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Delivering Quality Medical Care in Irish Nursing Homes

Current Practice, Issues and Challenges

A Discussion Document

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The Discussion Document was developed using a qualitative research approach based on a short review of selected literature and consultation with the key stakeholders. The latter was conducted on the basis of confidentiality and anonymity, and, therefore, points and statements in the Document are not attributed to any party but rather expressed in a general way. Care was taken to include all perspectives in the narrative.

This discussion document was prepared for Sage Advocacy by **Dr Michael Browne**.

Acknowledgements

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Key Points

- There is a need for debate about medical care in nursing homes in Ireland so that nursing home residents receive medical care on an equal basis with those in the community.
- The medical care of nursing home residents is widely regarded as presenting a serious challenge on many fronts and there is no agreed 'one-size fits all' model.
- Ireland is by no means unique in facing challenges in delivering high quality medical care to nursing home residents – there is strong evidence internationally that the current approach to delivering GP services in nursing homes is far from optimal.
- The situation in Ireland is compounded by the growing shortage of GPs generally and a basic lack of connectedness between nursing homes and community care services.
- The proportion (around 70%) of residents in aged 80 years and over presents a significant challenge for the delivery of medical care given that many are likely to have complex medical conditions, multi-morbidity and that many will require end-of-life care.
- There is a need to develop a uniform national approach to the provision of medical care in nursing homes so that the current 'lottery' effect related to location, nursing home size, GP availability and whether a nursing home is public or private is eliminated.
- GPs want to provide good quality medical care – there is a need for an honest debate around issues, including resourcing, that impact on their ability to do so.
- There is potential for more collaboration and joint multi-disciplinary training between nursing home staff, GPs, Allied Health Professionals and geriatricians in respect of delivering quality medical care in the nursing home setting.
- There is a need to ensure that the mechanisms in place for meeting regulatory and professional requirements are fully cognisant of the role of GPs therein and that appropriate GMS contractual provision is made.
- There is strong evidence internationally that where there is an effective GP input in the nursing home setting, this reduces hospital admissions and facilitates earlier discharge.
- There is a need for a new GMS contract for GPs which will create the conditions for the delivery of the type of medical care in nursing homes to which GPs, nursing homes and the public aspire to.
- While nursing home staff, GPs, geriatricians, other professionals and relatives frequently provide an advocacy support role for nursing home residents, there is additional role for independent advocates in order to ensure that each resident's will and preferences are met.

Introduction

Focus of Discussion Document

The Discussion Document is aimed at encouraging debate about medical care in nursing homes in Ireland by identifying current practice and highlighting issues as identified by key stakeholders. It describes existing policy, legislative and regulatory provisions and current practice by GPs and locates these, as far as possible, with reflective practices in other comparable jurisdictions. It also describes blockages and challenges identified by key stakeholders and sets out possible options for addressing these. Areas where further research and development would be helpful are also identified.

It is not intended that the Discussion Document would be a definitive statement on the matter but rather a broad narrative on:

- a. Current GP practice in providing the medical care required by nursing home residents
- b. The current and evolving challenges in doing so in a manner that is effective in meeting patients' needs, and
- c. Delivering care of the highest quality possible, and sustainable in the longer-term

It is envisaged that the Document could be used as a basis for ongoing dialogue and policy discourse in order to ensure that nursing home residents get the best possible medical care and on an equal basis with those living in the community.

Why this Discussion Document is important

The health and wellbeing of older people in nursing homes depends on them accessing GP services in a timely way. The provision of timely and high-quality GP services in nursing homes is essential for this expanding population who have substantial and complex health care needs.

There is growing evidence internationally that current methods of delivering GP services to this population are not optimal! The situation in Ireland is compounded by the growing shortage of GPs generally and a basic lack of connectedness between nursing homes and community care services generally,

Methodology

The Discussion Document was developed using the following methodology:

1. A review of selected relevant literature
2. Consultation with a number of GPs who provide medical services to nursing home residents²
3. Consultation with HIQA and the HSE
4. Consultation with Nursing Homes Ireland (NHI) and with Directors of Nursing in four nursing homes (3 private and 1 public)
5. Consultation with the Irish Society of Physicians in Geriatric Medicine
6. A Focus Group with Sage Advocacy personnel providing independent advocacy services to nursing home residents
7. Consideration of a Draft Document and comment by the ICGP Nursing Home Group

Outline of Document

- | | |
|------------|--|
| Section 1: | Background and contextual factors |
| Section 2: | Medical care in nursing homes: selected research findings |
| Section 3: | Medical care in nursing homes in Ireland: views and perspectives of stakeholders |
| Section 4: | Key considerations and discussion points |

Four Appendices are included.

¹ Richard L Reed, Models of general practitioner services in residential aged care facilities, <https://www.racgp.org.au/afp/2015/april/models-of-general-practitioner-services-in-residential-aged-care-facilities/>

² This involved a Focus Group with 8 GPs and individual interviews with 6 GPs.

Section One: Background and Contextual Factors

Relevant factors

In exploring the matter of medical care in nursing homes, the Discussion Document takes the following considerations into account:

- Nursing home residents should evidently retain equal access to the wide range of health services that are essential in order to support and promote their health and well-being.
- Older age-groups typically have more multi-morbidities than the rest of the population and, therefore, their healthcare needs are more demanding.
- Polypharmacy is most common in the older population and medications need to be reviewed and checked regularly by healthcare professionals.
- The relatively high level of frailty and complexity among nursing home residents means that patients require regular health visits.
- Responding to the medical care needs of the increasing number of people with dementia and reduced decision-making capacity presents huge challenges for GPs – this is compounded by the current health system background which includes a shortage of GPs generally.
- Since a quarter of all deaths occur in residential care settings, providing quality palliative and end-of-life care is an essential component of medical care in nursing homes.
- Some nursing home residents may have moved a distance from their original GP which triggers a need for a change of GP – this can present difficulties in some instances.
- While under the GMS, nursing home patients who do not have a GP can be assigned one, a number of GPs across the country are no longer accepting patients.³
- There is some evidence recently of the HSE assigning nursing home patients to GPs, particularly in Dublin and the surrounding counties but some GPs have resisted such moves by the HSE, citing concerns regarding patient safety and workload as grounds to decline assigned patients.
- Difficulties being experienced by the HSE in filling Medical Officer post vacancies have been reported with some posts remaining vacant and some being filled only on a temporary basis.⁴
- The role of Medical Officer post in public nursing homes is not at present well stated or supported within the broader healthcare system in Ireland.
- In order to ensure the continued availability of GPs to provide quality care to residents, some private nursing homes (particularly in the Dublin region) enter into an arrangement with a GP practice for payment of a ‘retainer’ fee. Most nursing homes absorb the cost of these fees, but a minority are passing it on to their residents, presenting another layer of costs for nursing home residents.
- GP visiting rates tend to be higher in nursing homes than in the community and the high workload involved in caring for nursing home patients is not reflected in the current levels of remuneration for GPs.

Best practice considerations

While people residing in nursing homes generally have more complex health care needs than the average older person, their experiences of health care services has been found to be of variable quality.⁵ In particular, the provision of primary

³ See *Sunday Independent*, 25th September 2019

⁴ *Medical Independent*, 22 August 2018.

⁵ <https://www.nuffieldtrust.org.uk/files/2018-04/transforming-care-report-final-web.pdf>

care to nursing homes is too often reactive, with little proactive or anticipatory care and little in the way of continuity.⁶ As a result, residents sometimes have a poor experience, receive sub-optimal medication and have frequent unplanned admissions to hospital.⁷ (This matter is dealt with more fully in Section Two below and in Appendix Four).

Impact of the demographic shift

A significant demographic shift is taking place in Ireland and is likely to continue over the medium to longer-term. This will have significant implications for the funding of health care services generally as well as long-term care. The very old population (i.e., those aged 80 years of age and over) is projected to rise substantially in the coming decades, increasing to some 540,000 by 2051 (from 147,800 in 2016). A 70% increase in demand for home care and an almost doubling in demand for primary care is projected. Compared with 2015, by 2030, 10,000 additional Home Care Packages will be needed; 7.7 million extra home help hours; and 15,600 extra nursing home places (see Appendix 1: ESRI Infographic). An ageing population, coupled with increased prevalence of complex multi-morbidity, increased regulation, and growing public expectations, will present huge challenges in both community-based and residential care settings. Increased demands for palliative care services and for quality end-of-life care present new medical care challenges.

Despite the enormous strides in keeping people healthier for longer, the reality is that there will be a growing number of people who may require some level of additional care for a period of 20 years or more of their lives. Under current health and social care provisions, some 5% of the older population reside in nursing homes, the average length of stay being less just under 2 years.⁸ It has been reported⁹ that older patients discharged from hospital to long-term care in nursing homes live 30 months on average.

While precise up-to-date data for length of stay in nursing homes in other comparable jurisdictions is difficult to find, anecdotal evidence suggests that the duration of stay in Irish nursing homes is higher than in other comparable countries. This difference may be indicative of a stronger community care infrastructure in such countries.

Number of nursing home residents

Census 2016 shows that 22,762 people aged 65 years and older were recorded as living in nursing homes, an increase of 9.4% on the 2011 figure. More than three-quarters (79%) of Nursing Home Support Scheme (NHSS/'Fair Deal') recipients are in private nursing homes compared to 21% in public¹⁰. The age breakdown of NHSS recipients between private and public is outlined in Table 1 below.

Table 1: Percentages of NHSS recipients by age in public and private nursing home

Age profile	Private homes	Public homes
Under 65	5.2%	4.7%
65-69	4.1%	4.2%
70-74	7.1%	8.1%
75-79	12.2%	14.8%
80-84	20.6%	21.1%
85 & Over	50.9%	47.2%

Source: [http://www.budget.gov.ie/Budgets/2019/Documents/Trends%20in%20General%20Medical%20Services%20\(GMS\)%20Scheme.pdf](http://www.budget.gov.ie/Budgets/2019/Documents/Trends%20in%20General%20Medical%20Services%20(GMS)%20Scheme.pdf)

The proportion (around 70%) of residents in private and public nursing homes aged 80 years and over presents a significant challenge for the delivery of quality medical care by GPs given that many are likely to have complex medical conditions. This challenge will become more acute as the projected increase in the older population generally takes effect.

