

Care homes - Improving the effectiveness of multidisciplinary working

The British Geriatrics Society (BGS) report Quest for Quality called for integrated provision;¹

'The needs of care home residents require co-ordinated input from generalists and specialists of multiple disciplines in partnership with social care professionals and care home staff. Partnerships are essential, built on shared goals, reliable communication and mutual trust'.

The report highlighted the need for:

- Comprehensive assessment of new residents on admission and the development of a patient-centred care plan within a specified time period.
- Prompt recognition of residents requiring imminent end of life care, identifying issues and goals and making appropriate treatment plans within a shorter specified time period.
- A regular structured multidimensional review at least every six months or sooner if clinically indicated. This should be used to modify healthcare goals, and guide clinical interventions in and out of hours.
- Assessments to include medication review in partnership with the community/care home's pharmacist. These should be at a frequency over and above essential General Medical Services (GMS) standards, at least every six months. A medication review should also be completed following discharge from an acute hospital admission.
- Assessments to include risk assessment, for example for falls, with appropriate prevention strategies.
- Creation of an advanced care plan for acute events and for preferred end of life care, in partnership with residents, their relatives/representatives and advocates.
- Regular scheduled visits by an appropriately commissioned GP or specialist nurse. This is to review particular residents with new needs. Also perform routine reviews and to liaise with other health and social care professionals - including geriatricians - who are, or who need to be, involved in a patient's care.

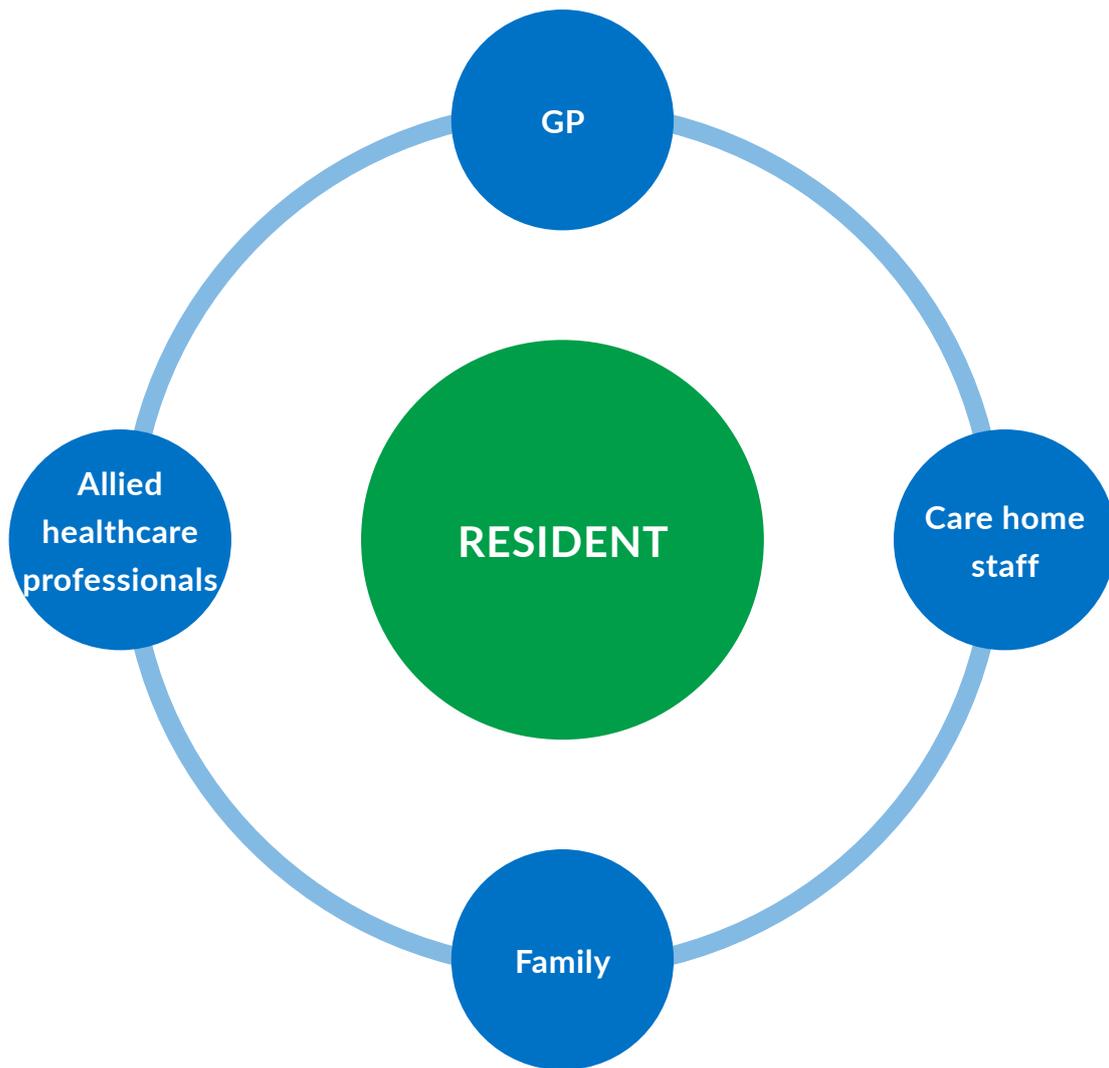
Multidisciplinary team (MDT) working is defined by NHS England as *'how health and care professionals work together to support people with complex care needs that have been identified through risk stratification and case finding'*.²

