Case Study 3 - Improving end of life care for Care Homes residents

GSF helps improve systematic proactive care and collaboration between GP practice and nursing home.

Case Study Summary - GP Dr Laura Pugh Cape Hill Medical Centre 2010-2018

Context. In this case study a GSF trained and GSF accredited GP practice (Cape Hill Medical Centre, Sandwell) reviewed the impact of the GSF training on their largest nursing home (63 beds). Comparative data collected over an 8-year period between 2010 and 2018 shows substantial improvements in care of their residents following introduction of GSF to the practice and care home.

Method. Data from Laura Pugh's report to CCG following LIS and GSF roll out.

Comparative data from before GSF training (2010-2012) and post training (2016-18) was taken. From 2013 intensive weekly ward rounds were initiated applying the principles learned through the GSF training, including personalised care, advance care planning, cross boundary communication and anticipatory care. Data was collected retrospectively from EMIS and from the nursing home records. The data collected included admission rates, hospital bed days, place of death and extra unscheduled primary care nursing home visits and telephone consultations. Qualitative data was also collected from residents, relatives and the nursing home staff.

At the start of the time 23 of the residents were registered at Cape Hill Medical Centre. By 2016 all 63 were registered at the practice.

Results- Measurable outcomes

Comparing the outcomes before and after GSF training:

- Admission rates: Dropped by a third on average (60-38)
- Hospital bed days: Were more than halved (488-222)
- Died in chosen place of death: Increased by 2.8 times (11-31)
- Residents who died in hospital: Dropped by 6-fold from 19 to 3
- Unscheduled GP home visit requests: dropped 14-fold from 5.04 to 0.35 per resident per year.
- Unscheduled GP telephone call requests: Dropped 16-fold from 7.47 to 0.45 per resident per year.
- The scheduled input from the practice increased from 0 to 2 sessions a week (One GP and one ANP session by 2018)

The qualitative outcomes from residents, relatives and staff was positive, for example:

> '' A very good rapport is established with the residents and their families because the GP and ANP give time in discussing the plan of care of with them.''
>
> ''It has improved the Home's reputation and the quality of service provided to our residents.''
>
> '' We feel reassured that mom is looked after well and can be seen by a regular GP/ ANP who knows her needs and is able to provide the necessary treatment and care.''