Scenario 4

A resident in a nursing home (living with dementia) becomes acutely unwell with pneumonia

WHAT HAPPENS NOW?

Two scenarios were played out based on what happens now;

1. GP visit and resident put on medication and observations but stays at the home
2. Admitted to hospital

It should be questioned whether an Advanced Care Plan/Advance statements were in place and whether the person had expressed any wishes. However the ACPs in place vary in quality and not everyone in care homes will have one.

A number of issues and learning points were raised for each scenario.

1. GP visit and resident put on medication and observations but stays at the home

- OOH GPs tend to admit to hospital as don't know the resident
- Resident might need IV, could this be done in the home once staff are trained
- Intensive Home Based Treatment Team – should they be involved?
- Rapid Response Team – only get involved once the condition (pneumonia) has been treated

2. Admitted to hospital

In this scenario, which was thought to happen most frequently, the following process was identified;

- Patient could go straight to AAU, but not the case if full
- Patient would always get antibiotics in A&E
- Patient would be on ED for 4 hrs + and carer from care home would have to stay with resident until admitted
- Patient would then be admitted to a ward (G41)
- Patient might have a SaLT assessment

Issues identified were;

- The out of hours handover form is not available / shared in care homes
- Could be moved at least 5 times in hospital and end up in Dewsbury before going home
- Ownership of covert meds
- Gold Standards Framework being rolled out in the Trust but not yet embedded in practice
- Responsibility to inform the families – needs to be clear
- No discharge notes are sent back with the resident
- TTO are a problem
- Perspective of care needed – 1:1 care deemed appropriate in hospital may not be the case in a care home, this may delay residents going back to their home
- Care home may want to re-assess resident before being discharged back to care home

- Understand rehabilitation potential for residents through MY Therapies, particularly with Dementia

WHAT SHOULD HAPPEN

1. Proactive Advanced Care Planning - ACP needs to be carried out whilst people have the capacity to make decisions. This could be carried out iteratively by a number of professionals; GPs, community nurses, consultants, in hospital if people are admitted.

*It was recognised that an ACP may not include cover for all scenarios that could arise. Therefore ongoing discussions about care need to be carried out with assessments carried out as required, i.e. quality of life assessment, swallow review.

2. Lasting Power of Attorney - Encourage those with dementia to set up LPA's whilst they still have capacity, particularly for health and social care needs.

It was recognised that cost can be a barrier to this and also the reluctance of families / individuals in having difficult conversations and setting these up. It was noted that the Alzheimer's Society have volunteers to help support people in setting these up.

3. All residents should be able to be admitted to AAU (72hr turnaround) – should more beds be available

4. Training available for care home general nursing staff to be able to administer IV or look at other models across the country

5. Discharge planning to start as soon as resident it admitted onto ward – linking into the new Trusted Assessor Model

6. Discharge notes should arrange back with the resident – introduction of NHS.net to care homes should help with sending information securing

.