A multidisciplinary approach involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations.²

The benefits of effective multidisciplinary working include:

- Improved health outcomes for residents.
- The promotion of person-centred care (success is highly dependent on taking into consideration the needs, circumstances and preferences of the individual receiving care).
- Increased satisfaction for residents, their relatives/representatives and care home staff.
- More efficient use of resources.
- Enhanced knowledge sharing and education.

The resident is an integral part of any multidisciplinary team



Communication

Effective methods of communication are vital for everyone involved to work together to enhance patient care.

- Develop relationships with key individuals and teams such as the GP and their practice staff; the community pharmacist and the other pharmacy staff; dentist, dietician, continence nurse, tissue viability nurse (TVN) and the resident's relatives/representatives. Named people can be kept on a key contacts list (see attachment 1).
- Ensure the key individuals are kept up-to-date with any relevant changes within the care home. For example change of pharmaceutical provider, change of medical services provider, new medication administration systems, and new systems for recording resident information.
- Identify how any issues that have been identified can be communicated effectively and a way of moving forward.
- Agree how urgent information will be communicated, e.g. sent in written form by fax followed up by a telephone call to confirm receipt.

Examples in the care home include:

- Ensuring accurate information is available about the resident to be able to identify their health needs generally and during a formal review. This includes access to up-to-date records such as:
 - » Medication Administration Record (MAR) chart
 - » Antecedent-Behavior-Consequence (ABC) charts

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- » Waterlow scores
- » Pain assessments
- » Bowel charts
- » Skin care charts
- » Pressure ulcer prevention charts
- » Weight
- » Body Mass Index (BMI)
- » Malnutrition Universal Screening Tool (MUST) screens
- » Blood glucose test results
- » Blood pressure readings
- » Clinic/discharge letters and hand held documents such as anticoagulant books or catheter passports.

Ensuring that a record of medicines administered by visiting health professionals is kept on the resident's MAR chart.³ Health professionals who are visiting the care home to administer a medicine(s) to residents should make their record of administration available to care home staff, if asked by the care home.

Having a robust system for dealing with medical correspondence which facilitates timely action, review or follow up and ensures that where necessary other healthcare professionals are made aware and can act accordingly. This includes diary dates.

Making the most of the GP visit

The visit by the GP is an opportunity not only for the assessment of residents who are acutely unwell but also to be proactive in addressing the health needs of others.

The list of residents to be seen at the visit should be communicated to the GP in a timely manner, as agreed with the surgery, see attachment 2 (GP visit request form). The urgent GP visit request form (attachment 3) can be adapted for local use. Attachment 4 has an example of a post GP visit, medication change form.

Proactive examples include:

- Prompting the review of laxatives, analgesia, anxiolytics, hypnotics and antipsychotics for the treatment of behavioural and psychological symptoms of dementia (BPSD).
- Discussing patients where dementia is suspected.
- Discussing the risk associated with the resident refusing their medication. Explore the reasons for refusal of medication e.g. if nausea, document the reasons and request an antiemetic prescription (but do not add to repeat template). This will help the resident to take their medication and return to normal functioning.
- Discussing blood pressure and blood glucose readings as well as issues with hydration and nutrition.
- Reviewing the need for seasonal medication such as antihistamines.
- Discussing the timing of medication, e.g. if the resident tends to be asleep during the medication round.

In advance of the GP visit identify any issues relating to individual patients. For each issue identified establish any information that may be relevant to inform the visit.