⁶ Robbins I, Gordon A, Dyas J, Logan P and Gladman J (2013) Explaining the barriers to and tensions in delivering effective healthcare in UK care homes: a qualitative study, <https://bmjopen.bmj.com/content/3/7/e003178.full>.

⁷ Smith P, Sherlaw-Johnson C, Ariti C and Bardsley M (2015) *Focus on: hospital admissions from care homes*. The Nuffield Trust and The Health Foundation, https://www.health.org.uk/sites/default/files/QualityWatch_FocusOnHospitalAdmissionsFromCareHomes.pdf

⁸ <https://www.independent.ie/irish-news/health/fewer-older-people-opt-for-nursing-home-care-37534589.html>

⁹ <https://www.irishtimes.com/news/health/nursing-home-survival-rates-half-that-of-those-in-community-1.924583>

¹⁰ <http://www.budget.gov.ie/Budgets/2018/Documents/7.Nursing%20Homes%20Support%20Scheme%20%E2%80%93%20Trends%20and%20Figures.pdf>

Entitlements under the GMS

Under the General Medical Services (GMS) scheme, people with a Medical Card are entitled to free GP services, prescribed drugs and medicines (subject to a charge per item prescribed). A significant percentage of nursing home residents qualify for a Medical Card. In addition to GP services, they are entitled free of charge to community care services, including physiotherapy, occupational therapy, chiropody, speech therapy, dietitians and social workers and medical and surgical aids and appliances(e.g., wheelchairs and walking aids). HIQA has noted¹¹ that in recent years, nursing home providers have reported significant delays and a lack of priority when seeking to access various services on behalf of residents who have a Medical Card. HIQA has concluded that:

Such delays have significant consequences for residents of these centres whose health and wellbeing may deteriorate further if they cannot access the therapy they require in a timely manner. The consequences include diminished independence, such as residents unable to get out of bed because a suitable chair, which they would be entitled to receive, has not been provided.¹²

HIQA has also noted that some providers, in recognition of the regulatory requirement to ensure a resident's healthcare needs are addressed, have secured the services of allied healthcare professionals on a fee-per-session basis which is then often passed on to the resident or his/her family. Residents and families are then faced with the choice of paying for the service privately if they can afford it or seeing their relative's health and/or quality of life deteriorate further.

HIQA makes the important point that nursing home residents should not be in any way disadvantaged by virtue of living in a nursing home and that services that they could have availed of free of charge in the community should equally be available to them on moving to live in a nursing home.

Regulation of medical care in nursing homes

The framework for the regulation of residential services for older people consists of the Health Act 2007 as amended, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, and the National Standards for Residential Care Settings for Older People in Ireland.

Section 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 contains the following requirements:

- (1) *The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.*
- (2) *The person in charge shall, in so far as is reasonably practical, make available to a resident:*
 - (a) *A medical practitioner chosen by or acceptable to that resident, Where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment,*
 - (b) *Where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.*

Current provisions for medical care in nursing homes

Public nursing homes

Medical services for public nursing home residents are contracted to Medical Officers (usually GPs) with continuing contracts to provide services in the public units on a general basis. The standard Medical Officer contract is normally 15 hours per week and has an annual salary of approximately €30,000. The contract provision does not advise on the types of services to be

¹¹ <https://www.hiqa.ie/sites/default/files/2019-08/2018-DCOP-Overview-Report.pdf>

¹² *Ibid.* p. 49.

provided or the number of residents that would be cared for. This can mean a Medical Officer can support anything from 30 residents to 100+ residents (depending on the unit) under the same contract. Traditionally, the out of hours' provision to the unit was the responsibility of the nominated Medical Officer although this has changed somewhat over the past number of years with the introduction of GP out of hours' services.

A HSE Review Group Report (unpublished) made the following observations on current provisions for patient care in public nursing homes:

- The current Contract is not fit for purpose – this contract originated in the 1970s and does not take into account the growing frailty and health needs of the older population in the residential care sector.
- The Contract was put in place prior to HIQA regulation, the latter which includes a number of requirements and expectations around the services to be provided by a Medical Officer/GP supporting a unit.
- The contract provides for a set number of hours regardless of the number of residents in a unit. This can result in the Medical Officer working additional unpaid hours or certain residents being prioritised for attention.
- A large number of Medical Officers have retired or are close to retiring age and the availability of GPs to replace retiring GPs is an issue right across Ireland.
- The moratorium and reduction in funding in recent years has prevented Medical Officer posts being filled as Medical Officers have vacated positions.
- The salary for Medical Officers is not competitive in the context of the earnings that can be realised by a GP in private/ GMS practice,
- The introduction of Out of Hours Services has resulted sometimes in residents being treated by GPs who are not familiar with their medical history which can result in unnecessary hospital admissions. (Medical Officers typically would have built up comprehensive knowledge of the residents through their regular on-site presence).

Private nursing homes

For GPs with patients in private nursing homes, a supplementary payment operates. Reductions to this payment were introduced under the Financial Emergency Measures in the Public Interest Act 2009 (FEMPI). These reductions are now being reversed on a phased basis under a new Agreement between the IMO, the HSE and the Department of Health (see Section 3 below).

Since the introduction of HIQA regulations in 2009, the requirement for inputs from GPs in both public and private units has grown significantly. For example, Standard 3.4.2 of the *National Standards for Residential Care Settings for Older People in Ireland*¹³ requires that medicines management policies and procedures are implemented to manage the safe and appropriate prescribing, supplying, dispensing, administration, monitoring, review, storage, disposal, and medicine reconciliation in order to comply with legislation, and professional regulatory requirements or guidelines/guidance.

The HSE Review Group identified the following issues in respect of GP care in private nursing homes:

- When a person moves to a Nursing Home, the GP may not be able to continue the service due to location, etc. and this then puts a burden on the nursing home to find a new GP for the resident.
- Some private/voluntary nursing homes have set up a system of 'retainer fees' with GP practices in order to ensure that quality medical care is available to residents when required.
- There are issues with consistent and standardised medical record keeping across units.
- While nursing homes are required under regulation to provide an up to date Medication Administrative Record (MAR) for all residents, administrative work relating to completing such records does not form part of the GMS contract at present and is an extra service provided by GPs on a pro bono basis – this is an ongoing issue.

¹³ <https://www.hiqa.ie/sites/default/files/2017-01/National-Standards-for-Older-People.pdf>

- Nursing Homes under HIQA regulations require a three monthly review of residents and their medication. This can again be a challenge for some GPs due to the time requirements involved with completing this paperwork.
 - There can sometimes be an issue with the availability of a GP to attend a nursing home to certify the death of a resident and issues around registration of deaths due to lack of standardisation.
 - Out of hours GP services¹⁴ can be difficult to access by some nursing homes – such out of hours services are sometimes stretched to capacity and are not able to respond in situations where a GP has not been able to attend their nursing home patient.
 - There is a lack of consistency in practice models.
1. The shortage of GPs affecting general practice nationally is having a major impact on the availability of GPs for nursing home residents – vacancies for GMS posts are increasingly becoming a feature of the system, particularly in rural areas.
 2. Ireland has a lower rate of GPs (68 GPs per 100,000 of the population) than the OECD average and compares to 120 per 100,000 of the population in Australia and 110 in Canada.¹⁶
 3. Ireland needs at least 2,500 more GPs within next 7 years to guarantee existing levels of service.¹⁷
 4. Some 36% of GPs are aged over 55 and 20% of GPs who emigrate do not return – an ICGP survey has shown that two-thirds of GP trainees plan to emigrate.¹⁸

Access by nursing home residents to a GP

While, as stated above, nursing home residents are entitled to receive healthcare from a GP, increasingly, access to GPs by nursing home residents is becoming more problematic – this affects some parts of the country more than others. Indeed, the Minister for Health has commented on the “disparity in the level and frequency of GP services provided to nursing homes from one unit to another”. The term ‘crisis’ has been used to describe the current situation relating to getting GPs to take on GMS patients in nursing homes.¹⁵

There are a number of reasons why access to GP care in nursing homes presents difficulties:

5. The GMS contract does not cover the administrative work GPs are being asked to complete in nursing homes.
6. Capitation fees under GMS for patients aged 70 years or more who reside in a private nursing home were significantly reduced in 2010 under FEMPI and are gradually being restored over a 2-year period in return for the implementation of agreed reform and modernisation measures. The fall-out from the significant fees reduction between 2010 and 2019 is likely to take some time to dissipate.
7. The number of GP Practice Nurses in Ireland¹⁹ is relatively far lower than that in similar health systems – this has an impact on the ability of GPs to leave their practice and attend a Nursing Home.

¹⁴ Typically, Out of Hours Services would not have a contract with HSE run facilities for care of patients when the HSE has a Medical Officer in place

¹⁵ Medical Independent, 22 August 2018. <https://www.medicalindependent.ie/accessing-gp-care-in-nursing-homes-a-quiet-crisis/>

¹⁶ https://www.icgp.ie/go/about/policies_statements/2018/8D7F6B73-FC42-4C89-8641FD6409E750B4.html

¹⁷ Ibid.

¹⁸ <https://www.medicalindependent.ie/accessing-gp-care-in-nursing-homes-a-quiet-crisis/>

¹⁹ Currently, there are approximately 2,000 nurses employed in general practice.

