People living in care homes benefit from proactive multidisciplinary team working

Paul Baughan[1], Gyda Meeten[1], Lynne McMurtie[2]
[1] Dollar Health Centre, NHS Forth Valley, [2]Balhousie Care Group

Abbreviated abstract: People living in care homes often have complex health and social care needs which will benefit from a holistic palliative approach. We engaged with care home staff, family members and healthcare professionals to agree the components of a an 'excellent' anticipatory care plan (ACP). We established multidisciplinary team meetings between the GP practice, care home and specialist services to proactively discuss and consider the care needs of residents. The proportion of 'excellent ACPs' increased by 85% and the number of unscheduled hospital admissions reduced by 76%.

Related publications:

Baker M, Oliver D et al (2016) Integrated care for older people with frailty: innovative approaches in practice. London: Royal College of General Practitioners, British Geriatrics Society

Dollar Health Centre

Paul.Baughan@nhs.scot

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Previous work, challenge, and approach

The health and care needs of people living in older people's care homes are complex. A typical resident is likely to be living with a combination of frailty, disability and cognitive impairment, and will often be in their last year or two of life.

Good care goes beyond physical health, and includes social, psychological and spiritual care needs.

There is evidence that by asking '*What Matters to You?',* within the context of Anticipatory Care Planning, that it is possible to put in place the most appropriate care for an individual when there is a change in their health.

The aim of this study was to examine ways to enhance this proactive thinking ahead approach to care, and to look at how information could be shared more effectively between the various health and care professionals involved in supporting people living in a care home.

Healthcare Improvement Scotland toolkit for Anticipatory Care Planning

Dollar Health Centre

Paul.Baughan@nhs.scot

Techniques and Methods

There were 3 specific change ideas, or interventions that were tested during this project.

The components of both a ‘useful’ and an ‘excellent’ ACP were discussed and agreed with stakeholders.

Better ways to share existing information collected by care home staff and by the GP practice were explored.

1: Anticipatory Care Planning (ACP) template agreed with staff and families

2: Information sharing across health and social care

3: Regular fortnightly multidisciplinary team meetings via ‘TEAMS’

A fortnightly multidisciplinary team (MDT) meeting, lasting 1 hour, took place electronically through ‘TEAMS’ to discuss the care needs of residents. These were often new residents to the care home, those who were becoming more unwell, or those due a medication or other health review. Following discussion, it was agreed who would be the most appropriate person to speak with the resident or their family and to lead on any actions. The relevant electronic ACP held by the care home, and the GP practice’s ‘Key Information Summary’ were updated after each meeting. The outcome of any discussions and actions were then reviewed at the next MDT meeting.

Data were collected on a monthly basis, looking at the quality of ACPs on KIS and the number of unscheduled admissions to hospital. The COVID pandemic temporarily affected the collection of ACP data and was a compounding factor which is likely to have influenced results.

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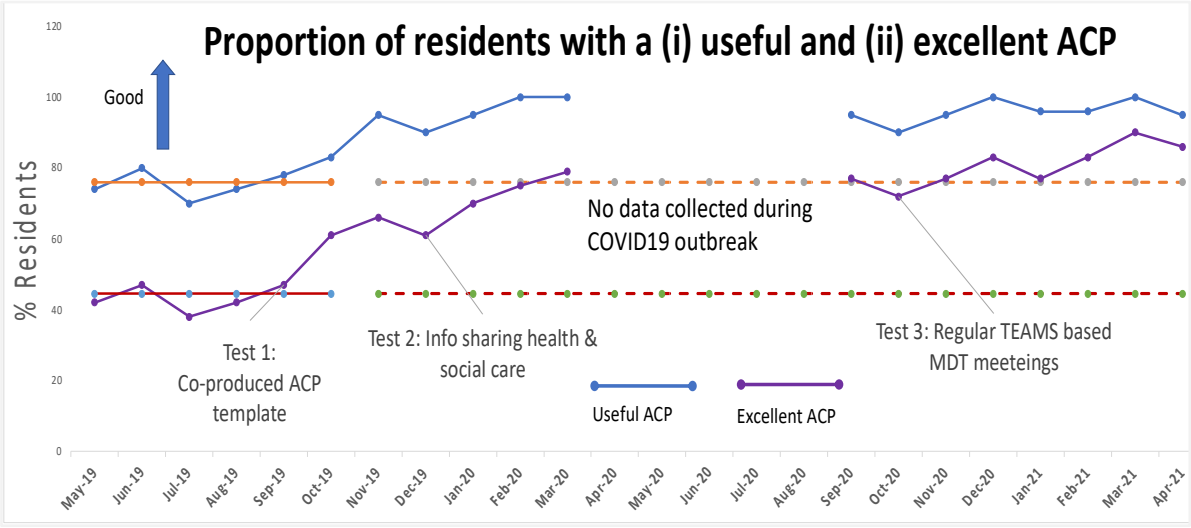
Paul.Baughan@nhs.scot

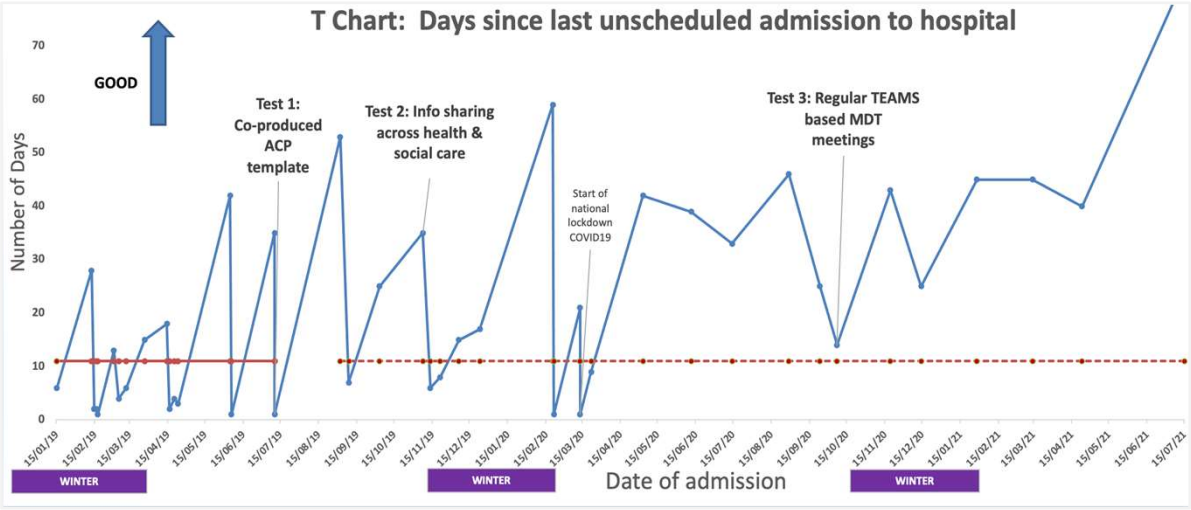
Results and Conclusions

There was an 84% increase in the proportion of ACPs that were assessed as ‘excellent’, and a 76% reduction in unscheduled admissions to hospital during this 2 year study period. This reduction in admissions continued after lockdown restrictions eased, suggesting that it was not all COVID related.

This approach requires health and care professionals to prioritise and invest regular time to review and proactively plan care.

As well as delivering better outcomes for residents, those involved valued the opportunity to connect, review and plan care together through the regular MDT meetings. This promoted a better understanding, mutual respect and closer working relationships between the health and care professionals involved.





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