

## How GSF helps support GP collaboration

The Gold Standards Framework (GSF) programme shares the aims of the Framework for Enhanced Health in Care Homes:

- Ensuring the provision of high quality care in Care Homes
- Individuals have access to the right care and the right health services in the place of their choosing
- Best use of resources by reducing unnecessary conveyances to hospitals, hospital admissions and bed stays whilst ensuring the best care for residents.

GSF recognises the need for integrated working, good communication and proactive planning and care to deliver person centred care in accordance with an individual's wishes, in order to support each person to live well and die well in their place of choice. To achieve this GP collaboration is vital and is one of the four key standards that GSF accredited Homes must attain and demonstrate.

Each Home will work differently with their GPs; some will liaise with just one surgery, others with several. The important aspect is the working relationship and the respect for each other. GSF provides a systematic approach that achieves this and enables staff to grow in confidence and knowledge.

Working closely together using the GSF, Care Homes and GPs are aiming for the same goals and speaking the same language

### Key aspects of collaborative work with GPs and the primary care team

**Coding** – Needs based coding is used to plan ahead and put things in place that may be required in a timely manner. All residents are coded and GPs are informed of the coding and are encouraged to add the residents to the surgery's GSF/supportive care register to promote whole team planning and care. Needs based matrices help to identify what may be needed at each code and these can be used in both the Home and the surgery.

**GP visits** – Some GPs visit the Homes on a regular basis, offering a 'ward round', again being proactive rather than reactive. Others visit when required. All work with the Home to plan ahead. Some Homes will also have district nurses, community matrons or Nurse Practitioners visit regularly to review the coding and needs of the residents with staff. In some areas care Home staff attend the surgery GSF meeting, promoting integrated working with the wider MDT.

**Advance Care Plans** – Another key requirement of GSF Homes is that they offer all residents the opportunity to have an advance care planning discussion, to ascertain their wishes should a time come when they cannot communicate this. For those that lack capacity, a best interest discussion is offered to the family. With the individual's permission, this information is shared with the GP and others as appropriate. This often helps the team in making best interest decisions e.g. hospital admission. GSF enables staff to develop their skills in having these conversations, creating a more open culture to discuss dying and a resident's fears and concerns. DNACPR may often be part of these discussions and GSF Homes have been very proactive in initiating these discussions and requesting GPs come in and further these discussions and complete the necessary paperwork as appropriate.

**Out of Hours Notification** – Part of planning ahead includes informing the Out of Hours service about residents who are less well. Notification is sent through by the Home or surgery either by fax or electronic system, depending on the area. Having this information supports the OOH team to make appropriate decisions, ensuring the right clinician is involved, e.g. GP or nurse, the right course of action is taken and often avoids a hospital admission.

**Anticipatory Prescribing** – By using the Needs Support Matrix, staff will discuss with GPs about the need for anticipatory medication. To avoid unnecessary delay in treating symptoms, Homes request end of life medication be in the Home 'just in case' it is required. Many will have experienced the long and difficult delay in treating symptoms when medication has not been prescribed and is not available particularly at night or over weekends. Furthermore, staff will discuss with GPs the efficacy of having other medications available for individuals e.g. antibiotics, steroids, anticonvulsants etc. to be able to promptly treat a problem and again often avoid a hospital admission.

**Verification of Death** – GSF Nursing Homes have been proactive in training their nurses to verify expected death. This ensures that it happens in a timely fashion and relieves the GP and OOH service of this task. In many cases the GP has been involved in the process by assessing the nurse's competency.

**Avoiding Unnecessary Hospital Admission** – GSF Homes have greatly reduced inappropriate hospital admissions and hospital deaths. By planning ahead with the resident, family and GP, admissions can often be avoided. This has been facilitated by amongst other things: ACP discussions, notification to OOH, anticipatory prescribing and the GPs Avoiding Unplanned Admissions Directed Enhanced Service (DES).

**Care of the Dying** – By working together many GSF Homes can care for residents at the end of life, dying in a place that is familiar to them, their Home, and surrounded by people they know, both family and carers. This is achieved by Homes with good support from the GP and primary care team. Achieving this will often bring comfort to families and help in their bereavement.

By using a whole systems approach staff have a structure that supports best person centred care, collaboration and proactive planning. It gives them confidence to be a stronger advocate for their resident, to question opinions and decisions of other professionals if they are not in line with an individual's wishes. Together the Care Home and GP want to achieve what is best for each individual.

[Click here for a short video about the collaboration between GP Practices and Care Homes](#)