



Top Tips For GPs Caring For Care Homes

What is the best way to support the care homes I look after?

As GPs we continue to look after the most vulnerable in our communities during this pandemic in the same way as we did before: with ongoing continuity, individualised and holistic care. Many of us are liaising with our homes more than we did before and have naturally increased the care that we offer in line with demand.

For those of us who visit care homes on a regular basis, it is clear that many are not designed for isolating patients (which is advised for new residents and those with symptoms), and that from a wellbeing perspective it is not ideal to isolate vulnerable patients in their rooms for protracted periods of time. Social distancing of care home residents can also be very difficult, especially within dementia or learning disability environments, so we need to do everything that we can to support our patients and their carers during this difficult time.

The RCGP [clinical advisers](#) ¹ were surveyed to allow us to look at excellence in primary care practice across the UK during the pandemic and a summary of those interventions is provided in the following top tips. The list is not exhaustive and many of you will already be doing all that is contained in this guide and more. The aim is to show some of the excellent care home practice that is already happening across the UK.

If however, you are looking for ideas on how to further help your care home population, you may wish use some or all of the following examples. If you need more information on anything contained in the guide, you can contact clinicaladvisers@rcgp.org.uk

How is a care home formally defined?

A care home is defined by NHSE/I as “a CQC registered care home service with or without nursing”² and will include nursing homes, care homes and learning disability homes amongst others. We must always remember that the care home is the permanent, and only home that this vulnerable group have and we need to ensure whilst continuing to provide the best possible care, we also protect these residents, aiming to minimise the risk from us who inadvertently may bring the virus into their home.

How does covid-19 present in care home residents?

Whilst the vast majority of patients in the community present with typical Covid-19 symptoms including a new or persistent cough and high temperature, vulnerable care home residents may not. Instead, they may present with non-specific symptoms such as reduced appetite, falls, delirium or taking to their beds. This requires us to have a high index of suspicion for Covid-19 in care home residents, encouraging early isolation and barrier nursing until a more definitive diagnosis can be made.

Should I perform face to face consultations in care homes?

Martin Marshall as chair states “GPs continue to deliver care to patients in care homes, but as with all our patients, it might be delivered differently than usual, for example by telephone or video. This is in order to protect care home residents and staff, as well as ourselves and our other patients, against the spread of the COVID-19 virus”.³

The protection of our care home residents is of paramount importance due to their vulnerability and high risk of complications if they were to get Covid19. Where possible, routine reviews, ward rounds and consultations should be performed by remote consultation (telephone or video calls), with the help of care home staff, and many examples of this are in place across the UK. This is of course dependent on the care homes having access to video calls which should be provided by the homes themselves.

Clinical adviser examples: In Derbyshire, Grampian, Bradford and Lincoln, care homes are encouraged to buy their own video conferencing equipment for weekly or twice weekly ward rounds and for individual consultations. Occasionally care homes choose to use individual staff member phones and tablets for communication.

Should I ask the care home to buy their own equipment to take observations?

The [British Geriatric Society](#)⁴ has written 15 key recommendations for care homes which includes “care home staff should be trained to check the temperature of residents using a tympanic thermometer” and “where possible, to measure other vital signs including blood pressure, heart rate, pulse oximetry and respiratory rate”, to “enable external health care practitioners to triage and support residents according to need”. If the care homes are able and willing to follow this advice, it will increase the proportion of consultations we are able to undertake remotely and minimising the potential risk from health care professionals entering the home. Many care homes have already internally organised this, but some may require remote help from regional nurses (CCG, STP or health board), or on a more local level from practice nurses, how to use this equipment. A small amount of time invested to increase the confidence of care home staff in taking these observations will help increase the proportion of remote consultations we are able to perform as GPs.

If care homes do take observations, the British Geriatric Society states they “should be encouraged to use the [RESTORE2](#)⁵ scoring system, to recognise deterioration in residents and to communicate concerns to health care professionals”. RESTORE2 is based on the NEWS2 score from the Royal College of Physicians.

Clinical adviser examples: Bradford has invested in telemedicine for their care homes at a trust wide level with all 150 care homes having access to the equipment required for detailed remote clinical review. Derbyshire and Luton GPs have encouraged the homes to have access to simple and inexpensive equipment such as thermometers and blood pressure machines in line with the British geriatric society advice.

What If I cannot resolve the issue remotely, should I visit?

Not all clinical consultations, even with observations, will be completed remotely and some face-to-face reviews will need to be undertaken.

Different areas across the UK have varying solutions. Risk assessment should be undertaken, as with all patients, to determine the risk of covid-19 with as much of the history and management performed over the phone or video call as possible

If an examination is required, always ask, can the patient be brought to the practice safely?

