GP care in Aged Care Facilities

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Living and Dying in Care Homes (RACFs) in the UK -a model for improvement using the GSF in Care Homes Programme

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Melbourne Aug 30th 07
Context

- Half a million people live in Care Homes-about 1%
- 20% deaths in care homes
- 86% all deaths in people over 65, 51% in people over 80
- The sector employs about 1.2 million people
- People stay on average 2-2.5 years in Nursing Homes
- An average home has about a third/quarter turnaround/year

Context

- Increasing use of care homes for dying patients
- Patients with high co-morbidities +/- dementia
- Variable standards- little clinical governance
- Some specific issues with lack of support from GPs
- Specific issues eg private ownership, staff turnover
- High crisis hospital admission rate
- Previous purely educational initiatives had difficulties
- A need to develop good measurement tools
- **New focus on Care Homes – National End of Life Care Strategy in England due end 07**
How could we improve this?
Develop a proactive system of assessment and support

Care Home and PHCT

Identify prognostic stage - code
Needs Support Matrix
Planning meeting
Advance Care Plan
Right care at right time
OOH Handover form
Confidence to cope in home
Anticipatory prescribing
Family meetings and information
Staff support
Follow protocol for final days

The Gold Standards Framework

A framework to deliver a ‘gold standard of care’ for all people approaching the end of their lives

A systematic approach to optimising the care delivered by healthcare professionals

www.goldstandardsframework.nhs.uk
The Gold Standards Framework in Care Homes Programme – GSFCH

“The biggest palliative care initiative in care homes so far”

- Based on GSF Primary Care
- New fully adapted model for care homes
- Developed since 03- phased 3 stage programme
- Almost 400 homes so far (mainly nursing homes)
- Systems focussed, patient centred + education - ‘head, hands and heart’

The Gold Standards Framework in Care Homes Programme

Goals

1. To improve the quality of end of life care
2. To improve collaboration with primary care and palliative care specialists
3. To reduce numbers of hospital admissions and increase home deaths
GSFCH Care Homes Programme

- Structured programme over 1-2 years
  - 3 stages: Preparation, training, consolidation
  - 4 gears, 4 workshops + homework
  - Facilitator training and support

- Fully resourced+ Locally facilitated

- Quality assurance- Accreditation process

- Evaluation- Improved quality of care, Decreased hospital admissions by 12%, Decreased hospital deaths by 8%

- See Briefing Paper and DVD

3 stage process
Preparation, training and consolidation + accreditation

<table>
<thead>
<tr>
<th>Stage I Preparation</th>
<th></th>
<th>Stage III Consolidation + Sustainability</th>
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</thead>
<tbody>
<tr>
<td>3-6 months</td>
<td>workshops in 9 months</td>
<td>9 – 12 months</td>
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</tbody>
</table>

- Enrolment of Care Homes
- Awareness Raising Meeting
- Local Coordinator Meetings
- Workshop 1
- Workshop 2
- Workshop 3
- Workshop 4
- ADA Before
- ADA After
- Ongoing ADA
- Final Appraisal
- GSFCH Accreditation
Four Gears

1. Getting going
   1. Coding, Register
   2. Meeting,
   3. Coordinator

2. Moving on
   1. Assessment of symptoms + Advanced care Planning
   2. Out of hours continuity
   3. Education and reflection

3. Gaining Speed
   1. Education and reflection
   2. Carers and family support Bereavement (and staff)
   3. Care in Final days

4. Cruising
   1. Sustain
   2. Embed
   3. Extend

Improved collaboration with GPs and specialist nurses

- Structured approach
- Working to agreed plans and procedures eg anticipatory medication
- Improved means of communication and documentation
Improved proactive planning
Prognostic Indicator Guidance

• Who can be considered to be nearing the end of life?

• Developed Prognostic Indicator Guidance paper (PIG) in consultation with national leads

1. Surprise question
2. Choice/ Need
3. Clinical Indicators

• See website

Identification of need in Care Homes patients- GSFCH

Prognostic coding ABCD

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

<table>
<thead>
<tr>
<th>Needs</th>
<th>Support from staff</th>
<th>Support from GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years</td>
<td></td>
<td></td>
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<tr>
<td>Months</td>
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<tr>
<td>Weeks</td>
<td></td>
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<tr>
<td>Days</td>
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</tbody>
</table>

### Advanced Care Planning

- **Advanced statement**
  - formalizes what patients and their family do wish to happen to them
  - can be useful to clinicians in planning of patient’s individual care
  - not legally binding and may also need Advanced Directive and DNAR

- **Advanced Decisions**
  - formalizes what patients do not wish to happen to them
  - legally binding document
  - related to capacity of decision making, Mental Capacity Act, Living Will etc.
GSF - Advance Care Planning

GSF template includes:

- Thinking ahead - open questions
  - what matters to pt/ carer
  - what to do and what not to do
- Proxy - who else involved (LPOA)
- Who to call in a crisis
- Preferred place of care & death - PPC/D
- Other requests eg organ donation / special instructions, legal matters
- DNAR/CPR discussed (‘Allow Natural Death

Evaluation of GSF Phase 2

- **Attitudes, awareness and approach**
  - eg confidence, focus, quality of care, GP involvement
- **Processes/Patterns of working**
  - eg proactive planning, communication, recording, information,
- **Outcomes**
  - eg reduced admissions (12%) and hospital deaths (8%),
  - more advance care planning
- **Suggested improvements**
  - eg better preparation, improved resources, facilitator support,
  - improved use of ADA
**After Death Analysis tool**

Please complete for last 5 residents/patients from your Care Home who have died.

