IMPROVING THE EFFICIENCY AND EFFECTIVENESS OF CARE DELIVERY IN NURSING HOMES

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Every second counts….
Clinicians able to spend more good quality time with patients

Aim

To better utilise Clinician time which was being wasted by multiple trips to the same care home within the same week and also time consumed on arrival by poor organisation and communication about the patients needs and the GP arrival.

To improve Continuity of care for patients and improve the quality of outcomes by addressing whole patient needs rather than only immediate needs

To better support Care home teams who were struggling with growing regulatory demands, high staff turnover and the need to deal with multiple clinicians

Why is this important to service users and carers?

Staff in the care homes told us that the service was:

no consistency sporadic
communication issues
not brilliant hit and miss
difficult to get hold of GPs
quick to respond to emergencies
but difficult to deal with other stuff
no continuity no relationship

Clinicians delivering the service told us

Time is wasted on multiple visits
Often bump into another GP when I am there
Takes a while to get access to patients – frustrating
Only get to deal with the most pressing need

Key steps and changes

A-TEAM approach was used

A (Agree on requirement)
- Identify Nursing homes suitable for weekly ward round

T (Test commitment)
- Establish relationship with managers
- Agree with locality how to make long term change

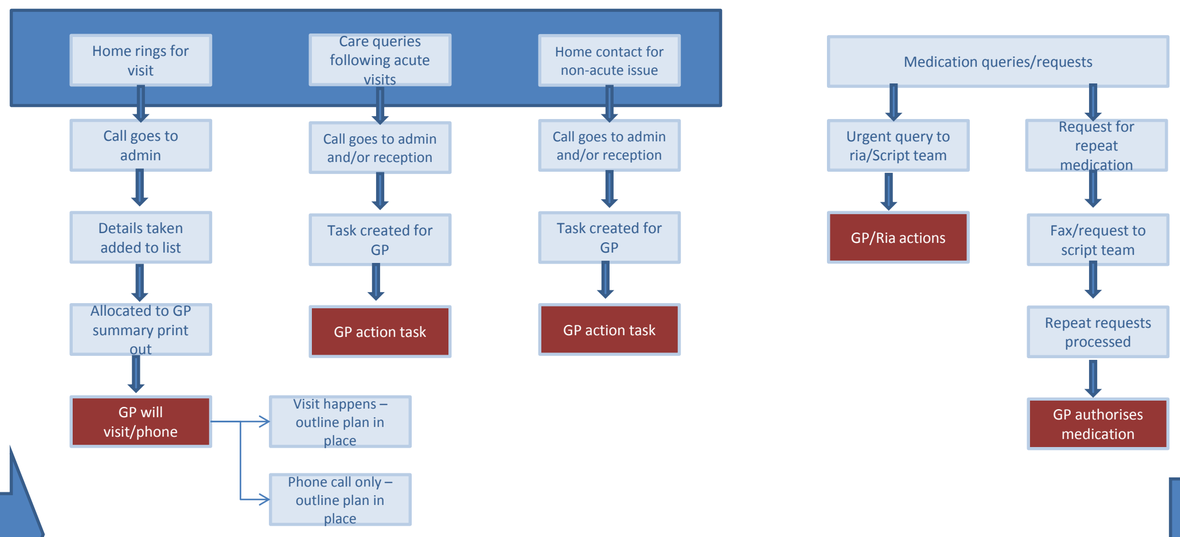
E (Establishing the baseline)
- Identify other teams involved in nursing homes
- Agree protocol for ward round

A Analysing the problems
- Access to reliable mobile record is key

M Measuring success
- Number of contacts
- Time saved
- Staff feedback
- Quality of care

