# Pilot – Care Home Project

## What is the impact of introducing an Advanced Clinical Practitioner into a residential setting?

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# Background

* Higher hospital admission rates from RH's compared with those from own home
* Unnecessary admissions
* Hospitalisation can cause irreversible decline in function, stress and anxiety
* Hospitalisation contributes to overcrowding and longer wait times in ED's
* Poor staff knowledge/competence leads to increased referrals to NHS services (GP/111)
* Increasingly complex health needs within RH population can be mostly managed by ACP

# Aim

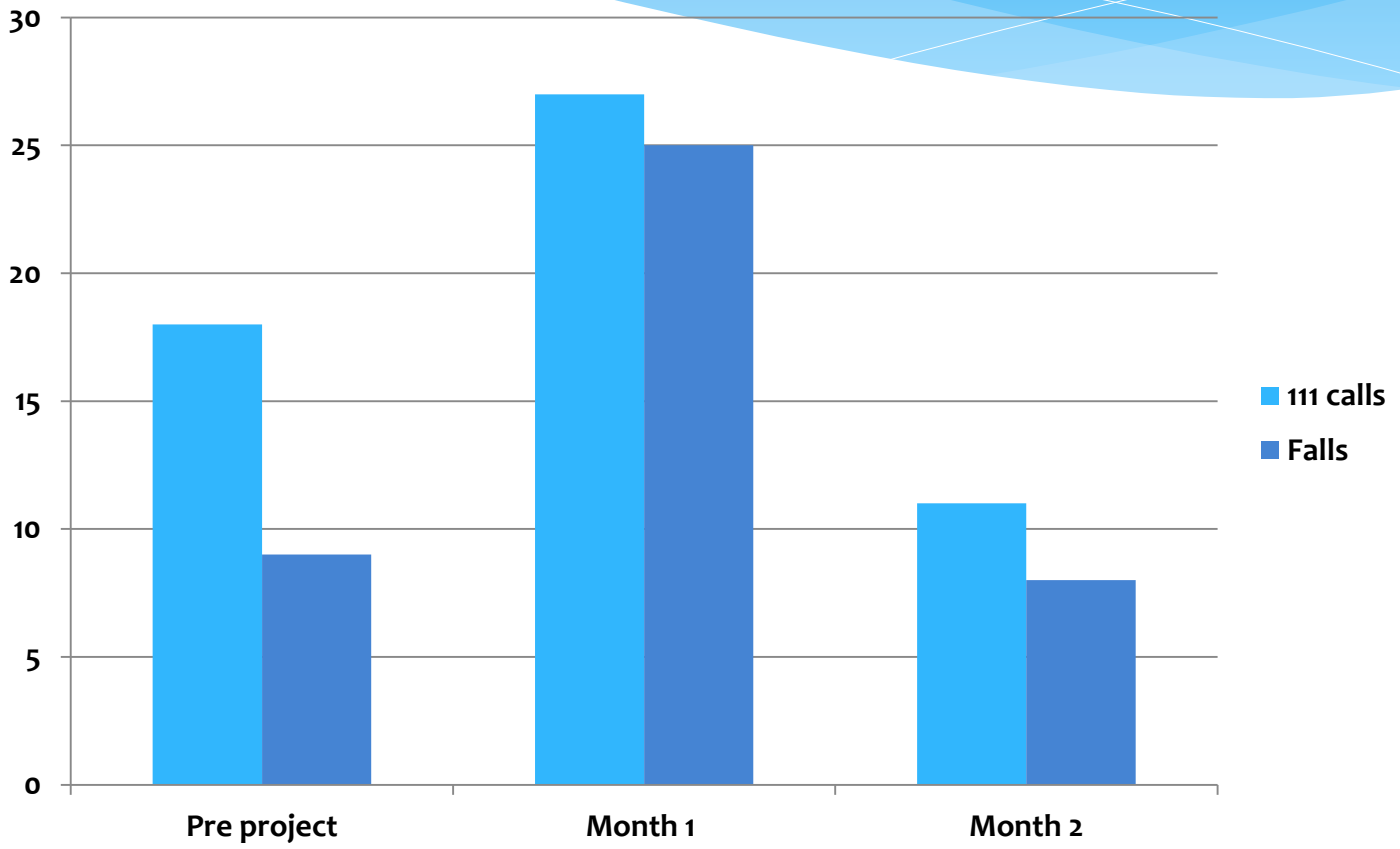
**To reduce unnecessary unplanned ED & hospital admissions from a Residential Care home on the Isle of Wight**

* Reduce 111/999 calls
* Ensure care home staff can recognise a deterioration
* Lessen GP callouts
* Provision of an alternative HCP
  * Holistic approach
  * Review/follow-up
  * Timely response
* Effective review/follow-up of acutely unwell residents to ensure effective treatment
* Decrease falls and conveyance
* Facilitate discharge
* Risk stratification of 'high risk' residents