- Some care homes will bring residents to see you with a carer. If this is possible, follow your local protocols for Covid-19/ non-Covid-19 patients, wearing appropriate PPE as per Public health guidelines⁶
- If the patient cannot be brought to you and a home visit is required, follow local protocols for Covid-19/ non Covid-19 patients.

Clinical adviser examples: Kent has a frailty home visiting service supporting care homes. In Wolverhampton and Derbyshire there is a red home visiting service for all confirmed and suspected Covid-19 residents, commissioned by the CCG, meaning individual GP practices do not need to visit these “at risk patients”.

Should I advise my care homes on PPE use?

Care homes as employers are responsible to ensure their staff are adequately protected with PPE based on public health guidance⁶. However, it is our collective responsibility to help all of our multidisciplinary team to keep everyone safe. If during your remote consultation video calls you notice PPE issues, then it is advisable to discuss it directly with the staff member and advise them to escalate concerns to their line manager as required.

Clinical adviser examples: A Bedfordshire GP states “we found a gap in the theory of PPE and the real understanding of non-medically trained staff and so repeatedly reinforce the messages when consulting remotely. I taught the correct mask use to a nurse and asked for her to disseminate the information to other team members”. A Derbyshire GP stated that the paramedics had called to raise concerns that care home staff were not donning and doffing PPE as per guidelines and had spent time teaching the care home whilst visiting a patient. The GP then followed up with the lead nurse and offered remote teaching to help the team.

Should I arrange training and teaching sessions for my care home?

As we learn more about Covid-19 and guidelines change, it is good practice to share this information. This will help build relationships and trust with the home, benefiting the holistic care of our patients and potentially saving us time in the longer term. In return, our care homes are more likely to share information with us, aiding the 2-way conversation and an increasing trust relationship to develop.

Impromptu teaching and sharing of ideas happen all the time in primary care, across the community teams, including in care homes. This should continue during the pandemic remotely, even when we are not visiting the care homes regularly.

Clinical adviser examples: In Milton Keynes repeated reinforcement of PPE during remote consultations and a handout produced for care home staff. In Kent, regular CCG multidisciplinary webinars to improve care of vulnerable resident. In Hertfordshire regular webinars used by the care providers association and in Derbyshire virtual educational meetings for care home staff 2-3 times per week lasting 45 minutes and a “good practice guide for care homes during the pandemic” developed to upskill on PPE and aspects of care relating to Covid-19. Many clinical advisers described impromptu training of PPE donning and doffing during video consultations.

Teamworking to benefit care homes

Many care homes across the UK are already aligned to individual GP surgeries to aid continuity of care, build relationships, increase trust and reduce the number of clinicians visiting each home.

The whole multidisciplinary team is essential to high quality care in this sector. Whilst a named or lead GP is essential for all patients (irrespective of where they live), in many areas advanced nurse practitioners (or equivalent) are the key link between practices and care homes. These clinicians feed into a wider multidisciplinary team including district nurses, GPs, palliative care nurses, phlebotomists, physiotherapists, occupational therapists, speech and language therapists, community psychiatric teams, pharmacists, care coordinators, social prescribers, the out of hours providers and many more. Choose the best person, ideally with the most experience or an interest in vulnerable populations to be your care home link, ensuring good record keeping and hand over. This person should, where possible, link in with any regional support teams available and chair any multidisciplinary meetings held for this cohort of patients as in some areas, the addition of a geriatrician or GP with a specialist interest in elderly care has been added at a regional level to support the GP practice when needed.

24-hour care is provided by primary care and out of hours teams across the UK with sharing of clinical notes possible in some (but by no means all) areas. GPs continue to aid 24-hour communication, even when IT systems are unable to talk to each other and writing detailed care plans and special notes (or equivalent) for the out of hours providers, giving hand over verbally when needed continues to be best practice.

Clinical adviser examples: All care homes have been aligned in Grampian for years building trust and proactive care. This enables the care home staff to be our eyes and ears. We trust their judgement when someone is unwell as we know them so well. The care homes also value this relationship with West Hallam Residential home stating "There is a fantastic relationship between the home and the GP surgery which is entirely built on trust... the GP surgery listens and takes everything we say on board, it is the same the other way around... the home absolutely trusts the GP surgery"

What is the best way to communicate with care homes?

During the pandemic, our care homes will require additional support for residents and staff if Covid-19 infects residents. GP surgeries should continue regular calls to care homes and it is clear many have increased the routine contact with homes to pre-empt patient deterioration, offer early advice, support and treatment. The use of telephone and video consultations has in many cases decreased the response time to support care homes, further aiding that support. Rather than waiting for a "home visit", residents can be assessed remotely as part of a standard GP clinic when emergencies arise which has been beneficial to residents and staff. In addition, GP surgeries and community teams can help with communication more widely with some examples below.