Table 1: Examples of possible issues and relevant information to consider in advance of the GP visit.

<p>Pain</p> <ul style="list-style-type: none"> • Is it new or old pain? • Indicate the type and location, frequency, duration. • Consider what could be the possible cause. • Has anything helped? • Refer to pain assessment tools 	<p>Emotion/mood</p> <ul style="list-style-type: none"> • Is the resident showing signs of depression? • Are they isolated, lonely, withdrawn? • Unmotivated? • Recently bereaved? • How frequently is this observed; sometimes/often?
<p>Behaviour</p> <ul style="list-style-type: none"> • Are they agitated and/or displaying behaviour that challenges others? • Are they putting themselves or others at risk? • Refer to the ABC chart. 	<p>Sleep</p> <ul style="list-style-type: none"> • Do they have difficulty falling asleep? • Do they wake up during the night? If so, are they agitated or do they remain in bed awake? • How frequently does this happen? Does anything help? <p>Ask colleagues on the night shift to keep detailed records, rather than just stating that the resident is awake or has difficulty sleeping.</p>
<p>Nutrition</p> <ul style="list-style-type: none"> • What is their eating and drinking like? • Do they remember to eat or drink? • Do they require assistance to eat or drink? • What is their weight over the last 3 months? • Are they on any special diets? • MUST score? • BMI? 	<p>Swallowing reflex</p> <ul style="list-style-type: none"> • Do they have problems swallowing food, drink or both? • Do they feed themselves? • Is their food or drink currently modified, e.g. soft diet, pureed diet or thickened fluids?

These areas should also be considered when the resident is due to be reviewed by other teams such as the mental health team or dietician.

Enhancing medication reviews

Medication can be a big part of the care provided to residents. The Care Home Medicines Use Study (CHUMS) identified that care home residents were taking seven medicines on average daily.⁴ It is therefore important that they are being prescribed and administered appropriately.

Frequency of review

- The frequency of review should be based on the health and care needs of the resident. However, the resident's safety should be the most important factor when deciding how often to do the review.³
- Palliative care/end of life patients should have a MDT review at least three-monthly.⁵
- The frequency of planned medication reviews should be recorded in the resident's care plan.³
- The interval between medication reviews should be no more than one year.³

Who should be prioritised for a medication review?

- Residents new to the care home.

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- Residents whose condition has changed significantly (decreased mobility, increasing frailty, cognitive decline, continence issues, risk of skin integrity being compromised).
- Residents who have had contact with other services such as those recently discharged from hospital (including those having recurrent hospital admissions) or attended A&E.
- Residents identified through risk stratification or case finding.
- Polypharmacy or medicines management issues.

The process

- Discuss the resident's history (medical as well as social history where necessary).
- Identify the resident's multidisciplinary care needs.
- Identify the resident's level of frailty, (falls, delirium, incontinence, immobility and susceptibility to side effects of medicines).
- Identify desired outcomes.
- Identify the tasks that need to be undertaken to achieve these outcomes and allocate tasks.
- Assess whether previously identified outcomes have been achieved.
- Record outcome of the meeting, see attachment 5 (Medical care plan - post MDT) for an example.

Remember the 3 R's

- Register – agree a method of coding residents in terms of their frailty.
- Recall – have a system of identifying residents due for review, this should be at least annually, perhaps their date of birth or date of admission to the care home.
- Review – prior to the review consider having the GP conduct a physical examination, enquire about any lab tests or laboratory results, identify issues for discussion and what support is required to manage the resident.

Multi-Disciplinary Teams (MDTs)

National Institute for Health and Care Excellence (NICE) guideline, SC1, Managing medicines in care homes highlighted that an effective approach to medication review is the multidisciplinary team approach.³

The team can comprise of health and social care practitioners plus the resident and/or their relatives/representatives or carers.

The healthcare and social care practitioners may include a:

- Pharmacist
- Community matron or specialist nurse, such as a community psychiatric nurse, palliative care nurse
- GP
- Member of the care home staff
- Practice nurse
- Social care practitioner
- Optician
- Palliative care consultant
- Geriatrician could possibly be involved.

Roles

- The GP or geriatrician would generally facilitate the discussion; they assist in diagnostics or management of the problem and resolution.
- The pharmacist assists in identifying and resolving medicine management problems. They consider the indication, safety and benefit of the medication.
- Allied health care professionals, e.g. physiotherapists, speech and language therapists, occupational therapists, dieticians and mental health practitioners, work within their speciality to diagnose or manage problems.
- The social care practitioner seeks to identify and resolve any barriers to providing effective care for that individual, e.g. issues regarding safeguarding.
- The resident's relatives/representatives should also be included.