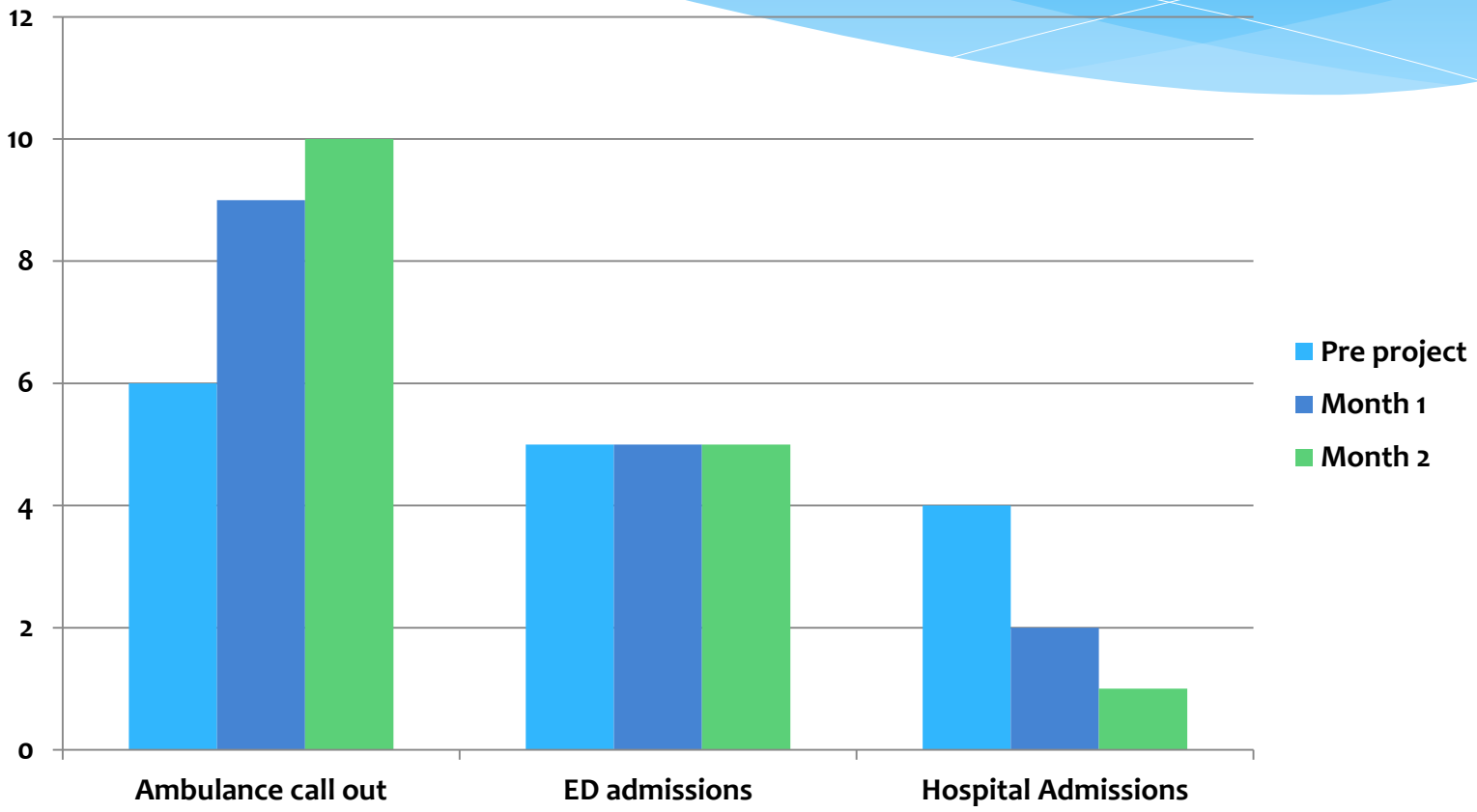
# Methodology

* Pre-project data collection
* Identification of RH, introduction to Manager and staff
* Face to face meetings – CCG, GP's,  Telehealth team
* Tool development/GP letter/Information leaflet/Questionnaires/referral letter
* Screened all residents using screening tool & development of RAG rating
* Education staff – 'soft signs'
* ACP daily visit for all acute referrals/falls – assessment, treatment, review/refer
* Collation of qualitative and quantitative date post project

