Bedale Primary Care Nursing Development Plan 14 9 15

We are proposing the following for the Bedale Primary Care Nursing Development Plan. We do not have any natural partner practices within the CCG: our local district nursing team is shared with Masham practice which is attached to a different CCG. We have however discussed our plans with Dr Charles Parker our CCG contact and a fellow GP. The plan was developed in collaboration with local district nurses, long term conditions nurses, members of the Intermediate Care Team and private nursing home managers. We consulted patient groups, and managers and carers in a local residential home.

Topic: Chronic disease management

Objectives

To make routine nurse led review of diabetes, hypertension, IHD, stroke, peripheral vascular disease, COPD, asthma and CKD available to housebound patents including those in care homes.

To improve the management of long term medical conditions in housebound patients.

To enhance the chronic disease management skills of nurses working in nursing homes, and of Long Terms Conditions Nurses.

Enhance the skills of practice diabetic nurses in insulin management.

To improve communication and the coordination of care.

To implement these changes safely under the supervision of experienced practitioners, given the potential vulnerability of this cohort of often frail elderly patients.

Changes in role

Practice nurses to visit housebound patients at home, whether in private or residential care homes, for review of chronic diseases. Blood and urine tests to be done by DN phlebotomy service as is currently the case. Spirometry and ECGs to be done at the patients home by practice HCA when needed. All domiciliary reviews to be notified to the patient's usual GP who will review the records afterwards.

Practice nurses to visit patients in nursing homes to review of chronic diseases. Nursing home staff are to perform necessary blood and urine tests, collate information, and complete a short report prior to the visit when a joint assessment will be performed by practice and nursing home staff. All nursing home chronic disease reviews to be notified to the patient's usual GP who will review the records.

Long term conditions nurses to review patients on their case load. Practice HCA to perform spirometry or ECG where appropriate. The LTCNs are to complete a written report following their assessment which is then to be reviewed by the patient's own GP who will decide on further management and take any necessary action. Data is then to be coded by office staff.

Practice diabetes nurses to extend their roles and be more actively involved in the adjustment of oral hypoglycaemic medication and particularly in the selection of patients for insulin therapy, and

the prescription, monitoring and adjustment of insulin regimes. In this locality these roles have traditionally been the prerogative of secondary care diabetes specialist nurses.

Staff involved

Practice Nurses (PNs)
Practice Health Care Assistant HCA)
Long Term Conditions Nurses (LTCNs)
Nursing home staff
DN phlebotomy
GPs

Skills gaps

LTCNS and nursing home staff have little experience in chronic disease management in general. This needs to be tempered as it applies to the frail and elderly and those with cognitive impairment.

LTCNs need further guidance on how they might usefully feedback to practices.

Practice nurses have some experience of working with the frail elderly and those with dementia but would benefit from more guidance on the management of chronic disease in this cohort of vulnerable patients.

The practice diabetes nurses require further training in the drug treatment of diabetes and insulin management.

We need more HCA capacity. This will mean training a new HCA to provide back fill, and specifically as far as this project is concerned in spirometry and ECGs.

Action points and time frame

Practice chronic disease management guidelines reviewed and additional guidelines drafted on chronic disease reviews in elderly patients, including those living independently, those dependent and those with frailty or cognitive impairment (Completed July- August 2015).

Drafting of a reporting template for LTCNs (Completed August 2015)

Dissemination of the above guidelines and discussion with Practice Nurses and LTCNs including any suggested amendments and necessary training (August /Sept 2015).

Drafting of a preliminary assessment template to be completed by nursing home staff prior to joint reviews with the Practice Nurse, consultation, amendments, agreement and any required training. (August/Sept 2015).

Training of an additional HCA. Mentoring by our current HCA and Practice Nurses and by attending a spirometry course. The mentoring can start when funding is released (Oct 2014) and spirometry training is arranged for 7th September 2015 (now completed) .