The role of the care home staff

During the MDT others may take the lead, but the role of the care home staff is fundamental in the planning and management of care for the residents.

Quite often the role of care home staff is to ensure the views and preferences of the resident, where known, are part of the discussion. This might also involve concerns of their relatives/representatives.

The care home staff are involved in the day to day care of the resident. Therefore they can provide insight upon likely success of a particular intervention. They can also advise on how realistic it is to implement.

Care home staff can ensure that actions agreed at the meeting are communicated to other members of the care home team and are implemented accordingly.

Preparing for an MDT

- Know which residents are going to be discussed at the MDT meeting.
- Ensure there is access to:
 - » Individual folder/care plan
 - » Test results or observations
 - » Future appointment dates
 - » Outcomes of recent reviews in the community
 - » MAR chart
 - » Other information that might be relevant, e.g. discharge letters.
- Discuss with care home colleagues in advance, any key issue(s) for each resident and prioritise them.

Transitions between care settings

It is essential that during transfers of care that there is effective communication and sharing of information. See the PrescQIPP transfer of care webkit for further information www.prescqipp.info/transfercare

Transfer to hospital

When the resident is admitted to hospital in addition to the transfer letter, ensure the following is communicated:

- Any advance care plans.
- Any information about their behavioural issues (e.g. triggers), communication needs, dietary needs etc.

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- Current medication (a copy of their current MAR chart should be sent indicating the total number of pages sent), highlighting when the last dose of 'when required' medication was administered.
- Details of their current GP.
- Any other relevant documents such as a catheter passport, copy of their body map showing the location of transdermal patches.

Discharge from hospital

When the resident is discharged the following information should be made available:

- Nursing transfer letter.
- Discharge summary. These should be stored securely and with the residents consent made available for their relatives/representatives to read.
- Supply of medication (where changes have occurred).
- Any other documents that were shared with the hospital e.g. catheter passport, advance care plan.

It is important that if any information is missing or unclear that this is followed up with the hospital.

References

1. Quest for Quality. The British Geriatrics Society (BGS) Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes: A Call for Leadership, Partnership and Quality Improvement report.* 2011. Accessed 28/05/2016. Available online at: www.bgs.org.uk/campaigns/carehomes/quest_quality_care_homes.pdf
2. MDT Development - Working toward an effective multidisciplinary/multiagency team. NHS England, 2014. Accessed 28/05/2016. Available online at: www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf
3. National Institute of Health and Care Excellence (NICE)SC1: Managing medicines in care homes. March 2014. Accessed 29/05/2016. Available online at: www.nice.org.uk/guidance/sc1
4. Alldred DP, Barber N, Buckle P, et al. Care Home Use of Medicines Study (CHUMS): prevalence, causes and potential harm of medication errors in care homes for older people. *Quality and Safety in Health Care* 2009; 18:341-346.
5. The Gold Standards Framework. Full Guidance on Using QOF to Improve Palliative/End of Life Care in Primary Care. Version 25. July 2006. Accessed 08/06/2016. Available online at: <http://www.goldstandardsframework.org.uk/library-3#lib-primary-care>

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Further reading

PrescQIPP Care Homes webkit, available at: www.prescqipp.info/carehomes

PrescQIPP Transfer of care webkit, available at: www.prescqipp.info/transercare

PrescQIPP Polypharmacy and deprescribing webkit, available here: www.prescqipp.info/polypharmacy-deprescribing-webkit

Royal Pharmaceutical Society. Referral Toolkit. December 2014. Available at: www.rpharms.com/unsecure-support-resources/referral-toolkit.asp

Royal Pharmaceutical Society. Transfer of Care. Available at: www.rpharms.com/clinical-and-pharmacy-practice/transfer-of-care.asp

Dorset Clinical Commissioning Group. Multi-Agency Strategy for the Prevention and Management of Pressure Ulcers. Available at: www.dorsetccg.nhs.uk/aboutus/corporate-policies.htm

Additional PrescQIPP resources



Implementation materials

Available here: <https://www.prescqipp.info/resources/category/335-care-homes-how-to-use-multidisciplinary-teams-effectively>

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Contact help@prescqipp.info with any queries or comments related to the content of this document.

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