GMS capitation rates for people in nursing homes

Up to July 2019, GMS capitation rates²⁰ in respect of people in a private nursing home are as follows:

- ✓ €434.15 per annum for persons aged 70 years > 5 weeks
- ✓ €271.62 per annum for persons aged 70 years < 5 weeks
- ✓ Sessional rate for 3 hours €73.18 (Fee-Per-Item Agreement)²¹
- ✓ Out of hours payment €41.63

The most recent (2019) Terms of Agreement between the Department of Health, the HSE and the IMO regarding GP Contractual Reform and Service Development²² details the gradual reversal of cuts introduced under FEMPI. This will be done over a two- year period and the fee rate increases will be applied in return for the implementation of agreed reform and modernisation measures which have been set out in the Agreement.²³ Since July 2019, GPs who sign up to the Agreement will receive service modernisation and reform fees for each patient on their panel. These will be in addition to the capitation fees set under S.I. 233 of 2016.²⁴ GPs who do not sign up to the Agreement will continue to receive the current capitation rates set out in S.I. 233 of 2016.

There is a marked difference between the level of remuneration that GPs receive from attending nursing home patients and the fees available from attending private patients. The discrepancy between hourly income for attending nursing home patients (estimated currently at €58) compared to €200 for private patients attending at a GP practice has been highlighted.²⁵

GP obligations under GMS contracts

GPs have defined contractual obligations under the GMS scheme which require them to provide all proper and necessary treatment to patients whether residing in the community or in a nursing home. The Irish Medical Organisation has listed a number of areas relating to nursing home patients which are not covered by existing contracts:

- Admission paperwork
- Quarterly assessments
- Kardex writing and sign-off
- Routine medication review
- Chronic care management, including phlebotomy
- Incident and accident report management
- Routine and scheduled care
- Care planning meetings
- Regular meetings with patient families

The lack of contractual provision for these services presents significant challenges for both nursing homes and GPs.

²⁰ These rates will be increased on a gradual basis under the 2019 agreement.

²¹ It would appear that the sessional rate for GPs to attend nursing homes has been withdrawn under the 2019 arrangements

²² <https://www.hse.ie/eng/about/who/gmscontracts/2019agreement/agreement-2019.pdf>

²³ The indicative service modernisation and reform fee rates for 2019 – 2022 are set out in the Agreement. These will be set by the Minister under Section 42 of the Public Service Pay and Pensions Act 2017 each year from 2019 – 2022.

²⁴ <https://www.imo.ie/i-am-a/gp/circulars/S.I-No.233-of-2016.pdf>

²⁵ Dr David McCaffrey, *The Real Cost to GPs of Caring for Nursing Home Patients*, Presentation to ICGP, 2017

Section Two: Meeting the Medical Care Needs of Nursing Home Residents: Key Research Findings

This section summarises a UK evidence review of best practice research followed by a synthesis of a UK practice survey on improving access to and experience of GP services for older people living in care homes. It also provides a synthesis of models of medical care in Australian nursing homes and summarises the findings of a UK Pilot GP in Nursing Homes Project.

Best practice research

Evidence review

An evidence review on partnership working between GPs, care home residents and care homes carried out in the UK²⁶ contains a number of findings relevant in the Irish context.

- Few research studies include residents and relatives as research participants.
- Positive relationships between GPs, residents and family members are associated with positive outcomes:
 - » Residents understanding medical issues and encouraged to take medication
 - » GPs following residents' preferences
 - » Reductions in hospital admissions
- GPs' lack of knowledge of residents tends to be associated by research participants with inappropriate hospital admissions and prescribing errors -- this especially applies to out of hours GPs.
- Reports and studies refer to high GP workloads as a result of work in care homes – the reported reasons include having to travel, being called out inappropriately, and the complexity of residents' health and illnesses, together with increasing concerns regarding increasing regulatory and administrative burden, much of which is not regarded by GPs as being either effective or intrinsically helpful or necessary.
- While several studies note the importance of leadership, persistence and proactivity from both care home managers and GPs in relation to residents' medical care (overseeing treatment for long-term conditions and coordinating care from health practitioners), a lack of advance care plans, medical reviews and medication reviews involving GPs is also reported.
- Both GPs and care staff state that if care staff have high levels of confidence and skills, this can facilitate relationships with GPs, and increase GPs confidence in care staff's work.
- While the literature includes examples of GPs and other health practitioners delivering quality improvement advice or training to care homes, the review found no evaluated examples of explicitly joint training or reflective practice between GPs and nursing homes.
- Several studies and reports refer to the importance of effective communication and information sharing in:
 - » Promoting better joint working between GPs and care homes
 - » Reducing hospital admissions
 - » Reducing medication errors, and
 - » Resolving difficulties obtaining medication

²⁶ <https://www.scie.org.uk/publications/guides/guide52/files/gp-services-evidence-review.pdf>

- Problems with record-keeping and sharing information reported include unclear, incomplete, out-of-date or inconsistent medical records and care home records; residents' records not available to GPs and out-of-hours doctors when they visit care homes and a lack of appropriate technology in care homes.
- Several studies suggest a leadership role for GPs, pharmacists, nurses, relatives or care staff in taking responsibility for medicines use in care homes, including regular medication reviews.
- While the literature describes practice models such as extended service schemes, preferred practice arrangements, multidisciplinary healthcare teams for care homes, and regular GP 'surgeries' in care homes, the review found little robust UK evidence on outcomes from studies comparing these models to usual GP care.
- There are examples of nurses and nurse-led teams mediating the relationship between care homes and GPs; taking on some of the GPs' work; and having a lead medical role in individual care homes or local service development.
- Research and practice literature discuss the need to ensure the right skill level if nurses partially replace GPs in medical care; but there was no robust evaluation found in the UK literature that gives evidence on outcomes.

UK practice survey

A UK practice survey²⁷ on improving access to and experience of GP services for older people living in care homes highlighted, *inter alia*, the following:

Experience of GP services

People who use services reported that they were happy with the service that they received from GPs, feeling that GPs took the time to listen to them and understand the specifics of their situation. However, few people reported regular

contact with their GPs, either because they felt they did not need it, or because sufficient care was provided within the home.

Good communication

The key factors seen as promoting joint working between care homes and GPs were establishing good communication and building a close working relationship. The majority of home managers reported that they had a good, very good or excellent relationship with the individual GPs they worked with. Regular meetings and reviews with GPs were felt to be important in achieving this, although not all GPs were willing to do this.

Record-keeping

One major problem reported by home managers was working with locums or out-of-hours GP services, where knowledge about individual residents was lacking, often leading to unnecessary hospitalisation. This was one part of a wider problem reported by home managers regarding record keeping and the way information was shared between the home and other health professionals.

Information flow

Most importantly, there is the sharing of information between different stakeholders, for example,

- ✓ The home which helped to design the GP's pre-admission assessment form so that they had the information they needed about new residents
- ✓ The home where GPs input the notes of any consultations with residents onto a record system so that nurses in the home can easily access the information.

Australian models of GP care in nursing homes

Models²⁸ for general practice services in Australia have been identified²⁹ as:

1. The Continuity Model, where GPs follow long-term patients into the residential aged care facilities (RACF)

²⁷ <https://www.scie.org.uk/publications/guides/guide52/files/practice-survey.pdf>

²⁸ These models are described in detail in Appendix 1

²⁹ Richard L Reed (2015), *Models of general practitioner services in residential aged care facilities* https://www.racgp.org.au/download/Documents/AFP/2015/April/April_Focus_Reed.pdf

2. The RACF Panel model, where GPs provide care to several patients in nearby RACFs
3. The GPs with Special Interest in Residential Aged Care (GPwSI RAC) model, where GPs provide regularly scheduled services to larger groups of patients
4. The Longitudinal General Practice Team (LGPT) model, where GPs provide team-based care
5. RACF-based models of care, where GPs partner with RACFs
6. Hospital-based models of care have also been developed to provide in-reach services to patients in RACFs during episodes of acute illness.

The review of these models noted that there is limited evidence for which of these models is most effective. It was suggested that more comprehensive models such as team or facility-based models have the potential to provide responsive and integrated services but are limited by low rates of reimbursement for GPs. New models of RACFs are developing that provide the opportunity for GPs to contribute to clinical governance and quality improvement. Historically, the development and evaluation of new models in this sector has relied on supplemental funding from a range of government or private sources and it has been noted that the sustainability of models currently in operation is likely to require ongoing subsidy.

The Review³⁰ recommended that those models of care which promote improvements in general practice services within RACFs, as well as effective involvement of GPs in clinical governance, should be supported. More rigorous evaluations of initiatives in this area were proposed in order to strengthen the case for increased public funding of these models.

Health 1000: A relevant UK Initiative

In 2014, in the UK, the Health 1000 pilot project was established as a 'one-stop-practice' for patients with complex health needs³¹. A dedicated multi-disciplinary team of NHS health care and voluntary sector professionals were recruited into the practice, including GPs,

specialist doctors, nurses, physiotherapists, occupational therapists, pharmacists, key workers and social workers.

While the Project initially focused on supporting the long-term condition cohort, it was agreed subsequently that it could support a new nursing home programme on a pilot basis. In December 2015, Havering Clinical Commissioning Group (CCG) commissioned a Care Home Alignment service to address the fragmented care received by patients residing in nursing homes. The new service aligned general practices to specific nursing homes in order to maintain and enhance the quality of health care by providing optimal health care cover in a consistent manner. It focused on nursing homes in the London Borough of Havering which had difficulty accessing GP services.

It was felt at the outset that this initiative would lead to improved relationships with nursing homes across the borough, a reduction in acute admissions, an increase in people dying in their preferred place of death, and a more consistent approach to care.

The Pilot Programme was targeted at four nursing homes and contained the following features:

- Proactive primary care, operated from a single practice, to four nursing homes that previously had difficulty accessing GP services
- The assignment of a single GP practice to all residents in a home
- Access to health care professionals with expertise in caring for older people with complex needs
- Extended access beyond normal GP hours
- Care guidance to nursing home staff
- Improved medicines management, and
- New approaches for managing people who are at the end of life
- An emphasis on developing a trusting relationship between professionals that provided confidence, support and a sense of shared responsibility.