Two Practice Diabetes Nurses and two GPs to attend a series of three seminars with a diabetes specialist nurse provided by Ashfield Clinical followed by mentoring sessions for the Practice Diabetes Nurses. (Sept /Oct 2015).

Performance Indicators

Number of domiciliary chronic disease reviews performed by practice nurses and LTCNs.

Number of joint chronic disease reviews done by practice nurses and nursing home staff.

Number of domiciliary spirometry performed

Number of domiciliary ECGs performed

Number of patients initiated on insulin in practice, Hba1c before initiation and 6 months after initiation and report on patient experience.

Topic: Frailty

Objectives

Improve the identification, assessment and management of frail patients. Optimise physical social and mental wellbeing, reduce emergency admissions. Maintain patient independence.

Background:
Frailty is the loss of physiological (or inner) reserve. It may present in crisis due to intervurrent illness (e.g. UTI) resulting in reduced independence or mobility, or as acute confusion / delirium / fall. Frailty can be considered a long term condition as it is a progressively abnormal health state. Frailty is very common, with a projected prevalence of 22-50% of people over 80 years old. It is a progressive condition with some preventable components. If well managed there are patient specific advantages such as maintaining wellbeing and independence, as well as advantages for health and social care as ongoing deteriorating frailty can cause a financial and resource strain.

Changes in role and practice

Identify patients on an ad hoc opportunistic basis. In addition use RAIDR to identify potentially at risk patients. When available the e-FI search can be used (available in Systm One but still in development for EMIS Web).

Assessment using SHARE-FI75+ done by any team member who suspects that the patient qualifies. Fuller assessment if the patient reaches threshold. Assessments are to be done at home for housebound patients by Drs, PNs, DNs, or LTCN or Intermediate Care if already on their case load.

Staff involved

Drs
PNs
Practice HCA
Office staff
DN service
LTCNs
Fast response nurses
Social services
Broadacres Housing Association

Assessment

Assessment can be undertaken using the SHARE-FI75+ toolkit.
http://bmjopen.bmj.com/content/4/12/e006645/suppl/DC1
(I suggest using the web based version as it calculates the score for you)

Questions are:

- Gender - Male / female
- Age- Age in years
- Fatigue- In the last month, have you had too little energy to do the things you wanted to do? Yes/No
- Appetite - What has your appetite been like? : reduced, same, eating more
- Weakness - Because of a health problem, do you have difficulty (expected to last more than 3 months): 1. getting up from chair after sitting for long periods? Yes/No
  2. Lifting or carrying weights over 10 pounds/5 kilos, like a heavy bag of groceries?

Yes/No

- Slowness - To be answered by the examiner: observed walking without help of another person or using support / observed walking with help of another person or using support / Not observed – in wheelchair or bedbound / Not observed – uncertain if impairment
- Physical activity - How often do you engage in activities that require a low or moderate level of energy such as gardening, cleaning the car, or doing a walk? More than once a week / once a week / one to three times a month / hardly ever, or never

A frailty score will then automatically be calculated and a frailty category assigned.
Read codes to be used:
Mild frailty: 2Jd0
Moderate frailty: 2Jd1
Severe Frailty: 2Jd2

General advice for all patients:

- Alcohol and smoking advice
- Optimise hearing and visual problems
- Check for low mood and offer intervention as required
- Check for memory impairment and offer intervention as needed
- Discuss diet and importance of nutrition
- Medication review
- Falls prevention advice / removing trip hazards etc
- Check continence issues
- Check for social isolation / loneliness
- Offer leaflets for
  - Safety at home - http://www.ageuk.org.uk/Documents/EN-GB/Information-guides/AgeUKIL7_Home_Safety_Checker_inf.pdf?epslanguage=en-GB?dtrk=true
  - Vaccination advice – annual flu vaccination leaflet
  - How to check your feet
  - Keeping warm and getting ready for winter - http://www.ageuk.org.uk/Documents/EN-GB/Information-guides/AgeUKIG27_Winter_wrapped_up_inf.pdf?dtrk=true
  - Guide to healthy ageing - http://www.nhs.uk/Livewell/men60-plus/Documents/Age%20UK%20and%20NHS%20A%20Guide%20To%20Healthy%20Ageing.pdf

