Principles for General Practice working with Care Homes in Tayside

Developing the Multi-disciplinary Team and supporting General Practice

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Approved by NHS Tayside Older People's Clinical Board: 21st October 2021

Principle one

Every care home in Tayside will have a clearly described multi-disciplinary team to support them which will include as a minimum:

- District nursing team
- Allied health professional team including dietician, SALT, physiotherapy and OT
- Community pharmacist
- Locality pharmacist
- General Practice
- Medicine for the Elderly Link Professional
- Care Manager
- Psychiatry of Old Age Liaison Service

Principle two

Residents in care homes will have equitable access to the services of a multidisciplinary team. No distinction will be made on whether the care home is a residential or nursing home, or on the basis of age or other protected characteristics. There may be opportunity to extend the team principle for those with complex needs living within their own home, however these initial principles apply to care homes only at this stage.

Principle three

The prescribing or supply of non-medicines including oral nutritional supplementation, fluid thickeners, catheter supplies and wound management supplies will be provided within a governance system which supports best value provision. Usually this will involve the professional group with the necessary expertise and GPs should not be expected to oversee prescribing of the vast majority of non-medicines items.

Principle four

Polypharmacy reviews in care homes involving a multi-disciplinary team should be offered to all care home residents on a minimum of annual basis. Reviews may involve pharmacy, nursing, carers, GP , Psychiatry of Old Age and MFE professionals according to the needs of the resident. Residents and relatives should be invited to participate where appropriate.

Principle five

There will be a 6 week review carried out with residents and their families. This will occur 6-8 weeks after a person enters a care home which will involve care management and a health professional provided by the health and social care partnership (e.g. MFE ANP or experienced DN). This will identify issues to be raised with the wider MDT and include issues such as polypharmacy, catheter care and anticipatory care planning.

Principle six

GP clusters and GP representatives will work together with care homes to clearly describe the GP provision for each care home. This will take into account the benefits of continuity of care for care home residents and the teams caring for them, while preserving the right of people to choose their own GP if they wish.

Principle seven

An Anticipatory Care Planning approach will be adopted by all members of the multi-disciplinary team. Care homes will lead on ensuring a comprehensive care plan within the care home. A treatment escalation plan will be developed by the most appropriate person, which may be a senior nurse or a General Practitioner (NHS Tayside format may be adopted or alternative format according to local agreement). This will be held both within the care home and also the General Practice. The General Practice where a patient is registered will be responsible for entering the treatment escalation plan and other relevant information into the eKIS system for all residents and ensure this is shared with the care home (e.g. print off from the eKIS system to be passed to the care home).

Principle eight

Recognising the importance of this issue to the overall COVID-19 response and the demands on limited workforce resources, it is generally expected that services will redeploy / re-prioritise existing resources to ensure the requirements can be delivered. For NHS employed staff this will be through management direction and for independent contractors this will be through re-direction aided by contractual re-prioritisation (e.g. existing LES, ECS, polypharmacy resources) if required.