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North Bristol Trust Ageing Well Project

NBT Care Home Interface Project (NCHIP)

Research Network Meeting: Palliative Care for Older People

26.09.2023

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Acute Onco-geriatric Liaison Service: Geriatrician with specialist interest in onco-geriatrics providing expert liaison assessment to inpatients with frailty and cancer

NBT Care Home Interface Project (NCHIP): Multidisciplinary Team conducting face to face holistic geriatric assessments of residents in care homes (including Structured Medication Review + Anticipatory Care Planning)

Parkinson's Disease Hub: Rapid access clinic and multidisciplinary team meeting for patients with PD who are deteriorating or at high risk of hospital admission

Elgar Enablement Unit: Experienced dementia matron conducting ACP discussions for patients on EEU (intermediate care) who are most at risk of deterioration/ readmission

Strong links between sub projects enable patients to be referred between teams

Training & education – Frailty Network, Care Home Training, 1:1 shadowing for HCPs

Summary of outcomes (at 1 year)

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Clinical activity:

- Provided specialist proactive care to 1463 patients across BNSSG, including person centred structured medication review
- 676 new/updated anticipatory care plans (ReSPECT forms)
- >300 new decisions to not admit in the event of acute illness

Impact on acute services:

- Reduced ambulance call outs and conveyance to hospital from care homes
- Reduced the risk of harm from inappropriate polypharmacy
- Reduced the number of admissions in rapidly deteriorating people with Parkinson's Disease

Financial implications:

- **Total savings £1,033,016 (yearly projected)**
- Avoided an estimated 171 unplanned admissions, worth £768,764
- Medication review has saved projected £264,252 in drug acquisition costs

Interface improvements:

- Achieved acceptability amongst stakeholders, demonstrated through multisource feedback
- Established a regional frailty network, delivering monthly educational sessions
- Strengthened links between primary, secondary and community services
- Developed an ACP (ReSPECT) competency framework for frailty practitioners
- Advisory input into ICB medicines optimisation/polypharmacy steering group

To date (September 2023): 2078 residents reviewed, 1061 updated ReSPECT forms, 544 new admission avoidance recommendations

NCHIP Care homes sites

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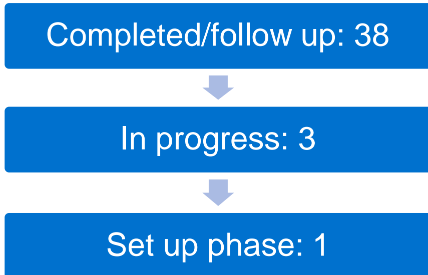
Initial sites identified through:

- NBT admission data/deaths in hospital
- GP self-referral
- CQC

Now targeting homes with high proportion of Pathway 3 beds

Total of 42 care homes across (to date) across 4 Locality Partnerships:

- Bristol Inner City & East
- North & West Bristol
- South Gloucestershire
- South Bristol



ReSPECT competency framework for frailty practitioners

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WHAT?

Valuable Advance Care Planning discussions enable residents and their families to share what’s important to them which guides medical decision making.

WHY?

- Identified possible expansion of scope of practice to increase service provision and distribution of workload
- MDT members of the team who are not doctors also have excellent communication skills and are willing and able to have these discussions but were previously not able to complete ReSPECT forms due to lack of clinical governance structures

HOW?

- Developed assessment framework to evidence competency and ensure highest of quality of patient care maintained
- Consulted national recommendations e.g. Resuscitation Council UK, RCP, GMC
- E-learning module > Case based discussions/Mini-CEX > Consultant Geriatrician sign off
- Competencies assessed include: understanding of TEP, Ethical considerations, physical and psychological influencing factors, complex communication skills

Admission avoidance examples:

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90 year old with vascular dementia
4 admissions in 5 months (seizure, humerus fracture, osteomyelitis, AKI)
Flagged to NCHIP for weight loss / poor intake
Reviewed and discussed with daughter- accepted trial of reducing medications but likely to be nearing end of life
ReSPECT decision – avoid admission if symptoms can be controlled
Passed away comfortably in care home 4 weeks later.

