

GSF in Care Homes
Celebrating Good Practice
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The importance of good clinical care for people in care homes

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Synopsis

- A little about the residents
- And the clinical issues
- Are the usual approaches suitable?
- The principles
- An example
- The absence of a regular proven model
- Some suggestions about what works

Common diagnoses

- Dementia
- Stroke
- Other neurodegenerative conditions, eg PD
- Cardio-respiratory failure

Important common co-morbidities

- Diabetes
- Osteoporosis
- Hypertension

Does this type of description guide clinical practice?

Common clinical challenges

- Pain at rest or on movement
- Disengagement or agitation
- Mouth care
- Eating and drinking difficulties
- Positioning in bed or chair
- Instability and falls
- Continence and skin integrity
- Etc
- Etc

Health status and assessed need on admission to nursing and residential homes

NOTTINGHAM

Follow-up measurements of dependency, cognitive impairment, mood and behavioural disturbance in a cohort of placements for nursing or residential care

Measure	Score	Nursing home (n=73)	Residential home (n=132)	Significance
Bathel activities of daily living	High dependency (0-4)	25 (34.2%)	22 (16.7%)	$\chi^2=24.68$, df=3, $P<0.001$
	Medium dependency (5-8)	21 (28.8%)	16 (12.1%)	
	Low/medium dependency (9-12)	10 (13.7%)	21 (15.9%)	
	Low dependency (13-20)	17 (23.3%)	73 (55.3%)	
Mini-Mental State Examination (MMSE)	0-9 (More impaired)	18 (45.0%)	24 (23.1%)	$\chi^2=6.92$, df=2, $P<0.05$
	10-19	10 (25.0%)	41 (39.4%)	
	20-30 (Less impaired)	12 (30.0%)	39 (37.5%)	
Geriatric Depression Scale	Not depressed (0-4)	18 (62.1%)	54 (61.4%)	$\chi^2=0.005$, df=1, $P=0.946$
	Depressed (5-20)	11 (37.9%)	34 (38.6%)	
Neuro-Psychiatric Inventory (NPI)	1-5 (Less severity)	33 (49.3%)	52 (47.3%)	$\chi^2=1.01$, df=4, $P=0.908$
	6-10	13 (19.4%)	26 (23.2%)	
	11-15	15 (22.4%)	20 (18.2%)	
	16-20	4 (6.0%)	7 (6.4%)	
	21-36 (More severity)	2 (3.0%)	5 (4.5%)	

Rothera I, et al *Age Ageing* 2003;32:303-9

Increases in need and dependency
(on follow-up assessments of residents)

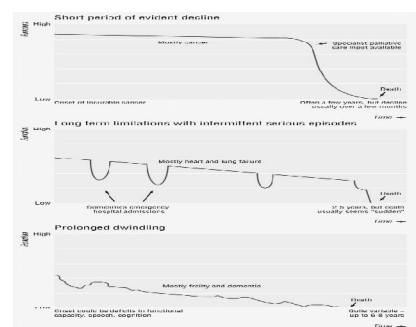
Care type	Nursing	Residential	Significance
Continence assessment			
	Higher needs 18 (21.7%)	58 (69.9%)	$\chi^2=7.29$, $P=0.01$
	Lower needs 5 (6.0%)	2 (2.4%)	
Orientation assessment			
	Higher dependency 5 (11.4%)	29 (65.9%)	$\chi^2=5.48$, $P=0.02$
	Lower dependency 5 (11.4%)	5 (11.4%)	

Rothera I, et al *Age Ageing* 2003;32:303-9

Residents differ

- Median survival is short, ~ a year or so,
 - some are clearly at EoL and may need predominantly palliative care,
 - but large minority stabilise and may live years
- Aspirations and support needs are different
- Success needs establishing realistic individual healthcare goals, and these are in context of overall goals and stage of life
 - Balance of palliative and other approaches

Trajectories towards death



Does clinical evidence help?

- NICE guidance on long term conditions:
 - Not derived from research with care home residents
 - Relative benefits differ with frailty etc
 - Absolute benefits differ with attributable risks associated in an individual with multiple co-morbidities
- Guidelines do not integrate co-morbidities
- Symptom orientated care combining multidisciplinary inputs is often more relevant but difficult to find

Do usual clinical approaches work?

