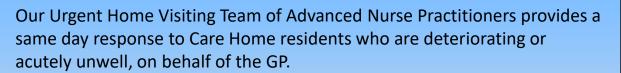
Dundee Urgent Home Visiting Team

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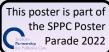


The Team supports care home staff to identify people approaching end of life, supporting symptom management and end of life care.

We work closely with multi-disciplinary colleagues to support residents, their relatives and care staff to prepare for, and deal effectively with, approaching end of life.







Challenge and Approach

The Situation

- Changes to the Local Enhanced Service Agreement meant that each of the 20 care homes in Dundee may be served by up to 10 different GP practices
- This resulted in multiple GPs visiting a single care home on any given day GPs were struggling to meet the demand
- Care Home residents with advancing dementia, frailty syndromes and Parkinson's disease can have a very slow journey to end of life, they often require multiple visits to support their symptom management as their health declines

What We Did:

- To help patients and care homes become familiar with the new arrangement, the Advanced Nurse Practitioner (ANP) made routine visits to care homes on agreed days
- We set up a single point of contact for all care homes from Mon to Fri 9am to 5pm
- Gradually we expanded the ANP team from 1 to 8 ANPs
- We increased the practices from 1 to 14 (58% of practices) & 100% of care homes



+ 1 Care Home

First Test

of Change

1 ANP

1 GP

Practice

Better for Patients, Better for Us

One Patient's Journey

- Patient moved into Nursing Home in December 2020 and registered with new GP practice
- He was reviewed by the GP, and the family agreed to follow-up care being provided by the ANP team.
- Over the next 18 months patient was reviewed by Urgent Home Visiting Team on 17 occasions, without need for GP review of Out of Hours (OOH) calls. ANPs cared for patient throughout his journey including
- recognising Sepsis, and, recognising the challenges of a potential hospital admission, they agreed an Anticipatory Care Plan with family members and care home staff to agree comfort care in the care home
- ANPs supported staff with both nursing care advice and symptom management by amending prescriptions and prescribing Just in Case Medicines at the appropriate time

What We Learned

- Routine ANP visits worked best with larger care homes
- Visits reduced need for OOH service care home staff waited till morning if ANP was visiting next day
- It is clinically recognised that identifying approaching end of life in people with advanced dementia, frailty symptoms is very difficult. ANPs used evidence-based indicators to identify care home residents who may benefit from a palliative approach to care: weight loss, loss of meaningful conversation, reduced oral



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Results

- Care home staff appreciate the single point of contact and the consistency of having support from one team rather than a large number of GPs
- In 2021 (our first full year) over 20% of visits to care homes were for non-acute care residents nearing the end of life needing a health or medication review due to frailty/cognitive decline.

Feedback, Results, Next Steps

Feedback

- From a GP: I was struck this year by how many patients identified as having cancer or long-term health conditions had been cared for at the end of their lives by your colleagues. Thank you.
- From a Senior Carer: This team is now an integral part to the MDT for staff in care homes to feel supported and valued. Really good therapeutic relationships have been established.
- From a Staff Nurse: Great service!

Future Plans

- Expand to all 24 GP practices using cluster model
- Test of Change to extend service to care at home

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From a Care Home Manager

ANPs work extremely hard... this is an excellent service... enhanced my home through support and care... GPs pass a lot to them

New Test of Change 3 ANPs

4 GP Practices
(1 cluster)

+
All visits to
care homes &

at home

