Reducing unplanned admissions from care homes:
Kent, Surrey and Sussex best practice guide
Reducing unplanned admissions from care homes: Kent, Surrey and Sussex best practice guide

This guide summarises some of the best practice examples that are in place across Kent, Surrey and Sussex to reduce the number of unplanned hospital admissions (and A&E attendances) from care homes and what is working well.

Thank you to all the NHS clinical commissioning groups, commissioners, acute trusts, community trusts, hospices and care homes who have provided information about their successes.

Topic areas

- Community geriatricians and/or matrons and services  2
- Training and education  5
- Data  7
- Discharge  7
- End of life care  7
- Medicines Management  8
- Nutrition and hydration  8
- Assessment  9
- Care home forums  9
- Communication  9
Community geriatricians and/or matrons and services

Admissions avoidance matrons - West Sussex CCG
Providing support, education and training in partnership with Sussex Community NHS Trust. Referrals can be made to the matrons directly from the care homes or from the rapid access intervention team.

Care home community matron - Surrey Heath CCG
Commissioned from the community provider to support care homes in reducing inappropriate hospital admissions and improve the quality of care for residents.

Care home team - Sussex Community NHS Trust
Providing a rolling training programme for catheters, pressure ulcers, wound care, falls, nutrition and hydration. The team works with identified care homes for a 10 week period developing action plans to reduce inappropriate hospital admissions.

Community based geriatrician assessment clinics - Ashford CCG
Enabling care home residents to attend out-patient services in their own GP practice as opposed to within the acute hospital setting. Referral to the service can be made by the community matron, GPs and A&E.

Community geriatrician and matron service - Ashford CCG and Canterbury and Coastal CCG
Supporting care homes to manage the care of their residents. All new admissions to care homes are referred to the community matron. Referrals to the community matron can also be made by GPs and the care home themselves. The community matron escalates to community geriatrician if required. Care plans put in place for all patients. GPs can also refer direct to the community geriatrician for support with patients residing in their own homes. Telephone advice line available to provide signposting for all care homes.
Community geriatrician care home project - Kent Community Health NHS Trust
Referral can be made by hospitals, GPs and care homes via the local referral unit to the lead matron or direct to the community geriatrician. An assessment visit is made by the matron to determine the resident’s needs – including physical assessment, medicines management review and development of an anticipatory care plan.

Community matron for care homes - North West Surrey CCG
Working with the 10 highest hospital admitting care homes to help them reduce the number of inappropriate hospital admissions by offering support, advice and training.

Dementia care home in-reach service - Sussex CCGs
Service provided by Sussex Partnership Trust applies a practice development approach to reducing antipsychotic prescribing through non pharmacological interventions, improving care, reducing avoidable admissions and slowing down escalation to higher levels of care in care homes.

Dementia home treatment team - Kent and Medway NHS and Social Care Partnership Trust
Multidisciplinary services providing six to seven weeks intensive support to people with dementia who are registered with the Community Mental Health team, available in six localities across East Kent. Provide education and training to support family and carers to keep people in their own homes or nursing home.

East Sussex nurse led rapid intervention in care homes (ENRICH) - Integrated 24 Ltd
Providing a holistic approach to improve communication skills and clinical decision making amongst care home staff. Sign posting to existing services.
Integrated response team - Crawley, Horsham and Mid Sussex CCGs
Multidisciplinary team assisting care homes to agree and deliver an action plan over a 10 week period which improves quality of care and reduces 999 calls, A&E attendance and unplanned admissions to hospital.

Link nurses - Frimley Park Hospital NHS Foundation Trust
Providing support to the care homes when a resident has been discharged from the hospital.

One call - Coastal West Sussex CCG
Providing support to care homes by offering a community based service referral process for care home staff available seven days a week.

Proactive care team - North West Sussex
Targeting a cohort of patients who are at the highest risk of admission to hospital. Collaborative programme set up across multidisciplinary teams located around GP practices. Any resident who is admitted to hospital from a care home or being discharged from hospital to a care home will be reviewed by the proactive care team.
Training and education

Education programme - Royal Surrey County Hospital NHS Foundation Trust
Providing training in partnership with the local hospice to enable the nursing staff in the care home to actively treat residents instead of transferring their care to the hospital and facilitating earlier discharges for those residents who have had to be admitted to hospital. Training includes tissue viability, falls prevention, nutrition, dementia awareness and safeguarding.

Education and medicines management support - North West Surrey CCG
Providing education sessions on “Food First”. Delivering dietician and feeding education training days. Planning education for care homes on the new NICE guidelines for medicines management in care homes.