- Will the patient set the pace?
- Is "demand led" response suitable?
- Who will notice and report symptoms?
- Interventions usually involve others as well as the patient, ie a resident in the context of care
- Are hospital clinics realistic or useful?
- Etc

50% of care homes residents who died in hospital could have been cared for elsewhere (National Audit Office Balance of Care, Nov 08,)

What are treatment objectives?

- Curative
- Disease modifying but not curative
- Symptomatic and palliative
- Watch and wait
- A combination of these

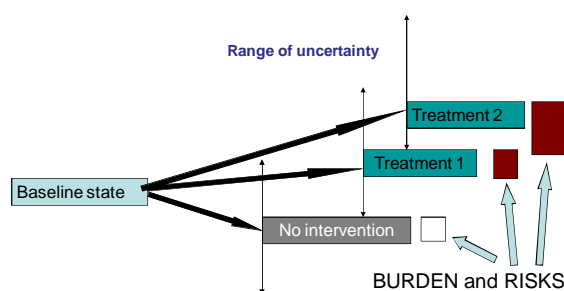
Ethics of clinical practice decisions

- **Beneficence** - the doctor's duty to the individual patient to relieve suffering, restore health (if possible) and preserve life.
- **Avoid harm** through healthcare actions
- **Promotion of autonomy** - uphold the individual's rights to act according to personal opinions and values
 - but NOT at expense of other's rights
- **Equity** - doctor's duty to act without prejudice, + in the public interest for fair use of resources

The doctor's responsibility is

- To judge the likely outcomes of various courses of action, including the treatments on offer.
 - What is likely happen without medical treatment?
 - How will the treatment affect the patient's symptoms, health and life span?
 - What are the likely risks and side effects of treatment?
 - How much burden will the treatment produce - disruption to normal life or discomfort

PREDICTING OUTCOMES



The patient's responsibility

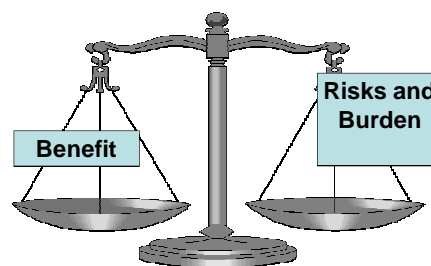
- is to decide what outcomes are worthwhile
- how much burden they are willing to experience to achieve these outcomes

Their judgement will be affected by

- personal preference
- previous experience
- cultural beliefs about normality
- religious beliefs about duty etc (God)

At different stages of life, individuals place different value on the potential outcomes

Does the patient think the treatment is worthwhile?



Informed decision means they can balance these factors in their decision about treatment options or no treatment

Getting informed consent may be difficult

- Poor information from the doctor or others
- the patient cannot communicate – (dysphasia or delirium or dementia)
- Other factors that could be changed – hearing, different language, noisy room etc
- The patient is under duress from others
- Capacity may be in doubt: uncertainty about capacity is acceptable in proportion to the decision at hand

Deciding “overall best interests”

- The clinician has evaluated the potential outcomes with and without various treatments -
- “How might the patient view these alternatives?”, taking personal and cultural factors into account
- Potential sources of information
 - **Advance statements or decisions**
 - clinical case notes
 - family or friends close to the patient
 - other members of the healthcare team

Our advanced clinical decision approach

- At a 28 bed NHS nursing home in London

1. Discussion...Thinking ahead

1. At this time in your life what is it that makes you happy?
2. What elements of care are important to you and what would you like to happen in future?
3. Is there anything you that you worry about?
4. What would you **NOT** want to happen?
5. Do you have a **Living Will** or **Legal Advance Decision** document? (*Mental Capacity Act 2007 enables people to make decisions that will be useful if at some future stage they can no longer express their views*)
Who has a copy?

Support for future clinical decisions

1. predictable likely event, eg aspiration pneumonia
2. predictable likely event, eg.....
3. non-life-threatening unexpected event, eg.....
4. life-threatening unexpected event, eg. GI bleed

A - comport measures only, with transfer to hospital only if necessary to achieve this

B - treatment in care home

C - transfer to hospital if better but no escalation

D - transfer to hospital if better and escalation

An example – a care home resident with weight loss which seem to be due to eating and drinking difficulties

An example – a care home resident with weight loss which seem to be due to eating and drinking difficulties

Lets assume she has significant cognition problems as that is common

Will nutritional intervention help the patient with dementia?