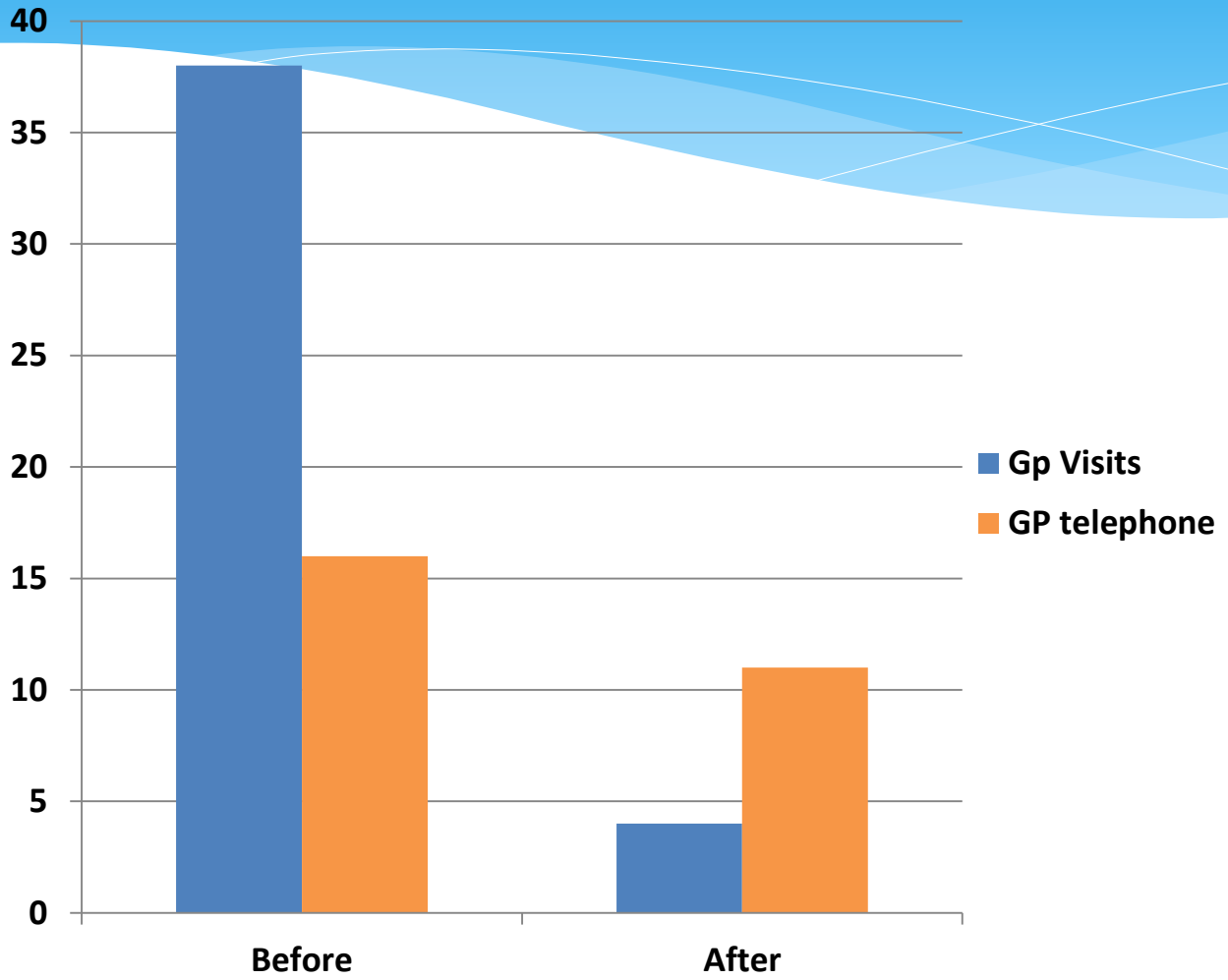
# Results- Impact on Acute services 1



# Results- Impact on Acute services 2



# Results - Impact on GP's

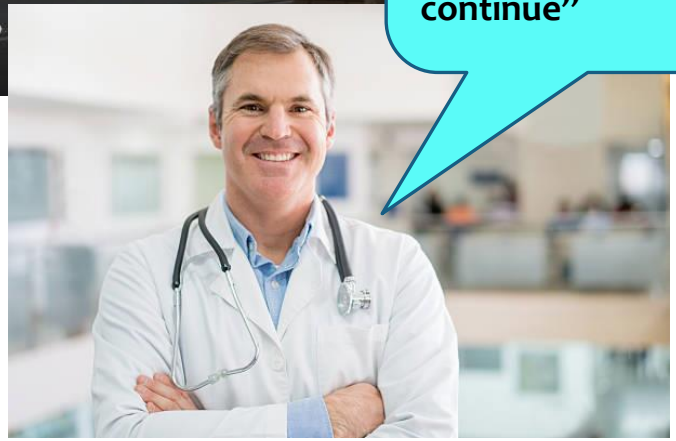


# Feedback

"Treatment is swifter as we don't have to wait for a visit which can sometimes be up to a week, when the patient often deteriorates"


"content to be treated by an alternative HCP, just want to be treated quickly and effectively"

"home visits reduced from an average of 6-8 per week to 1-2, I would like to see the project continue"



# Conclusion & Limitations

**Key findings:**

* Overall – Reduced 111 calls, admissions, GP callouts & falls
* Potential cost saving implications
* Limited requirement for discharge facilitation

**Limitations:**

* Small study in one care home – not comparable
* Time constraints
  * Unable to undertake full health reviews of 'high-risk' patients
  * Unable to undertake preventative chronic disease management
  * Data collection and analysis
* Full cost-effectiveness yet to be established
* Some inappropriate referrals
* Education of staff
* Equipment
* Independent care home policies and protocols

# Future Development

* Telehealth will assist with triaging remotely – save time and appropriateness
* Small project over a short period of time - needs to continue and be expanded out to other localities and introduce more care homes – larger and more meaningful data
* Monitor admitted patients to assist in early discharge and work with 'Hospital to Home' project – Alison Spearman

# Thankyou to:

* Mark Rawlinson – South Wight Locality Lead
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