

# Complex care Team

*working together to support best care for each resident*

an enhanced medical service to care homes supported  
by the Federation of primary care practices in  
Bridgwater and the surrounding area

# Background

Average stay in residential home 4 yrs

Average stay in nursing home 2 yrs

Their journey to the placement has often been difficult and the culmination of deteriorating health with a history of crisis admissions to hospitals.

There will be a change in care needs over time and the focus will inevitably shift from stable monitoring to “end of life”.

Care needs to keep pace with their change to avoid admissions to hospital not in their best interest and the continuation of medication no longer appropriate

National pressure on secondary care beds with a recognition that current admission rates are unsustainable

## What can happen

Recurring admissions to hospital

Accident and emergency / MAU trolley waits

Production line management

(less time to reflect)

Medication regimens changing

Dies in unfamiliar surroundings with unfamiliar carers

## What we would ideally like to happen

Identification, assessment and planning ahead; keeping pace with changing health

Planning for crisis times

Thinking about advanced care planning, preferred priorities of care. What's best and where?

Thinking about expectations and outcomes of admissions to hospital past, present and future

Managing medication to avoid burdensome or inappropriate load

*“living well until you die”*

*“dying in preferred place”*

*“familiar place familiar surroundings”*

~~12-month pilot project for two care homes in Bridgwater over 2010~~  
One GP undertaking weekly ward round reviews

## **Outcomes**

**Around 30% reduction in admissions from the care homes to secondary care ward**

**Increased percentage dying at the care home vs hospital**

**Increased percentage of residents with advanced care planning documentation**

**Increased use of communication to out of hours services to enhance continuity of care and direct out of hours clinicians to supporting “best care in best place”**

**Increased confidence and use of staff in end of life care pathways**

**Improved medicines management, sorting out non compliance issues, sorting out what is no longer helpful for them to continue taking**

## Identify

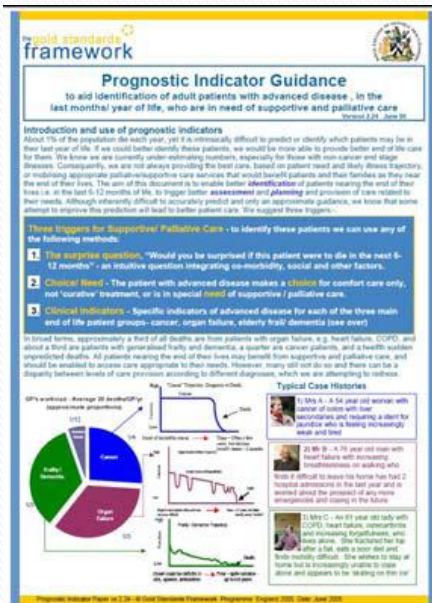
communication

## Assess

communication

## Plan

Prognostic indicator guidance



"would you be surprised if the patient (resident) were to die in the next 6 months"  
Henry et al 2007

Needs Matrix

- A - All residents on admission- years plus
- B - Benefits (DS1500) – months
- C - Continuing care funding – weeks
- D - Last days of life pathway- days

After death analysis audit (ADA). Root cause analysis admissions

What did we do well? What could we have improved on? What would we change in the future?

Advanced care planning / Preferred priorities of care

A process of discussion and documentation to enable residents to have their references and wishes made known to plan for their care in the future.

DNAR status

## The role of the complex care team

*Working together to support best care for each resident*

**Learning** from you to support you to achieve what you know to be the best for your resident

**To support** care and coordination of residents at the **end of their life**

To support the use of the **Gold Standard Framework** for care homes through the systematic use of tools which look to identify assess and plan ahead those deteriorating or entering into the last months of their life

To support the use of **advanced care planning documentation**.

To **communicate** to out of hours services specific directives the individual and or relatives/staff would like known to enhance continuity of care

**Review of medication** to assess each medication continues to be the best suited for that individual where they are at with their health

Put into place step up/**escalation plans and just in case medicines to avoid admissions** to hospital for conditions that could be managed at the care home

## Problems within the role

1. We are consulting on behalf of the resident's own general practitioner  
Some GPs may feel we are imposing upon a history of their individual care  
But we have to come to terms with things being less personal (OOhrs)  
Prescribing and monitoring more complicated  
Expectations higher...a need for systematic approaches rather than adhoc home visiting
2. We cannot directly prescribe ...all medication issues must go via their own GP, this keeps it safe but can be frustrating...hospital clinicians rely on us reading and acting upon their clinic letters etc
3. Care homes may worry about our intentions....to stop all admissions, to save prescribing costs
4. We can find ourselves bogged down with agendas...  
prescribing to keep a resident sedated to stop wandering at night  
changing medication regimens because of a lack of motivation of imagination to help compliance  
changing medication regimens because "it doesn't work" ....dealing with expectations and varying experience of chronic health conditions...eg dry skin (emollients) mood (antidepressants) agitation (benzodiazepines)  
swallowing issues, weight loss, requests for SIP feeds
5. Finding ourselves caught between clinicians and primary and secondary care, not being party to the whole picture
6. Talking about resuscitation..... A misunderstood often rather irrelevant dead end bunny trail to go down but with some skill can be turned to serve a useful purpose

## **My observations.**

There is nothing new about this role

It is just putting together good practice which many have done for many years

BUT.....