- What is the mechanism of the feeding difficulty?
– At which stage of the process is the problem?

Pre-oral stage factors

- Mood
- Appetite
- Cognition
- Help available
- Context
- Food quality
- etc

Are the patient's difficulties due to dementia?

End stage dementia is unlikely unless....

- Severe cognitive impairment (eg MMSE < 10/30)
- Failure to recognise close relatives or carers.
- Absence of intelligible or coherent communication.
- High level of dependency for basic ADL.
- Incontinence of bladder and bowel function without any apparent awareness.
- Lost basic psychomotor skills, writing, walking.

Will nutritional intervention help the patient with advanced dementia?

- What is the patient's nutrition + hydration state?
- What is the overall health and co-morbidities?
- **Likely future trajectory, with and without optimising nutritional and hydration**
- Can simple measures solve the problem?
- **What are the risks and burden to this patient?**
- Can nutritional and fluid requirements be met by oral feeding, including with assistance?
- **What would be the potential benefits?**

What does research tells us

Objectives

- Satisfaction with eating and drinking
 - enjoyment
 - a sense of normality
 - social interaction
- maintaining nutritional health and hydration
- avoidance of distress during eating and drinking.

no good evidence for any of these objectives
no evidence for longer survival in late dementia
NG and PEG do not prevent aspiration

Emotional considerations

- Eating and drinking are cultural + social events
- There may be benefits for carers - giving food and water may represent love and concern
- "Overall benefit" includes emotional as well as physical or nutritional impact of the procedure.
- Therefore - decisions about ANH can be controversial and difficult
- Decision making needs clarity about process

Do current service models enable this pro-active approach

- Mostly – haphazard, many GPs with few residents, no coordinated specialist support
- Most care homes find this unsatisfactory
- Elsewhere – plenty of initiatives with average lifespan of 7 years, and provider led rather than commissioning led

Examples of service models in UK

- Enhanced primary care
- Dedicated primary care
- Specialist support teams
- Integrated primary-secondary care

Care Homes Support team in South London boroughs (pop 0.9 million)

- 2 specialist nurses per 500 residents
- Mental health specialist nurse
- Old age psychiatrist
- Sessional geriatricians from local trust
- Pharmacist from community service
- GPs now on LES

Nurse reviews prompt others activities + training

GPs may refer direct

Infrastructure for GSF etc,

The future?

- Need for adapted interpretation of current clinical knowledge
- New evidence
- Consistent models of care eg to enable advanced clinical planning and GSF etc
- Commissioners will need to commit

Reserve slides on service models

Dedicated primary care - Durham

- Provides primary medical care to 200 patients in 14 care homes, two IC units and a hospice.
- A nurse practitioner, community matron, part-time GP specialist in geriatrics and additional GP sessions.
- Weekly visits pro-active in style.
- Quality & Outcome Framework modified
 - less relevant issues (e.g. statins) replaced with falls, osteoporosis, EoL planning
- Training - reduced reliance on community nurses

Nursing Home Medical Practice in Glasgow

- 2003 - dedicated service, combination of salaried doctors and 12 contracted practices
- 2,700 residents in 61 homes—85% of homes in the city.
- Now includes liaison nurses, pharmacists and a small multidisciplinary team.
- Twice weekly medical visits and out-of-hours cover.

Leeds: LES + sessional geriatrician

- LES with local GPs
- Weekly visits, anticipatory care, regular reviews.
- For some homes, additional support from community matrons and a community geriatrician, visiting complex cases every 6 weeks.
- Initial 63% reduction in emergency admissions
- Management plans for complex patients after hospital admissions

Integrated primary and secondary – Manchester 2005

- Adv. nurse practitioner, GP, consultant sessions
- routine reviews of all residents
- anticipatory care focussed on the management of sepsis, hydration and nutrition
- Advance clinical plans
- Liverpool Care Pathway is embedded in practice
- Networks to other community services
- Significant improvements in outcome
 - 35% drop in emergency hospital admissions

Integrated Care for Care Home Residents in Sheffield

- All residents in a home with a single GP practice
- Weekly surgery in the home and reviews
- Annual medical review with resident and family, identifying healthcare objectives
- Summary care plan shared with the care home staff and GP out of hours service, kept in the home for other visiting professionals