³⁰ *Ibid.*

³¹ Defined as having five or more chronic conditions, including coronary heart disease, high blood pressure, heart failure, stroke or mini stroke, diabetes, chronic obstructive pulmonary disease (COPD), depression and dementia.

The Nuffield Trust was commissioned by the Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) to evaluate the pilot nursing home service.³² There was a specific evaluation focus on assessing the impact of the new service on staff and on the use of hospital services.

Shortcomings in medical care in nursing homes prior to the pilot identified by the Nuffield Trust included:

1. Inefficient use of resources, for example, residents being sent to hospital unnecessarily
2. Nursing home staff spending large amounts of time on administrative tasks because they had to liaise with multiple GPs
3. Impact on quality of care, for example, in relation to how medications were managed
4. GPs under pressure
5. Risk-averse behaviours within nursing homes, e.g., immediately sending residents to A&E

Perceived impact of new service

- There was improved access to GPs and to related clinical advice, both for triaging and ongoing learning support;
- There were improvements in medicines management, enabling quicker access to medicines and reductions in polypharmacy and waste achieved through medicines reviews and deleting unnecessary repeat prescriptions;
- Reductions in emergency admissions were most notable during the last three months of a person's life;
- Emergency inpatient admissions fell by 36%, and emergency bed days by 53%³³ – the biggest reductions occurred towards the end of a person's life;
- There were significant increases in outpatient hospital appointments since registration with Health 1000, but this seemed to be influenced by a very small number of residents in one of the homes attending multiple times for anti-coagulation.

- Previous lack of timely access to primary care appeared to have been driving risk-averse behaviour at the homes, which meant that staff were more likely to send residents to A&E than to call the GP.
- Staff reported feeling more supported and more confident in managing risk as a result of having quick access to GP advice via phone and the certainty of a regular weekly visit from a GP who knew the home, staff and residents.
- Staff, managers and GPs observed improvements in the proactive management of medications and in end-of-life planning, but said there was still room for improvement in both these areas
- On the negative side, some GPs expressed frustration that they were required to complete forms for the nursing home company that were not directly relevant to the patient's care.

The Nuffield Evaluation Report noted that whether the results of this scheme can be replicated elsewhere is likely to depend on the context in which it is being implemented. Success will depend on the quality and continuity of relationships between the GPs and nursing homes, and it will take time to establish such relationships where they do not already exist. The report also noted that this would be more difficult in areas where there are staffing shortages or high numbers of temporary staff, and may be further exacerbated by provider instability in the nursing homes market.

The fact that the Health 1000 pilot nursing homes project was driven forward by a group of committed individuals who were instrumental in designing and implementing the service was highlighted.

³² <https://www.nuffieldtrust.org.uk/files/2018-04/transforming-care-report-final-web.pdf>

³³ After adjusting for case mix, these were all significantly larger reductions than observed among a control group of similar nursing homes in the area, although there is a reasonably large margin of error.

Section Three

Current Practice and Future Challenges: Views and Perspectives of Stakeholders Consulted

Stakeholders³⁴ consulted during the compilation of this Discussion Document were asked to identify:

- Medical care needs of nursing home residents
- What constitutes good quality medical care in nursing homes
- Right of access by nursing home residents to quality medical care
- Current GP practice in Ireland in the provision of medical care to nursing home residents
- Gaps/blockages to nursing home residents receiving quality medical care
- Resourcing and administrative matters
- Possible mechanisms for addressing current gaps/blockages

The findings of the stakeholder consultations are set out here under four main headings:

1. What constitutes good medical practice in nursing homes
2. Different models of delivering medical care
3. Current difficulties and challenges in Ireland
4. How difficulties identified might be addressed

Components of good quality care in nursing homes identified

The following components of good practice were identified by stakeholders.³⁵

Individually-tailored care

- ✓ Continuity and consistency of medical care
- ✓ Supporting residents to balance the right to self-determine with responsible risk-taking
- ✓ Consulting with and assessing people in their own homes prior to admission to a nursing home
- ✓ Establishing clearly residents' will and preferences in respect of their medical care, with particular reference to end-of-life care preferences, and planning accordingly
- ✓ Recording people's end-of-life care preferences and ensuring that any end-of-life care directives are readily accessible by relevant persons, e.g., out-of-hours GPs
- ✓ The GP, nursing team and community pharmacist, together with all staff within a nursing home, monitoring changes that occur in residents over time and identifying and managing triggers, e.g., in the case of people experiencing behavioural and psychological symptoms of dementia (BPSD)³⁶

³⁴ The stakeholders consulted were GPs (a selected sample), HSE, HIQA, Nursing Homes Ireland (NHI), Irish Society of Physicians in Geriatric Medicine, Directors of Nursing (in 4 nursing homes) and Sage Advocacy personnel working in nursing homes

³⁵ See also Kildare Clinical Society Draft Guideline, November 2016, Dr Brendan O' Shea/Dr Michael McEniffe

³⁶ See ICGP Quality and Safety in Practice Committee Report, *Guidance for Improving the Care of People with Behavioural and Psychological Symptoms of Dementia (BPSD) in the Residential Care Home Setting* <https://www.icgp.ie/speck/properties/asset/asset.cfm?type=LibraryAsset&id=B9FA70A1%2DC5B0%2D4F63%2D950B-22DEFA00A806&property=asset&revision=tip&disposition=inline&app=icgp&filename=BPSD%5FQRG%5F-14%2E08%2E2019%2Epdf>

- ✓ A holistic approach to manage multiple medication
- ✓ Periodic medication reviews
- ✓ Planned and regular GP visits rather than on a reactive basis
- ✓ Regular and consistent liaison between GPs and nursing staff to facilitate good working relationships and an effective dynamic
- ✓ The presence in nursing homes of Advanced Nurse Practitioners and Nurse Prescribers
- ✓ Easy access to dental, ophthalmic and chiropody services
- ✓ Standardised reporting and recording systems
- ✓ Recording people's end-of-life care preferences and ensuring that any end-of-life care directives are readily accessible by relevant persons, e.g., out-of-hours GPs
- ✓ GPs having easy access to specialist support -- geriatricians, psychiatrists and allied specialities and disciplines
- ✓ Collaboration between GPs, geriatricians and nurses in care planning and support³⁷
- ✓ Clarity about the prescribing of Oral Nutrition Supplements (ONS) and related guidelines³⁸

Organisational and planning

- ✓ The provision of a spectrum of care – sheltered housing, assisted living and nursing home
- ✓ GP practice, day care, step-up and step-down facilities, nursing home and Independent living accommodation on the same site which allows oversight and integrated management by a GP practice and provides for a continuum of support and care in accordance with need
- ✓ More integrated planning around nursing home location and access to services – currently nursing homes are frequently isolated and away from other services
- ✓ A community model of care reflected in nursing homes – fostering choice, independence and interaction with the community
- ✓ Provision for community care teams going into nursing homes and delivering necessary support services not available in the nursing home
- ✓ GPs and Allied Health Professionals working in a multi-disciplinary approach with nursing homes to provide quality care for residents
- ✓ Team-working between nursing home staff, GPs and community-based Allied Healthcare professionals – occupational therapy, physiotherapy, speech and language therapists and dieticians

Different models of delivering medical care in nursing homes

Stakeholders were asked for their views on three different models of medical care in nursing homes – Medical Officer model, GP practice responsibility, and individual GPs ‘following’ the person into a nursing home.

In looking at models, it is necessary to make a distinction between public nursing homes and private nursing homes. As noted in Section One above, many public nursing homes have historically employed GP Medical Officers to care for the medical needs of patients. This situation may be changing, however, as more Medical Officers retire and difficulties emerge in recruiting GPs for such roles. Among the reasons for the latter identified by some GPs is that the post is not well remunerated and the heavy workload associated with the role acts as a deterrent for some.

In the case of private nursing homes, different practices operate. Many larger private nursing homes engage a local GP practice on a ‘retainer’ fee basis while smaller private nursing homes are dependent on GPs visiting on an ‘as needed’ basis.

³⁷ Potential areas for more geriatrician involvement identified were polypharmacy, delirium, advanced Parkinson's disease and nursing home residents with mental health difficulties.

³⁸ It is noted that the 2019 Terms of Agreement between the Department of Health, the HSE and the IMO regarding GP Contractual Reform and Service Development states that an administrative system will be implemented, whereby if the prescriber selects an ONS product from the preferred list then no prior approval requirements will arise for the prescriber, but where they prescribe an ONS product outside of this list there will be an approval process which the GP will follow.

As might be expected, there was a range of views and perspectives and a general consensus that there is no ‘one size fits all’ model. Also, it was noted as a general point that all vocationally trained GPs who are on the Medical Council Specialist Register for General Practice have the requisite skills to provide care to nursing home patients. There was consensus among stakeholders that there will be variations in practice arising from a number of factors:

- Whether a nursing home is private or public
- Size and location of nursing home
- Some GPs wishing to ‘follow’ their patients into a nursing home and able to do so
- Some GPs preference for a mix of patients between community-based and nursing home residents
- Size of GP practice

Figure 1 (below) sets out the main advantages and disadvantage of each model as perceived by the stakeholders consulted.