ENRICH - Brighton and Hove CCG
Providing education and resources to nursing home staff for example SBAR, Stop and Watch, with a focus on end of life care and advance care planning, falls and dementia.

Gold standards framework - Coombe Dingle Nursing Home
Training facilitated by St Christopher Hospice to enable staff to care for their residents with dignity and to facilitate difficult discussions with families.
Health and care training - First Community Health & Care
Joint project between key partners including First Community Health & Care, St Catherine’s Hospice, nurse advisors to care homes, Alzheimer’s Society and Admiral Nurse. Providing training and support to care homes in developing advance care plans for all residents with dementia.

“I don’t want to go back to hospital” - St Wilfred’s Hospice
Providing a 3 day training course for RGN or senior carers which emphasises the importance of assessment, planning, delivery and evaluation of care. Focusing on the resident’s wishes to stay at their care home.

Improving end of life care - Princess Alice Hospice
Supporting care homes to provide the best care for patients with dementia using GSF for care homes.

Improving oral care -
Health Education England, Kent Surrey Sussex
Promoting better oral care in care homes. Providing a training package and tools to enable staff to provide good oral care to their residents.

Principles of end of life care - St Wilfred’s Hospice
Providing a 6 day training course for health and social care workers QCF Level 3 for working in end of life care. Enabling participants to understand the different aspects of end of life care.
Data

Quality and safety dashboard - North West Surrey CCG
Developing a template to capture ‘soft’ data relating to quality issues that may not be captured through other processes such as CQC and safeguarding.

Discharge

Integrated discharge team - Dartford and Gravesham NHS Trust
Enabling proactive and safe discharge from acute setting. The discharged patient is given a care plan which outlines the agreed pathway and case management approach.

End of life care

PEACE project - East Sussex Healthcare NHS Trust (Conquest Hospital, Hastings)
Improving end of life care for residents and reducing the number of transfers from nursing homes to hospital; by recording discussions between patients/residents, family members, GP and the geriatric multidisciplinary team as part of the PEACE document (Proactive Elderly Persons’ Advisory CarE).
Medicines Management

Medical management care home plan - Ashford CCG and Canterbury and Coastal CCG
Enabling GPs, paramedics, community and acute clinicians to have comprehensive information about a resident’s care plan and wishes. Uploaded onto the electronic “Share My Care” system.

Medication reviews and education by pharmacists - Surrey Heath CCG
Reviewing medication for all residents. Providing education on using sip feeds. Development of catheter formulary.

Medicines management and education - North West Surrey CCG
Providing education sessions on “Food First”. Developing a dietician and feeding education day. Producing a medicines management newsletter.

Resident reviews - Surrey Heath CCG
Reviews undertaken by GPs to ensure all residents have up to date medication review, physical review, dementia screening and end of life care review.

Nutrition and hydration

Hydrate project - North East Hampshire & Farnham CCG
Providing education to care homes on the benefit of good hydration. Resource pack, promotion material provided to the care homes. Evaluation being undertaken by Surrey University School of Health & Social Care.

Nutrition and hydration stations - Sunrise Nursing Homes
Ensuring snacks and drinks are available at all times for residents within the dementia units.
Assessment

Older Persons’ Assessment and Liaison Services - Ashford and St Peter’s Hospitals NHS Foundation Trust
Reducing length of stay and repeat admissions in over 75 year olds from residential homes or patient’s own home. Multidisciplinary team approach undertaking assessments based on the British Geriatric Society Silver Book carried out on admission to the hospital.

Care home forums

Ashford, Canterbury and Coastal, North East Hampshire & Farnham, North West Surrey CCGs
Providing training, education and networking opportunities for care home managers and partners from across health and social care. A wide variety of discussion topics with the aim of improving quality and safety in care homes.

Communications

Care homes communication tool - Ashford CCG and Canterbury and Coastal CCG
Developed by members of the care home forum to improve communication of information between care homes and the acute trust. Contains information about the resident and discharge summary information from A&E.
Feedback

For more information about any of these initiatives, to provide further examples for the next edition or to give feedback on this guide please contact:

Gill Potts
Improvement Manager
Kent Surrey Sussex Academic Health Science Network

gill.potts1@nhs.net
Contact details

Kent Surrey Sussex Academic Health Science Network
First floor, Wentworth House
Crawley Hospital, West Green Drive
Crawley, West Sussex RH11 7DH

0300 303 8660

www.kssahsn.net

enquiries@kssahsn.net

@KSSAHSN