When “trust” existed and life was “simpler” the doctor pronounced a plan and this was largely unchallenged.

We are now facing a need to be transparent, collective and sharing in our decision making involving issues of mental capacity and consent.

This process can be time consuming and individuals, their NOK and staff may not want to or feel able to engage with decision making.

How do we balance our clinical judgement vs the drive toward ever inclusiveness?

Making decisions about resuscitation

Making decisions about future hospital admission

Lack of leadership > lack of ownership > lack of management and direction > poor care

Our role provides leadership....sometimes our clinical judgement will override others because the decision has come down to one of clinical outcome.....and we are best positioned to make that call.

## Case studies

1. 99 year old on the dementia unit. Ex heavy smoker. IHD. Lung lesion on CXR , respiratory team feel most likely represents malignancy. Asymptomatic from his chest. Mobilises with frame. Needs assistance with personal care. Able to eat unaided. Family agree not for resuscitation and feel they would like his end of life care to be at the care home. **How do we go about planning to avoid an inappropriate admission for this gentleman? What would we write on the special message form to out of hours to help any attending doctor.**
2. 88 year old dementia with history of Parkinson's. Bed bound, full hoist, double incontinence, no verbalisation, full assistance with feeds, fluids, personal care. Arms and legs fixed in flexion, rigid body. Very difficult to take bloods without distress or needle stick injury, very difficult to take bp  
Medication: Aspirin 75mg, Fludrocortisone 100mcg tds, Levothyroxine 50mcg , Movicol, Lactulose, Modopar 125mg tds  
**How do we manage this gentleman to avoid an inappropriate admission?**  
**Would an admission for him ever be appropriate?**  
**What do we do if his family tell you they want him to be admitted with his chesty cough and fever because the antibiotics are not working.**  
**Would we make any adjustments to his medication?**

## Case studies

3.

94 yr old gentleman residential dementia unit. Diagnosed with TCC bladder dec 2010 after several episodes haematuria during an admission following fractured neck of femur. Follow up cystoscopy planned. Daily haematuria, happily confused, mobilising with frame, eating well, always pleased see the doctor.

Hb 5.6 six weeks after discharge mph but is asymptomatic “staff think perhaps a little more tired”. BCH for transfusion. Back at care home on going haematuria. Family undecided re fu cystoscopy and what’s best, urology feel TCC not invasive, superficial on initial cystoscopy so could be amenable to treatment. He remains very well in himself, catheter now in situ to manage incontinence of bleeding. **How do we best manage this chap to avoid an inappropriate admission? What do we communicate to out of hours?**

4. 74 yr old with dementia on nursing unit. Past hx of schizophrenia. Known to psychiatric services many yrs. Independently mobile, self toileting, eats well unassisted. Very little verbal communication. No signif pmhx of health issues. Medication lorazepam 0.5mg nocte, haloperidol 3mg mane, procyclidine 5mg tds. Staff concerned that he wanders the corridor all night, sleeps a lot during day but does wake to eat his meals well. **They request you help his wandering.**

**He develops intermittent frank painless haematuria...how do we manage this?**

## Case studies

5.

88 yr old with dementia. Recently admitted from the community after his wife increasingly struggled to control his bizarre and often aggressive behaviour at home. He has a past hx of AF, MI , High BP, PMR and previous stroke with some slight residual weakness in his right side. He comes in walking with a stick. His initial behaviour is very disturbed with aggressive outbursts, hitting staff, trying to force his way out through the exit door. He is also sexually inappropriate with female staff. His language and behaviour is very distressing to his wife and family. Medication on admission:

Lorazepam 0.5mg bd, Trazadone 150mg nocte, Olanzapine 5mg mane, bisoprolol 5mg, Ramipril 5mg, Prednisolone 5.0mg, Alendronic acid 70mg weekly, Omeprazole 10mg, Aspirin 75mg daily, Lactulose 10mls bd, Furosemide 40mg od, Bendrofluazide 2.5mg , Allpurinol 300mg od, Quinine sulphate 100mg od.

**Would you change any of his medication on admission to help sort out the behaviour?**

4 months later he is very settled on the unit, polite, helpful, happily confused and compliant with all medication. No behavioural issues. **When do we consider altering his psychotropic medication?**

2 yrs later he is very frail, functionally he now requires assistance with all care, feeding and toileting and cannot mobilise without assistance. He is increasingly struggling to manage his tablet load and compliance has become an issue. **How do we rationalise his medication?**



This is about them ....and us  
one day.. to provide the best  
care in the best place towards  
the end of a life





What is your take home message?

How will you change your practice?

What will you pass on to your colleagues?