Figure 1: Stakeholder perceptions on different models of medical care in nursing homes

Model	Advantages	Disadvantages
GP ‘following’ resident into nursing home	<p>Continuity of care;</p> <p>Professional and trusting relationship already established;</p> <p>Understanding of resident’s history/ health;</p> <p>Attuned to the person’s will and preferences.</p>	<p>Not always practical when factoring in travel distance for some;</p> <p>Danger of over-familiarity (taking relationship for granted);</p> <p>Nursing home staff having to liaise with multiple GPs;</p>
One GP practice having responsibility	<p>Access to GP may be better;</p> <p>Nursing home staff only have to liaise with one GP practice;</p> <p>Continuity of care;</p> <p>Professional relationship established;</p> <p>Facilitates a proactive rather than a reactive approach.</p>	<p>Geographical limitations;</p> <p>Some GPs work on their own;</p> <p>Nursing home residents who are unable to find a GP under the GMS being assigned one by the HSE;</p> <p>Costs to patients may apply;</p> <p>Could result in lack of choice;</p>
Medical Officer model	<p>Access to medical care as required;</p> <p>Good overall understanding of all residents’ health and co-ordination of care needs;</p> <p>More time to talk to resident/review medication;</p> <p>Easier for nursing home staff;</p> <p>Facilitates a proactive rather than a reactive approach.</p>	<p>Could lead to patient not having a choice in their care;</p> <p>Difficulties in recruiting GPs for posts in some parts of the country;</p> <p>Smaller private nursing homes would not have the volume of patients required to make it feasible.</p>

Current issues and challenges

Shortage of GPs in the health system generally

According to a 2017 ICGP survey³⁹, 17% of GPs in Ireland are over 60 years of age and close to retirement, 30% of GP trainees are considering emigration, 18% of recent graduates have already emigrated and an additional 17% of recent graduates definitely or possibly will emigrate. These figures highlight the significant challenge generally in respect of GP availability with obvious potential knock-on effects on the availability of GPs to take on nursing home patients. There are related difficulties in the availability of GPs to provide out-of-hours services. Some private nursing homes are in effect dependent on the goodwill of GPs to provide services with some GPs having limited capacity to do so. Providing a service to a nursing home requires a GP to be absent from their Practice. Difficulties arising from this were seen as being exacerbated by a shortage of Practice Nurses.

Some GPs have a positive attitude to working in nursing homes and are happy to work with nursing home residents. Some wish to 'follow their patients' into a nursing home where this is feasible.

There are other GPs do not want to work in nursing homes for various reasons, including:

- They are already over-worked in their practices
- It can be time-consuming
- There is no financial incentive
- There are additional paperwork and form-signing requirements which are too time-consuming

There was a perception that newly qualified GPs may have less interest in working in nursing homes.

Administrative work requirements for GPs attending in nursing homes

GPs are expected to carry out significant additional work in nursing homes which they are not contracted or paid to provide. This relates specifically to the KARDEX system (Instruction to Nursing Home to administer drugs) which the Irish Nurses and Midwives Organisation (INMO) requires to be in place before nurses can administer drugs. GP practices, already under strain, being asked to complete a considerable workload that they are not contracted for or paid to provide has the potential to create relationship issues between a GP and a Nursing Home. From a nursing home perspective, the non-availability of GPs to write up or sign Drug Kardexes places the nursing home in the position where it is non-compliant with medication management requirements. The key point here is that a GP's relationship is primarily with their patients rather than with the nursing home.

Nursing home staffing: experience and skill sets of nurses

While nursing homes strive to have an adequate complement of suitably trained and qualified nursing staff available at all times, in practice, there can at times be difficulties in recruiting nurses with relevant experience.

The point was made that nursing home staff may not have the exposure, experience and training available in acute hospitals. It was also suggested that skills sets of nurses working in nursing homes may have gone down in recent years with a concomitant fear of making decisions in potentially crisis situations.

Some GPs believe practical and staffing deficits in private nursing homes are contributing to the problem, as many private nursing homes are understaffed and existing staff are sometimes inexperienced in respect of handling complex healthcare needs. GPs have complained of receiving numerous and often times unnecessary calls from inexperienced staff with regard to patient care in nursing homes, which one GP described as being 'majorly disruptive' to their daily working schedule.

The lack of experience of nursing staff and lack of confidence in relying on their own

³⁹ <https://www.icgp.ie/speck/properties/asset/asset.cfm?type=LibraryAsset&id=3F28C56A%2DC888%2DBEA2%2D-B565AD559FED465F&property=asset&revision=tip&disposition=inline&app=icgp&filename=ICGP%5FCareer%5FSurvey%5FReport%5F2017%5FSCREEN%2Epdf>

clinical judgements was seen by some of those consulted as sometimes resulting in:

- » Warning signs being missed
- » A deferral of decisions until the GP attends or an unnecessary referral to a GP

Unnecessary hospital admissions

- Difficulty in accessing an 'Out of Hours' GP can sometimes result in an unnecessary referral to A&E;
- Non-familiarity with the patient and their condition/behaviour can present difficulties for an 'Out of Hours' GP attending on a once-off basis;
- Waiting for scheduled GP visits (if only once/twice a week) can shift a non-emergency medical issue into an emergency issue;
- Residents can sometimes have specific behavioural issues where staff are unable to manage the situation but are unable to find a GP to attend.

Inadequate integration and linkages with community care services

Ongoing deficits in community care and the lack of connection between nursing homes and primary care services was seen as resulting in a very fragmented care system for older people with chronic conditions. Indeed, it was noted that, in many instances, the GP is the only professional link between the community and the nursing home. The point was made, for example, that nursing home residents typically do not have access to community-based day care facilities which would have the potential to enable nursing home residents to maintain existing social and personal networks or develop new ones.

There was a perception that nursing home residents tended to be regarded by community care staff as receiving an adequate level of care and so given less priority than others in the community in access to therapies and other supports. This was seen as a far from satisfactory view given the fact that, as one respondent put it, "If you need an Occupational Therapist, you need one, irrespective of where you live".

It was acknowledged that the Sláintecare model does provide the context within which a better fit between community-based care and residential care can be achieved. However, this will not happen without strong proactive implementation involving the HSE, HIQA and the Department of Health. The Irish Medical Organisation (IMO), the ICGP and the Irish

Nurses and Midwifery Organisation (INMO) were also seen as needing to be actively engaged in the process of ensuring that there are stronger linkages between community care services and nursing home services. There is a need for a stronger emphasis on the concept of a continuum of supports irrespective of whether a person lives in their own home, in sheltered accommodation/assisted living housing or in a nursing home.

People with reduced decision-making capacity

There was a general consensus that the full implementation of the ADM (Capacity) Act should bring some clarity to the process of engaging with people with reduced decision-making capacity. While GPs feel competent to assess people known to them in relation to functional capacity aspects, making assessments of people unknown to them is more challenging, and requires adequate time to engage with the individual and at times their extended care network, including families. This was seen as an evolving situation which needs careful monitoring.

Assignment of GMS patients by the HSE

The assignment by the HSE of a GMS patient to a GP was seen as having the potential to create a less than satisfactory relationship between the GP and the nursing home, particularly where a patient has high or complex care needs which clearly many nursing home residents have.⁴⁰ A GP assigned a nursing home patient by the HSE may feel that they are unable to provide the level and quality of patient care required and/or that each nursing home should have their own GP.

⁴⁰ It was pointed out that there is a proportion of nursing home residents who are younger, e.g., people with MS, people with spinal injuries.

Other issues identified

- There is insufficient discussion with residents (and with relatives) about end-of-life care and 'Do Not Actively Resuscitate' (DNAR) instructions.
- Relevant and appropriate end-of-life care is not adequately considered in some instances which sometimes results in inappropriate admissions to an A&E department.
- Many Nursing Home GPs visit 1-2 times a week on set days which, while positive in many ways, was seen as sometimes resulting in a deferral of decisions or calling 'out-of-hours' services.
- Once admitted to a nursing home, a resident may have no choice but to move to a new GP (either where the nursing home has a contract with a GP practice or where their GP is not in a position to keep them on) - this may undermine the principle of choice of GP.
- There was some perception of 'over-regulation' of nursing homes which results in GPs being expected by nursing homes to carry out additional administrative tasks relating to, for example, filling in Kardexes.
- Residents in some private nursing homes were reported as being asked to pay €30/€40 a month for a GP service even though they have a Medical Card - the impression overall was that such charges are becoming more prevalent.
- Catheter care was reported as being an issue on occasions, especially when out of hours doctors are not available to attend at a Nursing Home.
- There was some experience reported of changes to medication made by hospital doctors sometimes not having been notified to the GP or Nursing Home.
- The fact that GPs are not enabled at present to give intravenous (IV) medications to nursing home patients means that these patients have to be referred to A&E. (It was noted that the issue of intravenous medication administration is a complex matter and frequently involves issues related to end-of-life care, appropriateness of IV therapy, diagnostic uncertainty in the absence of diagnostic services, guidelines, responsibility, governance and upkeep and maintenance of IV lines).

How difficulties identified might be addressed

The following were identified during the consultation process as ways of addressing some of the blockages and difficulties identified.

Multi-disciplinary training

There was a general consensus that education and training in relation to medical care in nursing homes should be enabled within General Practice and that this should be multi-disciplinary in order to improve morale and enhance shared learning and practice. For example, it was noted that some GPs work in isolation.

Areas identified where multi-disciplinary training would be useful were:

- ✓ Respective responsibilities of GPs and nurses
- ✓ Dementia awareness and care for people with dementia
- ✓ End-of-life care
- ✓ Advanced Care Directives
- ✓ Working with families, particularly around the limited role of next-of-kin
- ✓ Implementing the provisions of the ADM (Capacity) Act 2015 with particular reference to Advanced Healthcare Directives and supported decision-making
- ✓ Components of quality of life for nursing home residents

Planning Ahead

People need to be encouraged to proactively plan in order to ensure that their will and preferences are respected in all care scenarios, in particular, emergency medical care requirements, serious/ chronic illness, dementia and end-of-life care.

A number of intervention approaches are required to promote planning ahead in line with the principles and measures of the ADM (Capacity) Act 2015, e.g., decision-making support, co-decision making, the role of advance healthcare directives, enduring power of attorney, 'Think Ahead'.