- Exercise advice - http://www.nhs.uk/Livewell/fitness/Documents/older-adults-65-years.pdf

Patients with **mild** frailty should be offered supportive self management

- Medication review, referral to SS for support if needed, identify any personal goals and plan how to achieve them

Patients with **moderate** frailty should be offered care and support planning

- As for mild frailty as above
- Preventing unplanned admissions template can be used
- May benefit from formal advanced care directive / LPA

Patients with **severe** frailty should be offered a comprehensive geriatric assessment.

- Consider referral to local MDT service (meetings held on first Monday of the month)
- Complete assessment on page 16 – 21 of http://www.bgs.org.uk/pdfs/2015_gen_prac_frailty_toolkit.pdf This is the same form used for the unplanned admissions assessment form
- For more background info see guidelines at http://www.bgs.org.uk/campaigns/fff/fff_full.pdf
- May be more pragmatic to refer to frailty "hot clinics" for complex patients

Those patients who have a care plan made will have a copy in their own home, a scanned/electronic copy on the GP record, and notification of the Out of Hours service and Social services as appropriate.

Action points:

- Discuss at practice meeting and inform all practice GPs of document during September
- Attend next MDT meeting and present document to MDT team at next MDT meeting September – discussed 7.9.15
- Attend Practice Nurse meeting and inform them of document in September

Topic: COPD

Objectives

Review COPD care and increase support for patients during acute exacerbations and when discharged from hospital after exacerbation of COPD.

Improve functioning, reduce the frequency of subsequent exacerbations and reduce emergency admissions.

Improve monitoring via spirometry and nurse review for housebound patients

Changes in role and practice

Respiratory specialist nurse, practice nurse COPD lead, and practice medical COPD lead to review practice COPD guidelines generally with particular emphasis on the management of acute exacerbations.

Practice nurses and HCA to start home spirometry and COPD reviews

Staff involved

RSN

PNs
Dr Rhiannon Bigham

Changes in role and practice

PNs DNs and LTCNs and Respiratory Specialist Nurse to work together to offer telephone and/or face to face follow up of patients during acute exacerbations and after discharge from hospital, making such support more widely accessible. Such support will be of a lower level than that provided than the respiratory specialist nurses and will not involve blood gases or parental antibiotics but about providing more basic care well, eg. inhaler devices and technique and monitoring/follow up during an episode, prevention and anticipatory care. Home visits for housebound patients to be more widely available. Nurses to give advice re treatment of acute exacerbations and develop personal management plans for these.

Staff involved

PNs
LTCNs
Fast Response Team

Actions

Liaison with Respiratory Nurses to develop common approach and protocols incorporating South Tees Hospital protocols for treatment plans and management of exacerbations. Completed 9 Sept 2015.

Introduce ‘Personal Exacerbation plans’ – explain these during COPD reviews and consider the use of ‘rescue pack medication’. Rolled out as patients reviewed over the next year.

Develop ways of monitoring ‘rescue medication’ administered by practice, OOH, A+E, hospital etc. Oct – Dec 2015.

Preparation of draft updated practice guidelines on management of COPD and in particular acute exacerbations. (RSN, lead PN and RB by end Nov 2015)

Nurses especially Nurse prescribers to develop confidence in treating acute exacerbations. – mentoring by GPs/resp nurses. Practice nurses to go out on joint visits with the Respiratory Specialist Nurse over the next few months (October 1015 –March 2016)
Nurses and HCA to develop confidence re home visits – mentoring with resp. nurses /LTCN (Oct 2015-March 2015)

Presentation and discussion of draft guidelines by end of Nov 2015

- Other Drs, Linda Driver (PN), Sue Robinson (Practice HCA).
- DNs, LTCNs, Fast Response Team (?)