For **Place of death** use: CH = Care Home, H = Hospital, Ho = Hospice, O = Other

**Quality of care** On a scale of 1 to 5 where 1 = Very poor care, 2 = Poor care, 3 = Average, 4 = Good care, 5 = Excellent care

**Date** = date of death.

<table>
<thead>
<tr>
<th>Main Diagnosis</th>
<th>Second diagnosis</th>
<th>Cause of death</th>
<th>Place of death</th>
<th>Stay in Care Home</th>
<th>Hospital stay in last 6 months</th>
<th>Crisis Events in last 6 months</th>
<th>Crisis admissions in last 6 months</th>
<th>ACP Used</th>
<th>PRN drugs listed</th>
<th>Last days pathway</th>
<th>Written information to family</th>
<th>Quality of Care</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>1</td>
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</tbody>
</table>

**ADA categories**

- **Diagnosis**
- **Cause** of death
- **Place** of death
- **Stay** in Care Home
- **Hospital** stay in last 6 months
- **Crisis Events** in last 6 months
- **Crisis admissions** in last 6 months

- Advanced care plan
- PRN drugs listed
- Last days pathway
- Written information to family
- **Quality of Care**
- Comments
Care homes residents place of death
Matched homes

<table>
<thead>
<tr>
<th></th>
<th>Pre GSF n=220</th>
<th>Post GSF n=217</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care home</td>
<td>80.9%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Hospital</td>
<td>18.2%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Other</td>
<td>1.5%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Staff quotes

- “It has helped them in their confidence ..to feel more valued as nurses. They have more confidence talking to GPs and taking the initiative”
- “It has made the team much more proactive and person centred with the care they provide”
- “ The ethos of GSF is proving itself...the feedback from staff has been very positive and the results have been positive for residents and relatives.”
Overall conclusions
Clifford C. Badger F.
University of Birmingham Study Phase 2

1. The GSFCH programme makes a positive difference to the quality of end of life care in Care Homes

2. Evidence of reduction of crisis admissions to hospital - changing place of death.

3. The ADA tool is a simple effective measurement tool for end of life care-ongoing benchmarking potential.

Palliative Care in RACF
Australian perspective

A/Professor Chris Toye
Professor Linda Kristjanson
A/Professor Samar Aoun

WA Centre for Cancer
And Palliative Care
This presentation will cover

- The profile of the population of older adults living in Australian residential aged care facilities
- How the concept of a palliative approach may be applied to this population
- The possible role of the GP as a member of the team delivering a palliative approach in aged care facilities

Most people living in Australian residential aged care facilities:

- are of a very advanced age (69% > 80yrs)
- have multiple co-morbidities and, therefore, multiple symptoms;
- have most of these needs over long periods of time; but
- require only a short period of end of life care¹.
Outcomes for permanent residents

• Death in the setting - 86.1%
• Discharge to hospital - 4.9%
• Return to home and/or family - 3.3%

Note:
Figures are from 2002
1.6% listed as “other”,
4% discharged to another aged care facility

Prevalence of Dementia

Occupied bed days accounted for by people with possible or probable dementia were 80% in 2001-2

### Australians aged 85+ with profound or severe restriction


<table>
<thead>
<tr>
<th>Condition</th>
<th>1998 (%)</th>
<th>2006 (n × 1000)</th>
<th>2031 (n × 1000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal</td>
<td>19.93%</td>
<td>62.5</td>
<td>134.9</td>
</tr>
<tr>
<td>Nervous system</td>
<td>15.87%</td>
<td>49.7</td>
<td>107.4</td>
</tr>
<tr>
<td>Circulatory</td>
<td>6.69%</td>
<td>21.0</td>
<td>45.3</td>
</tr>
<tr>
<td>Stroke</td>
<td>5.44%</td>
<td>17.0</td>
<td>36.8</td>
</tr>
<tr>
<td>Vision</td>
<td>3.50%</td>
<td>11.0</td>
<td>23.7</td>
</tr>
<tr>
<td>Respiratory</td>
<td>2.39%</td>
<td>7.5</td>
<td>16.2</td>
</tr>
<tr>
<td>Hearing</td>
<td>1.93%</td>
<td>6.0</td>
<td>13.0</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>1.58%</td>
<td>5.0</td>
<td>10.7</td>
</tr>
<tr>
<td>Cancer</td>
<td>0.80%</td>
<td>2.5</td>
<td>5.4</td>
</tr>
</tbody>
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**A Palliative Approach will**