Identified factors that would enhance the delivery of medical care in nursing homes

- ✓ More use of integrated IT systems to allow for patients' medical records to be accessed in both nursing homes and in GP practice (taking into account data protection requirements)
- ✓ More use of Advanced Nurse Practitioners and Nurse Prescribers⁴¹
- ✓ Greater use of technology in liaison between GP practices and nursing homes
- ✓ Protected time for GPs attending at nursing homes
- ✓ Regular medication reviews to ensure unnecessary medical complications are avoided
- ✓ Easier access to allied health professionals
- ✓ More emphasis on community-based medical care
- ✓ More emphasis on social care
- ✓ More provision for palliative care in the community

Greater role for Advanced Nurse Practitioners

In looking at medical care in nursing homes, it was felt that it was important to take cognisance of the critical role played by nurses in both nursing homes and GP practices, including facilitating communication between nursing homes and GPs. Increasing the numbers of GP Practice Nurses in Ireland would be desirable for many reasons and may contribute to freeing up some GP time for nursing home work. However, more relevant, perhaps, is the potential role of Advanced Nurse Practitioners (nurses trained up to a high level in one particular speciality) which could be extended to take over some of the workload of GPs in nursing homes. For example, Advanced Nurse Practitioners could be attached to a group of nursing homes in an area and work with GPs who are visiting these homes on a regular basis.

Addressing the shortfalls in current GMS contracts

There is a need for increased funding for GPs and practice nurses. For example, the current flat remuneration rate does not recognise peaks in care needs, e.g., at end of life. This matter is under ongoing discussion between the Department of Health, the HSE and the IMO and is regarded as a critical issue in the difficulty in attracting younger GPs to work with nursing home patients. The urgent need to negotiate a new GMS contract in respect of private nursing home patients was highlighted by the GPs consulted. The most recent Terms of Agreement between the Department of Health, the HSE and the IMO, while addressing to some extent the issue of remuneration, does not deal with the broader systemic issues relating to contractual provisions and models of GP services to nursing homes. Indeed, one view expressed was that the Department of Health and the HSE may have very unrealistic expectations of what GPs can do under current arrangements.

It was acknowledged by all stakeholders that very significant further intensive negotiation is required between the Department of Health, the HSE and the IMO in order to ensure that all appropriate medical services are available to all nursing home residents in a timely manner.

Three specific suggestions were made to help to ensure equality of access for nursing home residents to quality medical care in the Irish context.

1. There should be a review of GMS eligibility for nursing home residents, ensuring all have full Medical Cards as opposed to GP Visit Cards
2. The base capitation rate payable to GP practices for nursing home residents should be weighted and increased marginally, recognising the increased medical needs of this sub-group of eligible people – collectively this group makes up a very small proportion of all Medical Card eligible persons.
3. A review of the Medical Officer Contract and role should be undertaken to include review of payments and additional requirements relating to delivering quality medical care in nursing home – the review should include input of expertise from both private and public nursing homes.

⁴¹ Nurse prescribers are site-specific – the qualification does not move with the person. Also, a GP has to sanction the prescribing for a nurse prescriber and a GP also has to put it on GMS prescription.

Section Four

Key Considerations and Discussion Points

People resident in nursing homes are widely regarded as one of the most vulnerable groups in society and, therefore, require the highest possible quality of medical and nursing care. As the brief literature review carried out for this Discussion Document indicates, Ireland is by no means unique in facing challenges in delivering high quality medical care to nursing home residents. While obviously coming from different perspectives, all of the stakeholders consulted in the preparation of this Discussion Document were in broad agreement about the issues and, in particular, about the need to put patients at the centre in the context of funding and regulation and contractual provisions.

The requirement to deliver quality medical care becomes all the more important when it is acknowledged that many nursing home residents are not in a position (for various reasons) to give voice to their will and preferences and/or are reluctant to be seen as a burden or to ask for what they want and need.

The delivery of competent, compassionate and timely medical care in nursing homes requires a multi-faceted response built on collaborative working between all of the stakeholders – nursing homes, GPs, HIQA, the Irish Nurses & Midwives Organisation (INMO), consultant physicians in geriatric medicine, the HSE, the Department of Health and the Irish Medical Organisation (the latter in respect of negotiation of fit for purpose GMS contractual arrangements).

This final section distils a number of key overarching themes which would inform future deliberations on the matter.

A uniform national quality Nursing Home GP service

There is a need to explore further how a uniform national approach can be developed across both the private and public nursing home sectors which is clear to all and accepted by all so that the current ‘lottery’ effect related to location, GP availability and whether the nursing home is public or private is eliminated.

Resourcing medical care in nursing homes

Notwithstanding the fact that the primary policy focus should be on enabling people to remain in their own homes for as long as possible, there was a consensus that there is a clear need for better resourcing for medical care in nursing homes. Nursing home residents are entitled to quality medical care and GPs want to provide it. What is needed is a more structured and sustained engagement by the Department of Health and the HSE on the matter with a strong input from GPs and their representative bodies and an honest debate around the resourcing issue.

Enhanced communication

The open sharing of knowledge and information between different stakeholders – nursing homes, GPs, geriatricians, HIQA, the HSE and the INMO – is an important consideration and central to achieving best practice and an area which requires additional structures and protocols.

It is noted that the ICGP in conjunction with the HSE and the Department of Health (National GPiT Group) has compiled a document, *Clinical Information Systems for Nursing Homes; the requirements of General Practitioners*⁴², which details GP requirements for a nursing home information system. The document sets out ten requirements:

⁴² https://www.icgp.ie/speck/properties/asset/asset.cfm?type=Document&id=9C8276E0-87DE-4FE4-A6910B10AC548725&property=document&filename=Nursing_Home_EPR_GP_vO_4.pdf&revision=tip&mimetype=application%2Fpdf&app=icgp&disposition=inline

1. Support Clinical Notes
2. Facilitate a Summary of the Patient's Medical Problems
3. Provide the Ability to Code Diseases
4. Support the Ability to Scan and View Previous Letters and Records
5. Hold information on Current Medication
6. Support the Management of Immunisation
7. Support Medication Reviews
8. Integrate Laboratory and Radiology Reports
9. Support an End-of-Life Care Plan
10. Ensure Nursing Home Systems Can Be Accessed Remotely

Strengthening linkages with the community

There is a view that nursing home residents are perceived by community care staff as receiving an adequate level of care and so are given less priority than others in the community in access to therapies and other supports. There is a danger that this can lead to care and support needs not being addressed, a lower quality of life and possibly unnecessary hospitalisation.

Resolving different views

The medical care of nursing home patients is widely regarded as presenting a serious challenge on many fronts and, as the international research suggests, no one model is clearly better than others. There are two key considerations. Firstly, it is clearly desirable that both patients and GPs should be able to exercise choice. A GP who wishes to continue to provide care to their patients in a nursing home setting should usually be able to do so and patients should have that option. However, in some instances this will be impractical, e.g., where the nursing home is located outside the practice catchment area and/or where the GP is unable, for reasons relating usually to workload, to switch from a care plan that previously involved visits by the patient to the GP practice but now requires the GP to travel out of the Practice and which for resource reasons may be non-sustainable.

Strong evidence⁴³ exists that where there is an effective input of General Practice in the Nursing Home setting, this reduces admissions and facilitates earlier hospital discharge.

There is thus a strong argument that more effective medical care to all residents in a nursing home is delivered where most of the care is provided by one GP practice and/or where a Medical Officer model exists.

Revised GMS contracts

The care of nursing home patients and the resource implications of providing quality GP care needs to be addressed specifically and fully in ongoing negotiations in respect of GMS contracts.⁴⁴ This is necessary in order to:

- a. Deal with the rapidly evolving crisis in the availability of GPs to attend nursing home patients
- b. Ensure that access to medical care by nursing home residents is not dependent on geographical factors or nursing home size, and
- c. Facilitate GP practices in providing high quality care to nursing home residents.

The underlying focus should be on patient needs and equitable access to quality GP care irrespective of whether that care is provided in people's own home, in a public nursing home or in a private nursing home. Similar provision, therefore, needs to be made for medical care in both the public and private sectors which is not the case at present.

In essence, there is a crucial need for a new GMS contract for GPs which will create the conditions for the delivery of quality medical care in nursing homes to which GPs, nursing homes (and, presumably, the public) aspire to. This is at the core of the Slaintecare plan. All the evidence suggests that the current funding by Government is inadequate to deal with the increasing complexity of caring for an ageing population generally and, specifically, for those in nursing homes who are widely regarded as the most vulnerable.

⁴³ https://www.kingsfund.org.uk/sites/default/files/2017-11/Enhanced_health_care_homes_Kings_Fund_December_2017.pdf
<https://www.scie.org.uk/publications/guides/guide52/files/gp-services-evidence-review.pdf>
<https://www.nuffieldtrust.org.uk/files/2018-04/transforming-care-report-final-web.pdf>

⁴⁴ It is understood that the issue of nursing home care is among those included in ongoing GP contract negotiations between the IMO, the Department of Health and the HSE.

Role for independent advocacy

While nursing home staff, GPs geriatricians, other professionals and relatives frequently provide an advocacy support role for nursing home residents, there is additional role for independent advocates.⁴⁵ This is necessary in order to ensure that each resident gets what they have identified they need in terms of medical and nursing care and are not in any way treated less favourably in terms of access to GPs and allied health professionals than they would be if living in the community.⁴⁶ Independent advocacy is particularly important in respect of people who may be vulnerable because of reduced decision-making capacity.

Putting in place a clearer model of medical care provision in nursing homes

There is a clear need for a new overarching model for delivering medical care in nursing homes. Core components of such a model would be:

- ✓ Minimum services to be provided by GPs:
 - a. To ensure proactive and quality medical care
 - b. To support nursing homes in meeting regulatory requirements
- ✓ A national standardised approach to medical care in nursing homes
- ✓ A multi-disciplinary approach and clear linkages with community-based allied health professionals
- ✓ Minimum skill sets for nursing home staff and care givers in terms of communication and language competency
- ✓ An adequate financial framework
- ✓ Provision for some involvement by GPs in governance in the public nursing home sector

- ✓ Developing and resourcing additional mechanisms for collaboration between GPs, nursing homes and geriatricians (both hospital and community-based)

Best Practice Recommendations

A Guide for Care Home Managers in the UK has been developed by the Social Care Institute for Excellence (SCIE)⁴⁷ which is primarily written for managers and senior staff of care homes but has also been written with GPs in mind. The stated purpose of the Guide is to support managers and staff of care homes to work in partnership with GPs and primary care teams, with a view to improving access for residents to good medical services. The Guide places the resident at the centre of the picture, viewing from their perspective the need for, and benefits of, effective joint working between the home manager and the GP.

