearer information on how to access these services.

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