96 year old with severe frailty and dementia, recent admission for TIA.
Deep BCC on arm - considering operation/XRT, weight loss for which CT was booked.
Prognosis last short months shared with family.
Agreed to cancel CT and treatment for BCC, reduce medications, ReSPECT updated for admission avoidance.
Passed away 3 months later in care home.

79 year old with learning difficulties, multiple recent admissions, recurrent falls and reduce oral intake.
Discussion around short prognosis with NOK, decision not to readmit if symptoms controllable.
Advice Line telephone call from Paramedics 2 weeks later who were nervous to palliate in care home due to risk of aspiration, reassured and duty GP issues EOL medications.
Passed away in care home following day with family present.

98 year old referred to PD Hub for frequent falls and orthostatic hypotension. Had 4 inpatient admissions in the year prior to referral, spending 48 days in hospital in total. He was seen 3 days after referral for comprehensive assessment and medication review. No further inpatient admissions or ED attendances 7 months following review.

AKI – Acute Kidney Injury, BCC – Basal Cell Carcinoma, CT – Computed Tomography, EOL – End of Life, GP – General Practitioner, TIA – Transient Ischaemic Attack, NOK – Next of Kin, ReSPECT – Recommended Summary Plan for Emergency Care and Treatment, XRT – Radiotherapy

360° Feedback – Qualitative Content Analysis

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Background:

A care home MDT provided comprehensive geriatric assessment (CGA), structured medication review (SMR) and advance care planning (ACP) to a pilot cohort of frail residents in 17 care homes.

Aim:

To explore the acceptability and perceptions of proactive combined ACP, SMR and CGA.

Methodology:

Data collected using standardised questionnaires between February-September 2022, analysed using qualitative content analysis.

Results:

Four categories emerged from NOK data

Six categories from primary care staff

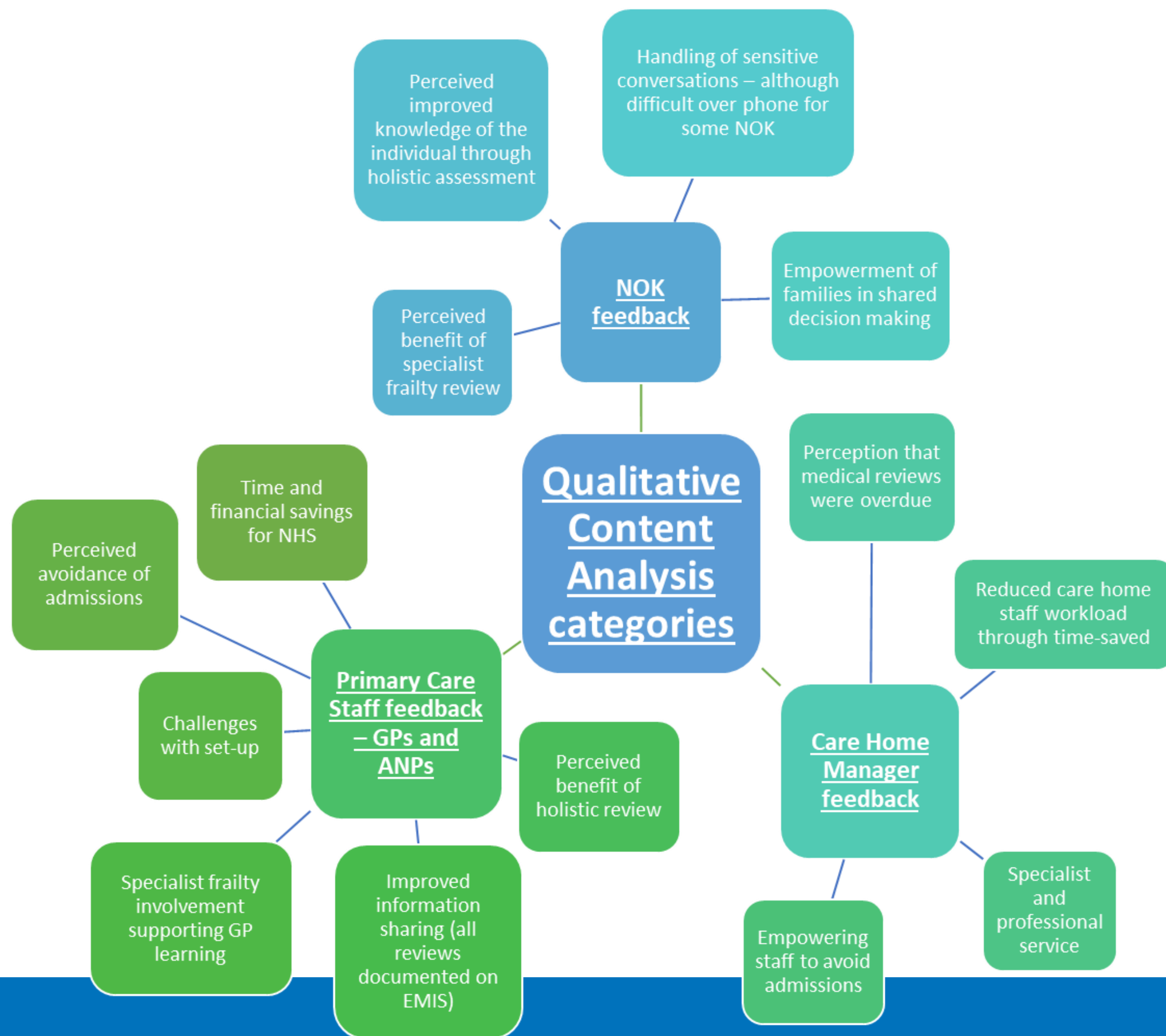
Four categories from care home managers

Conclusions:

1. Key feedback themes regarding the perceived value and acceptability were identified.
2. Stakeholders expressed positive views about the service, suggesting benefits for individual residents, primary and community healthcare staff, and the wider healthcare system.

With thanks to Dr Samantha Harding for methodology guidance and support

Collected using Envoy Messenger Surveys, AccuRx



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Outcomes: NCHIP 360° Feedback

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"When my mum stopped taking some medications, she felt much better" – **NOK**

"It was good to understand how doctors balance therapeutic effects and side effects for her condition" – **NOK**

"Proactive and careful approach allowing review of medications, which probably wouldn't happen otherwise. It felt like they had really taken my father's feelings and opinions into account as much as possible. Also specialist knowledge of issues with medication and the elderly very useful." – **NOK**

"Your team have more confidence and expertise in stopping unnecessary medications. You have been able to spend longer periods of time with the residents and their family to complete advanced care planning. Having clear decision on ReSPECT forms for all the residents has been very useful. Helpful to discuss acutely unwell patients as needed to prevent admission. Incredibly helpful that you have been able to make all the changes on meds and paperwork directly into EMIS" – **GP**

"We cannot stress how grateful we are for the review held here. It was in depth and shed light on a number of issues that are of great importance to our residents individual care plans. The review allowed families to be more involved with the updating of ReSPECT forms which will save uncertainty for families, ourselves and Paramedics at a sensitive time. The review into medication reduced the amount of time spent by ourselves and our residents GP discussing if and when changes were required." – **Care Home Manager**

What now?

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Where is the biggest unmet need?

Pathway 3 residents
Care homes with understaffed GP practice

What is the most efficient way of working?

Minimising travel time
Being available for advice
Tailoring ongoing follow up according to need

Can we spread the approach more widely?

Expand training & education
- Frailty network
- Care home training

Where do we have the biggest impact?

Multifactorial!
- **Care homes/GPs in distress**
- High admission rates
- High resident turnover
- Malnutrition indicator for need?

What is needed to expand the service more equitably across the ICB?

More clinical hours – expanding MDT
Strengthened links between services e.g. DWS/UHBW/Sirona/OneCare Weston
Improved information sharing e.g. access to local IT systems
Further evaluation of impact *(…it all takes time and expertise!)*
Collaboration with AHSN to validate QOL scoring tool for care home residents (ICE CAP)

Any other ideas?