Clinical adviser examples:

Homes supporting each other: *In Kent, care home managers have created a virtual support group to share information between homes and to offer support.*

GPs supporting care homes: *In Kettering a lead GP has set up a whatsapp care home group to enable easy access to medical support 24hours a day in line with the British Geriatric society guidance⁴. In Derbyshire, one practice holds a live white board of all residents in their care homes who have been unwell, admitted to hospital or are on end of life pathways. This ensures detailed hand over to all members of the clinical teams*

Regional support of care homes: *In Hertfordshire an online hub has been developed for all care providers with a dedicated phone line and email address for support. In Derbyshire a care home contingency cell with all key stakeholders including the CQC give enhanced support to care homes and is a single point of access for homes who need additional support and help and specialist centralised nurses proactively call each care home offering ongoing nursing support where needed.*

Out of hours communication: *Sharing of patient notes is the ideal solution to aid care outside of care GP hours, but despite this not being possible in many areas, GPs continue to provide care plans, special patient notes (and equivalent) with verbal handovers when needed. In Derbyshire care homes can now access 111 on a special bypass line, aiming to reduce any unnecessary wait for care home staff, and collaborative working guides have been developed to ensure joined up working with the regional ambulance service aiding continuity of care.*

What do I do when prescribing remotely for care homes using Medical Administration Record charts?

Most care homes will use MAR charts to aid with medication. For prescribers, when changing or issuing new medication, the RCGP and the Royal Pharmaceutical Society's "Involved and informed: Good community Medicines support" gives clear guidance on how to support community carers with medication⁹. It is not necessary for the prescribing GP to update the MAR chart, which if in use "should be updated with any changes (which) can be completed by the social care provider, pharmacist or dispensing GP as determined by local policies"⁹.

What is the advice on advanced care planning and hospital admissions for care homes?

One of the benefits of the continuity of care given by GP practices to care homes is that we often know the residents well. This information about their health and wellbeing and their disease burden, added to the knowledge from their carers and their family, enables us to have detailed and open discussions about escalations of care and what our patients want when they become more unwell. It also allows us to be open about the benefit (or otherwise) of hospital admissions.

The British Geriatric society⁴ state that during the pandemic advance care plans should be reviewed "as a matter of urgency with care home residents. This should include discussions

about how COVID-19 may cause residents to become critically unwell, and a clear decision about whether hospital admission would be considered in this circumstance.” These decisions must be individualised and the [RCGP](#)¹⁰ make it clear that “it is unacceptable for advanced care plans, with or without DNAR form completion to be applied to groups of people in community settings”

What guidance is available for end of life care?

For some residents in care homes treatment decisions are made with the patient, family and carers not to admit to hospital through personal choice, or because admission is thought to be futile. For these patients good symptomatic care is essential and guidance has been produced¹¹ to help with this during the pandemic and much of this care can be provided through remote consultations, working closely with the multidisciplinary team and care home staff.

Clinical adviser examples:

In [Bedfordshire](#), we ask the care homes to advise us if a patient is deteriorating to ensure we complete a video consultation to support the staff, family if in attendance, but also to ensure a doctor has seen the patient during their final illness.

In [Luton](#) GPs ensure bereavement calls are offered to relatives of care home residents who have sadly died, some of whom are very distressed by being separated from their loved ones, to answer questions and to give support.

In [Wolverhampton](#) there is support from the local hospice and palliative care teams to improve the symptomatic care of residents.

In [Derbyshire](#) there is a dedicated website for care homes to help with end of life care¹², virtual education sessions for care home staff and proactive contact with every home by a specialist nurse on a weekly basis to help with end of life symptom control.

What other support can I give the care homes?

The carers looking after our vulnerable patients are working tirelessly in very difficult circumstances. Some carers may also be scared or anxious about Covid-19 and the impact the disease may have on them or the home itself. Talking, listening and offering support to the carers, offering to talk to relatives when appropriate may help when time allows. Remember to look after yourself and your team. The relationship we have built with the care homes , patients and staff mean we also feel those losses.

Clinical adviser example: In [Bedfordshire](#), I have been making support calls to the nurses and managers of the care home who inevitably feels the impact of the losses. In [Hertfordshire](#), an employee assistance programme has been set up to give emotional support to care home staff when it is needed.

Acknowledgements

With thanks to the clinical advisers for their help in developing these top tips.

If you are a GP and are interested in influencing policy and practice in UK general practice, please consider joining the RCGP clinical adviser network [here](#) and if you have any additional examples of good practice in your area relating to care homes that is not covered here please contact clinicaladvisers@rcgp.org.uk

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