The Guide contains a series of recommendations under the headings of

1. Residents' entitlements and requirements
2. Managers' responsibilities
3. GPs' role in relation to the resident, the home and the wider NHS
4. Workforce development, standards and regulation

Many of these recommendations have resonance in the Irish context and they are summarised in Appendix 3. It is suggested that work should be carried out to explore in detail how these could be applied in the Irish context taking into account resources, current practices and difficulties and challenges encountered, particularly the relative shortage of GPs in the Irish health system at present.

Possible GP nursing homecare model

It is suggested that detailed consideration should be given to the approach being used in the UK Pilot Programme (Health 1000) which was discussed in Section 2 above with a view to developing a similar model in Ireland. The UK Programme contains the following features:

⁴⁵ Independent advocacy is that provided by an organisation that is structurally, financially and psychologically separate from the services that deliver health and social care.

⁴⁶ Sage Advocacy case evidence shows that nursing home residents experience a range of issues relating to the care they receive with particular reference to having their will and preferences respected

⁴⁷ <https://www.scie.org.uk/publications/guides/guide52/files/guide52.pdf>

- Steps to support linkages and the identification of a single GP practice to most or all residents in a home
- Uniform access to health care professionals with expertise in caring for older people with complex needs
- Uniform extended access beyond normal GP hours
- Effective and high standard care guidance provided by GPs to nursing home staff
- New and evolving protocols for medicines management, and
- New approaches for managing people who are at the end of life.
- Payment of an additional enhanced capitation rate to the GP practice where a practice provides medical care for 80% of the residents in any one Nursing Home.⁴⁸

Overview

The consultation carried out in the compilation of this Discussion Document suggests that many of the elements of a quality medical care system in nursing homes are already in place. A clear sense emerged of nursing homes for the most part having developed adequate working relationships with GPs and vice versa. However, these have evolved in a somewhat ad hoc manner and need to be consolidated and developed as a matter of some urgency, not least because of the increasing pressures on the GP primary care system and the expanding regulatory framework.

GPs consulted expressed confidence in their ability to look after nursing home patients. The strong sense that emerged from the consultation was that GPs, for the most part, want to and are interested in ensuring that nursing home residents receive quality medical care on an equal basis with people living in the community. However, current resources militate against this. Many GPs are continually balancing their social and professional responsibilities with their need to generate sufficient income to maintain a viable GP practice. Nursing homes clearly understand the vital role that GPs play in patient care and are very aware of their reliance on GPs to deliver

such care but are also at all times trying to ensure that they meet their regulatory obligations both to HIQA and to the INMO. The fact that GPs have no direct reporting relationship to HIQA presents its own difficulty and is something that needs to be addressed as part of a new and integrated medical care in nursing homes model.

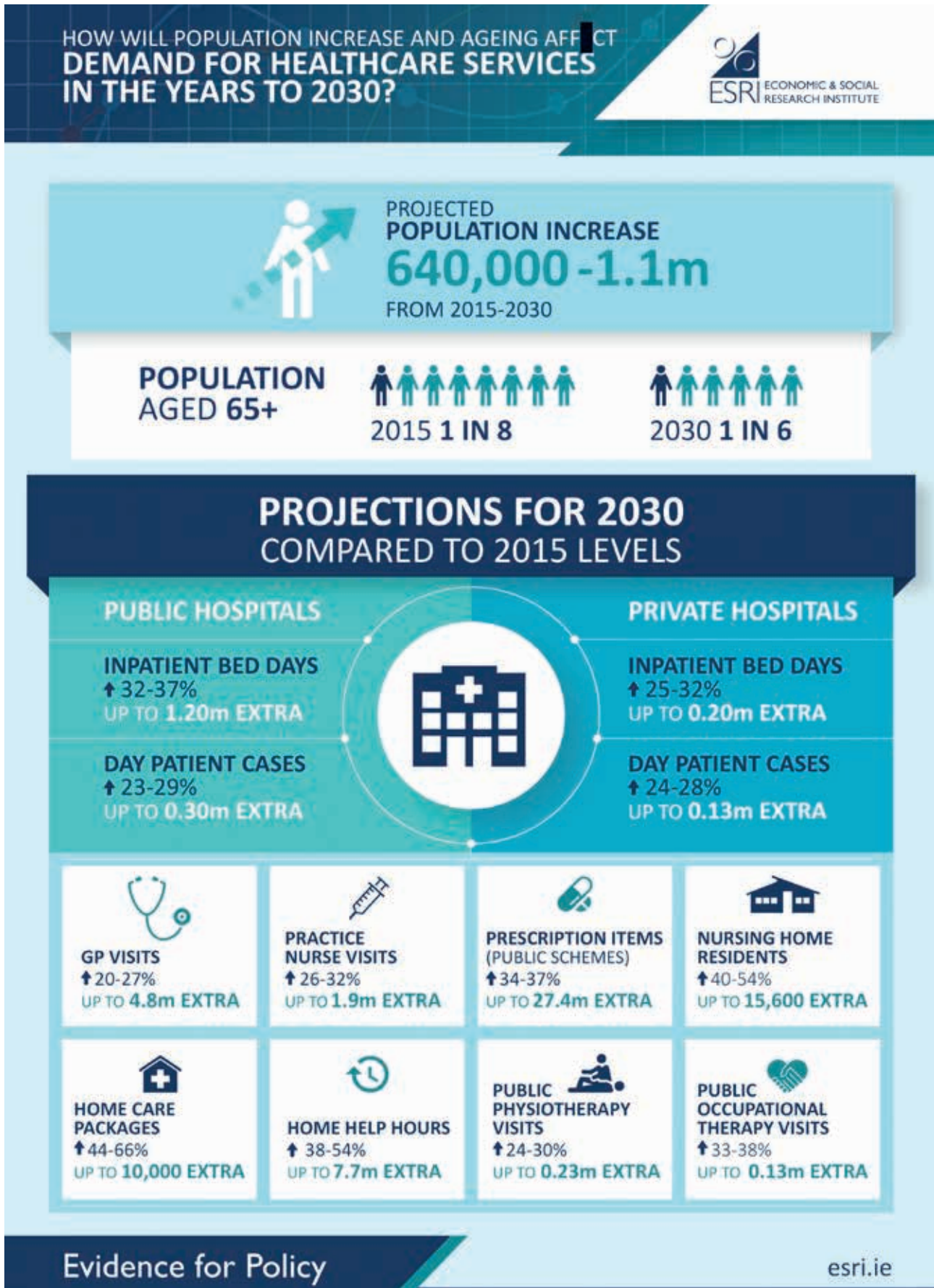
As a general observation, it is important that Irish society addresses the basic question of how we want people with chronic conditions and high levels of morbidity resident in nursing homes to be treated as they approach the end of their lives. Related to this is the fact that nursing homes tend to have a media/public image problem and, therefore, attract mostly negative publicity rather than a systematic engagement with how the medical care of nursing home residents can be delivered to the highest possible standard and the fact that this needs to be properly funded. This issue is exacerbated by the fact that nursing homes are typically disconnected from local communities – indeed, GPs are the only group that bridge that gap. This raises the broader question of how to link nursing home care (medical and social) into an integrated care system for people with complex conditions associated mainly with advanced age. The bottom line is that for nursing home residents, the nursing home is their home and all of the supports necessary for an optimal quality of life, including timely, appropriate and quality medical care should be readily available.

The general sense that emerges from the consultation and research carried out in compiling this Discussion Document is that the question of medical care in nursing homes has tended not to have been to the forefront of policy deliberations relating to nursing homes. While this is not surprising, given the various other dimensions to delivering nursing home care for an ageing population, it should now be put high up on the agenda with a view to addressing the range of blockages to delivering the best possible quality of medical care to nursing home patients. This is partly a GMS contractual issue but it is much broader than that, particularly in relation to GP availability currently and into the future and overall staffing levels in general practices.

As a final point, the basic right of the individual nursing home resident to choose their GP must be preserved.

⁴⁸ The 80% threshold is suggested to respect the right of individual residents to choose GPs other than those from the main Practice.

Appendix One ESRI Infographic



Source: <https://www.esri.ie/pubs/Infographic-26-October-2017.pdf>

Appendix Two

Models of GP Nursing Home Care in Australia

Source: https://www.racgp.org.au/download/Documents/AFP/2015/April/April_Focus_Reed.pdf

The continuity model

Many GPs continue to provide care for their long-term patients after they move to a residential aged care facility (RACF). This continuity model is viewed by the RACGP as the preferred model and that it is 'always best' for older patients to continue to see their regular GP.

However, the proportion of patients cared for in the continuity model is likely to be lower than is typically assumed. In the previously described CHA survey, respondents at 43% of these facilities indicated that most residents (70%) need to have alternative arrangements made for general practice care at admission.

Additionally, after entry to these facilities, 55% of homes surveyed reported that most residents (70%) had changed within a few months to a GP who has existing patients residing in the home. Lack of continuity of GPs was much greater in the major cities, where only 17% of RACFs reported that most residents (70%) continued to receive general practice services from their prior GP. BUPA Aged Care, which operates many RACFs across Australia, states that only 30% of GPs in their facilities continue to provide care to their patients following admission.

Disadvantages of changing GPs include loss of the long-term relationship and lack of information regarding prior healthcare. However, this may be mitigated by a fresh assessment by a different GP and potentially increased access to healthcare if the new GP is near the RACF. Evidence from the UK suggests having larger numbers of RACF patients at a facility results in more regular visiting by GPs.