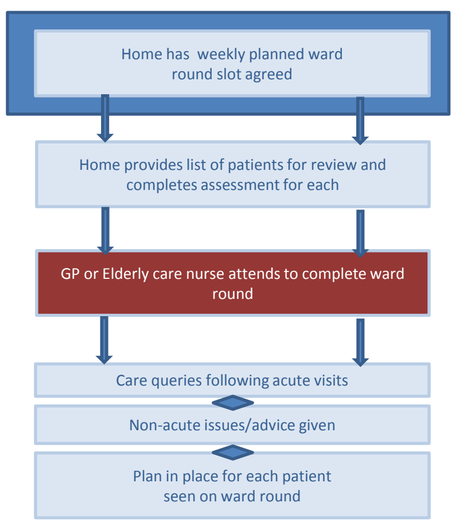
Process Maps

Process Map: Care home requests: **Before**

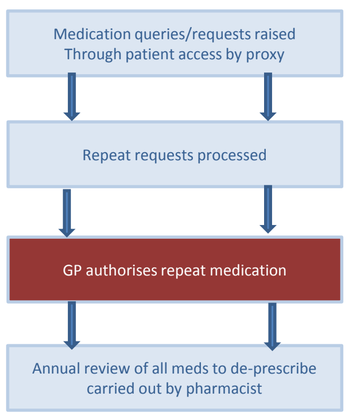


Process Map: Care home requests: **After**

Phase 1 - complete

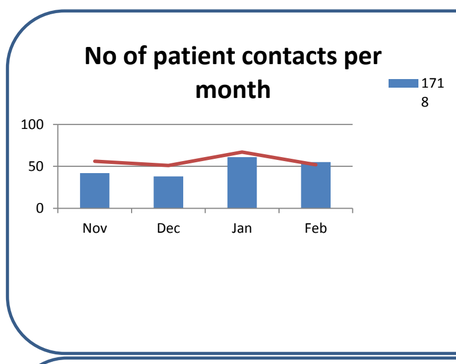


Phase 2 – 2019 Q2&3

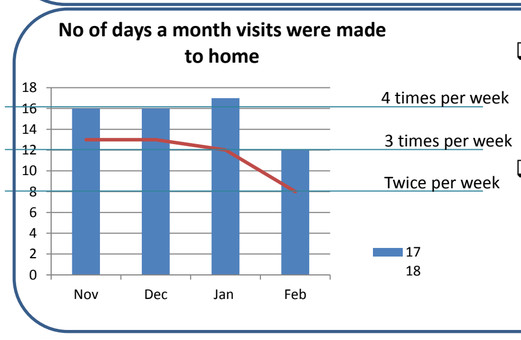


Data

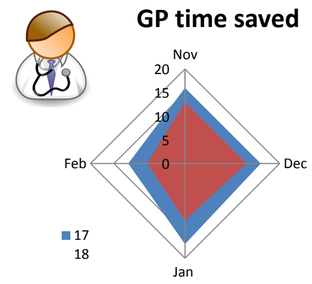
Work was undertaken in Autumn 2018 and delivered through the winter months on 2018/19



- Initially higher as we were offering enhanced proactive care model and comparing against just acute visits previous year
- By end of pilot number of contacts less than last year yet quality and depth of service far greater



- In base year we were visiting the home 4 times a week for 3 out of 4 months
- By end of pilot we were only visiting twice a week – ward round day plus one other for an acute problem that could not wait



- The red area represents GP travel time no longer required from being better organised
- In the pilot (1 home) this saved and avg of 1.3 hours per month (sounds small but…)
- For 46 homes in Fareham it equates to 60 GP hours a month

Helped the staff learn what is acute and what is chronic

Minimises number of separate phone calls to surgery

Reduced the number of emergency visits

Planned set day so can plan for this
Helpful to have structured approach

Easier for palliative reviews

Can plan in chronic issues

Face to face time is more efficient

CASE STUDY

Active issues :
Parkinsons, Hypotension, HB drop

Conversation with PD Consultant agreeing reached end stage PD and not for further OPA, agreed one blood transfusion to trial benefit as day case at Gosport, open access to advice
No investigation of cause of HB - conversation with patient, family and care home staff
Regular reviews to ensure symptoms controlled and HB monitoring
Avoided regular admissions as well documented chronic issues and limits of care
Future planning reinforced
Regular contact with NOK
Died peacefully at residential home which was PPC and PPD
Required consistent care to carry out patients wishes, avoidance of multiple admissions and support staff in admission avoidance

Learning and what next?

Learning:

1. There is a long term role for clinical pharmacists in Nursing home care
2. Continuity removes anxiety from Nursing home staff reducing their reliance on the GP
3. The culture of Nursing homes is a key factor
4. Getting the baseline data and choosing the key indicators is important

Future improvement activities:

1. More efficient and auditable medication ordering
2. There may be a place for skype consultation in the future model
3. Continuity and efficiency can be improved through regular virtual/telephone clinics in between ward rounds
4. Find clinical staff who are passionate about Frailty