- improve QOL for people with life limiting conditions or who are approaching death because of advanced age and frailty
- support the family

**A palliative approach is**

- an active approach to reducing symptoms and distress at any point in the trajectory
- not only relevant to end stage illness but does include end of life care
- tailored to meet the needs of the individual
A Palliative Approach involves early identification, assessment, and treatment of:

- pain and other physical symptoms &
- cultural, psychological, social, and spiritual needs

- Also involves a multi-disciplinary focus
- & collaboration and information sharing with the older person and the family

Palliative Care in Residential Aged Care Facilities

- Development of national guidelines for palliative care in residential aged care facilities
- Funded by Commonwealth Department of Health and Ageing
Principles Underpinning the Project

• There should be equal access to palliative care
• Palliative care practice should be based upon the best available evidence
• Guidelines for palliative care practice should reflect this evidence, a broad and inclusive process of consultation, and fit within the context of residential aged care
Domains addressed by APRAC Guidelines

- A palliative approach
- Dignity & quality of life
- Physical symptoms
- Indigenous support
- Family support
- Psychological support
- Spiritual support
- Cognitive Impairment
- Social support
- Advance Care Plans
- Bereavement support
- Volunteer support
- Cultural support
- Management Issues
- End of Life Care

Guideline Implementation

- Development of options for communication and implementation of the national guidelines and the national education and training program ($2.5 m committed)
- 10,000 copies of Guidelines printed, roll-out of training programs nationally, launched by Minister of Ageing (training kit, cds, video education)
- Issues considered:
  - Cost and accessibility
  - Rural and remote areas
  - Indigenous and cultural issues
  - Diversity of facilities and health care workers
The Role of the GP

In a palliative approach, each team member has a key role

GPs have special expertise related to:
- Diagnosis
- Disease trajectories and likely symptoms
- Treatments

- GPs are usually the only individuals able to prescribe medications for the residents of aged care facilities and to organise transfer to hospital
- GP needs to play an active role as coordinator of care
The complexity of the care requirements of this population demands

Communicating with other team members & the resident + the family about:

- active disease processes & likely symptoms
- likely disease trajectories
- advantages & disadvantages of various treatments

- Working with the team to ensure maximum effect from treatments plus minimum negative impact (eg side effects)
- Honouring the (informed) wishes of the resident
- Communicating effectively with outside agencies when needed (eg, specialist pall care, hospital settings)

what adjustments to practice can be considered to further the continuity of care and promote role of GP as coordinator of care?
RACF palliative Care from GP point of view

A/Prof Geoff Mitchell
Discipline of General Practice
University of Queensland
From GP point of view

• How to fit RACF patients in?
  – NH calls often routine
  – Reviews of medications
  – Emergencies - nursing assessment of severity of problems sometimes off the mark or protocols require GP response to relatively minor events (improving)
• Some GPs unwilling to do calls
• Some GPs unwilling to do out of hours

Systemic Problems

• Increasingly ill people admitted to aged care facilities – particularly hostel type care
• Registered Nursing supervision stretched, esp out of hours
• Culture of RACFs driven by the DoN, differs significantly.
• Accessing GP problematic
  – Timely reviews
  – Out of hours
Commonwealth Response
1. Aged Care Panels

- One per Division of General Practice
- Funded to improve GP access and improve quality at a local level.
- Agenda and work plans completely at discretion of the panel.

Examples of initiatives

1. GP clinics – one GP practice per NH. Routine care, regular assessments. Patients and GPs opt in or out of this arrangement

2. Local Palliative Care initiative: Emergency Palliative Care medicines kit
Commonwealth response
2. Enhanced Primary Care

- Funded annual assessment of persons in Aged Care
- Other Enhanced Primary Care initiatives:
  - Case conferences
  - Care Planning
  - Team Care Arrangements to access allied health

Challenges: GPs, out of hours call and managing very ill patients

- Identifying palliative patients in RACFs
- Reluctant GPs
- Delivery of out of hours care
- Judging when to admit to hospital
Suggestions for Discussion (1)

- The GP has a leadership role in development of advanced care plans. This needs to be documented and built into practice and thus staff will know what the next steps are even if the GP is not available.
- Covenant to family, embrace the family as a unit of care
- Ensure professional development in symptom management
- Focused symptom assessment clinic thus fostering a preventative approach instead of chasing symptoms (e.g. Silver Chain model)

Suggestions for Discussion (2)

- Regular case conferencing on patients
- GP practices can incorporate a nurse practitioner to work with RACF
- Consultation with aged care providers about communication issues (e.g., charting of symptoms)
- Organisation of joint study days for all members of the team to share perspectives and plan a strategy to maximise the positive outcomes for residents & families