Topic: Palliative Care

Problem
Not enough nurses who work in the community and our nursing homes are competent and confident in identifying patients at the end of life, discussing end of life care, helping patients complete advanced care plans, completing and reviewing DNACPR forms and confirming death. This can lead to delated management, patient's wishes not being met and inappropriate CRP, in shor substandard end of life care.

Objective

For as many of our care home nurses, practice nurses, district nurses, long term conditions nurses and GP's to be trained in appropriate end of life competences as possible. These need to be appropriate to their work and the situations they are likely to be involved with.

Action

A core educational team including Elizabeth Price (lead nurse in end of life care and bereavement), Patricia Pattinson (Macmillan nurse), Cathy Parle and Donna Bowen (Long Term Conditions nurses) to be involved in putting together and rolling out 2 educational programs. Respiratory Specialist nurse Sue Spence also to be involved in adding training on identification of end stage COPD, advice on management, and services available.

Program 1 is aimed at care home nurses and is likely to take place at the nursing homes. It will cover at least: (Oct – Dec 15).

- Philosophy of palliative care. Communication – dealing with difficult questions, advance planning, DNACPR.
- Management of symptoms without medication. Dietetic concerns towards end of life.
- Recognising the dying patient and care.
- Bereavement.

The aim is to also train the care home nurses on confirmation of expected death and on the management of syringe drivers with support from the community nurses.

Program 2 is aimed at practice nurses, district nurses, long term condition nurses and doctors and is likely to be held at the GP Practice. It will cover at least: (Oct – Dec 15).

- Relevent parts of program 1.
- DNACPR in more detail.
- Confirmation of expected death.

Not all of this will be relevant to the practice nurses.

Current Resources

A new Yorkshire and Humber DNACPR training video.

Policy for confirmation of expected death is currently going through approval.

Topic: Access to Aids

Objective

Improve urgent access to aids to help support patients at home especially so avoiding emergency admission and allowing more considered, managed and more efficient use of Fast Response Team .

Staff involved

PNs
DNs
LTCN
Nursing home staff
Drs

Action needed

Formalise arrangements with Fast Response Team and dedicated OT. Oct 2015)

Topic: Access to miscellaneous interventions

Objectives

Improve access to miscellaneous interventions to housebound patients and patients in care homes.

Changes in role and practice

Practice HCA to do ECGs and spirometry on housebound patients, at home and in care homes, when needed.

PNs to visit housebound patients at home or in care homes for ear syringing.

DNs and DN phlebotomy to support nursing homes on an occasional basis for urinary catheterisation phlebotomy and INR testing in the event of short term nursing home staffing problems.
DNs to support nursing home staff in maintaining competency in urinary catheterisation.

Staff involved

PNs
HCA
DNs
DN phlebotomy

Action needed

Still trying to get final commitment from Pam Thorne, District Nursing Manager. She is concerned re liability insurance. (Oct 2015)

Project Costings

The costings for this project are included on a separate sheet. Staffing will be met from our current practice nurses increasing hours of work during the course of the project to either undertake the work directly or to cover for a colleague who will undertake the work (two PNs have already provisionally agreed to increase hours) and from one of our Phlebotomists training up for some HCA duties to enable the HCA to undertake some of the work. We envisage an increase in nursing time of 7 hours per week and HCA 7 hours per week initially in order to commence the project. This will be reviewed periodically to ensure that enough time is being invested in the project to make it worthwhile. Equipment costs and licence fees will be met partly from start-up funding already received and partly from ongoing funding.

Monitoring and Evaluation

The project will be subject to periodic monitoring and evaluation (initially monthly and then quarterly) by a small task group consisting of the Practice Manager, Practice Nurse, District Nurse and a representative of a Care Home, and led by Dr Wilkinson. Other appropriate representatives may also be co-opted onto the task group as the project develops, including representatives from the voluntary sector, patient representatives and/or carers. Performance measures will be agreed at the outset and these will be developed and reported on at quarterly intervals. Mechanisms will be put into place to track progress on a regular basis including, but not exclusively, the number of patients seen and any impact on admission rates.