RAC panel model

Some GPs accept new patients in nearby aged care facilities or see all of the RACF patients for their practice, allowing them to continuously provide care to a number of RACF patients

referred to as a panel. Having a sufficiently sized panel allows GP access to the Aged Care Access Incentive (ACAI). This practice incentive payment (PIP) is currently worth up to \$5000 annually for GPs who provide more than 140 occasions of RACF-identifiable services. On the basis of reported annual rates of general practice services, this would require an individual GP panel of 8-12 residents to obtain the full incentive. The additional compensation paid to an individual GP substantially increases funding for a panel of this size; however, once 140 eligible annual services are provided, there is no additional incentive payment. GPs need to be attached to a PIP-eligible (accredited) practice to receive the ACAI.

Longitudinal general practice team (LGPT) model

Currently, there are few incentives for nurses to engage in the support of GPs in their work in RACFs. However, practice nurses have the capacity to enhance and substitute for GPs in this setting. The Australian Medical Association (AMA) and the RACGP wrote a position paper in 2006, which promoted a LGPT model that allows the doctor to delegate tasks related to the care of residents of aged care facilities to the general practice nurse (or, on occasion, other team members with clinical training) rather than to staff employed in the RACF. This paper also advocated for changes in Medicare Benefits Scheme (MBS) payments to facilitate this model.

Nurse practitioners can also provide RACF primary care services in a team-based model. However, evidence for this model of care is sparse and a recent systematic review using specified quality criteria was able to identify only two nurse practitioner studies from the USA that met the criteria.

These papers were published at least a decade ago. The two studies found some improvements in care, including higher family satisfaction and greater attainment of resident-specific goals. The MBS allows for payments for nurse practitioner services in RACFs if engaged in collaborative practice with a medical provider. However, the payments for these services

GPs with special interest in residential aged care (GPwSI RAC)

Some GPs regularly provide scheduled care in RACFs. These GPs tend to cluster their patients in a few facilities where they have established a relationship with RACF administration and staff and have substantial panel sizes. In the UK, these practitioners are referred to as GPs with Special Interest (GPwSI) and there are methods for accreditation, including for older adults. These GPwSI are typically very committed to providing aged care, despite the low compensation, and also appreciate the flexibility of working hours. As with many areas of specialisation in general practice, there are concerns raised regarding losses of generalist skills, particularly for those who solely provide care in this setting. However, GPwSI RAC are likely to be few in number but could account for care of a substantial number of RACF patients.

RACF-based models of care

Some RACFs have established relationships with specific GPs to take most patients in a facility who lack a GP willing to provide ongoing care. Many of these GPs also provide input into clinical governance. There is a long history of aged care facilities in the USA partnering with primary care doctors as the US federal government mandates that a doctor be involved in RACF governance as part of their accreditation standards. These US RACF medical directors take responsibility for overall clinical care carried out at the facility. They apply their clinical and administrative skills to guide the facility in providing care, help the facility develop and manage quality and safety initiatives, including risk management, and provide information to facility staff and medical practitioners to aid understanding and provision of high-quality care. This work is compensated by the facility.

The AMA has released position statements on the medical care of older adults that are consistent with this approach.

These statements recommend that all staff employed in RACFs should be appropriately trained and be involved in continuing educational programs. Regular discussion of patient care issues between the patient's GP and other providers of care is also recommended.

The document states that quality assurance procedures should also be established to facilitate monitoring by medical practitioners of the clinical services provided to residents and recommends retainer arrangements between RACFs and medical practitioners to support this. Recently BUPA Aged Care has begun employing GPs to work in its facilities in line with this approach.

Hospital-based in-reach services

People living in RACFs have high rates of transfer to hospital. A number of programs have been developed to reduce the rate of acute care service use, which are funded by the Australian states and territories that provide these services. These models of care include:

- The State of Victoria In-Reach Services, which provide a range of medical and nursing services to RACFs to reduce emergency department demand
- Programs using paramedics who visit RACFs to deal with acute problems such as minor suturing or replacing percutaneous endoscopic gastrostomy tubes
- Silverchain's Home Hospital program, which provides hospital level services (e.g., intravenous antibiotics) in community settings including RACFs.

These programs show promising results in reduction of acute care services use but often do not address ongoing care issues (e.g., lack of GP access or quality-of-care issues). These models return the patients to general practice care after a period of high need and do not add to the capability within the general practice.

Appendix Three

Sections 5 and 13 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013

Individual assessment and care plan

5. (1) The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).

(2) The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.

(3) The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.

(4) The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

(5) A care plan, or a revised care plan, prepared under this Regulation shall be available to the resident concerned and may, with the consent of that resident or where the person-in-charge considers it appropriate, be made available to his or her family.

End of life care

13. (1) Where a resident is approaching the end of his or her life, the person in charge shall ensure that —

- a. appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided,
- b. the religious and cultural needs of the resident concerned are, in so far as is reasonably practicable, met,
- c. the family and friends of the resident concerned are, with the resident's consent, informed of the resident's condition, and permitted to be with the resident and suitable facilities are provided for such persons,
- d. where the resident indicates a preference as to his or her location (for example a preference to return home or for a private room), such preference shall be facilitated in so far as is reasonably practicable.

Appendix Four

GP Services for Older People: A Guide for Care Home Managers in the UK, Summary of Key Recommendations

Source: <https://www.scie.org.uk/publications/guides/guide52/files/guide52.pdf>

Residents' entitlements and requirements

- Care home managers should ensure that residents are registered with a general practitioner (GP) of their choice. In order to make an informed decision, residents and their relatives may want help to consider the pros and cons of retaining their existing GP, if possible, or registering with a GP already providing services to other residents in the home.
- Providers and managers of care homes should take the necessary steps to ensure residents have appropriate, high-quality GP and primary care services readily available to them. These include daytime and out-of-hours general medical services (GMS) commissioned by NHS England area teams, and enhanced medical services commissioned by their local clinical commissioning group (CCG).
- Current variable standards need to be identified and harmonised by primary care leads in area teams. Quality of life and good end of life care are of particular importance to residents and relatives.
- All professionals should treat each resident as a person with experiences, aspirations and opinions, and not make assumptions about their capacity based on their age. People should be involved as fully as they wish in discussions about their health care and treatment.
- Provision of health services should be responsive to the needs of individual care home residents and reflect their wishes and preferences.
- Care homes should ensure that residents understand why information about their health is shared with other professionals and their consent should be sought. Health and care professionals should listen, explain and discuss health and care matters with residents, and their relatives and carers.
- Information-sharing between professionals should contribute to improved health outcomes for individual residents.
- Managers should make sure that residents have their human, civil and statutory rights protected in relation to their ongoing health care needs.
- Residents should have fair access to scarce resources and services, active involvement in their care plans and protection from discrimination on the grounds of age, gender and/or disability.
- Residents lacking mental capacity for decisions about particular matters, including health care, must be protected under the Mental Capacity Act 2005.

Managers' responsibilities and the NHS reforms

- Care home managers should establish ways of listening to and regularly checking the views and experience of residents and relatives regarding their medical care. Managers and care staff can take leadership and advocacy roles in relation to the health care needs and preferences of residents, relatives and carers.
- Managers and GPs should ensure that local pharmacists, dentists, opticians and hearing services, CCGs and NHS England area teams understand the needs of their residents.
- Care home managers should ensure that accurate, up-to-date, consistent records are kept on medical conditions, health care and medications.
- Residents who wish to have access to their health records have a right in law to do so, with assistance if their capacity requires it, and may wish to make their own entries in the record.
- Care homes should work with GPs and pharmacists to develop a strategy for medicines management, including regular (e.g. six-monthly) medication reviews conducted by GPs and/or pharmacists. Managers should consider with GPs how to address medication issues in order to reduce high levels of prescribing error, and have a plan to obtain medication out of hours through liaison with GPs and pharmacies.
- Care homes should ensure that they and their care staff are familiar with the new NHS structure and integration arrangements, especially in relation to what has been agreed locally. They should know how complaints and challenges are handled.
- Networking, joining local forums and service development groups could all be seen as part of their advocacy role at a strategic level.

GPs' role in relation to the resident, the home and the wider NHS

- A GP's primary relationship should be with the resident who is their patient, rather than with a care home. Working in partnership with the home is, however, essential to providing a good-quality service to residents.
- Practice suggests that good relationships between GPs and residents are built up through regular contact and respectful, interpersonal communication which builds trust and confidence.
- GPs should be proactive in offering residents the wide range of diagnostic and therapeutic services in primary care, and full access through referral to acute and specialist hospital-based physical and mental health services. These can all contribute to maintaining each resident's health, wellbeing and independence. GPs should be aware that access to secondary services (e.g. mental health services) may be a problem for older people in care homes.
- Care home managers and GPs should agree how to handle relationships, communications and joint working between the home and the practice, to deliver what works best for residents. Issues to be considered include GP availability and interest; alignment of practices and homes; continuity, joint GP services for older people: a guide for care home managers protocols and role clarity; and development of shared understanding through, for example, the use of end-of-life frameworks and pathways.
- Care homes and primary care providers should recognise and support the role that nurses in care homes and GP practices can play in facilitating communication between homes and GPs. This includes practice nurses undertaking initial assessment visits and nurses in homes raising professional concerns. Nurse practitioners and other senior nursing staff can share up-to-date knowledge and skills with nursing and care staff in homes, and with residents and relatives.

- **Workforce development, standards and regulation**
- Managers and proprietors should ensure that care staff are trained and supported to be aware of and understand the medical and health needs of residents, and respond appropriately. This has implications for leadership and culture in the care home; raising staff awareness of residents' health needs; and provision of training and staff development opportunities.
- Managers and owners should be aware, and inform their staff, of the Care Quality Commission's (CQC) requirements on care home providers. This applies in relation to the health care of residents and requirements of NHS England and the CQC on GPs in relation to the care of older people.

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24-26 Ormond Quay Upper,
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 01 536 7330

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CRO # 610824

RCN # 20162221

CHY # 22308