Healthcare framework for care homes

Scottish Government
Riaghaltas na h-Alba
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Introduction

33 thousand people live in care homes for adults in Scotland.

Most are living in a care home for older people and more than half of them have dementia.

People who live in care homes have a right to have their healthcare needs met in a way that:

- is person-centred and meets all their needs
- they can depend on
- is planned, with different services working well together
- supports them to live the best life possible

Care homes are where people live and call home.

They should be supported to live their best life possible.

A **framework** is a type of plan.

This framework will look to find ways for people to get better help with their healthcare – now, in the future, and if their needs change.

How did we find out what people think?

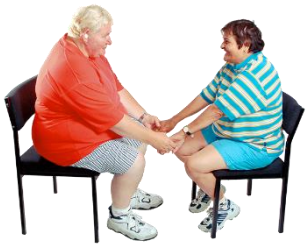
From November 2021 to April 2022 we:

- had events online
- had focus groups
- sent an online survey to all Scottish care homes
- used social media to get information and ideas from:
    - organisations that plan and deliver care
    - care home residents and their families
    - care home staff
    - the Care Inspectorate and Healthcare Improvement Scotland
    - voluntary organisations

We will keep asking people what they think as services start work to make the recommendations in this report happen.

We thank everyone who has given their thoughts, ideas and suggestions so far.

A nurturing environment – a safe place to live where people feel happy and well



Good healthcare and feeling comfortable, healthy and happy is supported by:

- a safe and homely environment with things to do every day, good healthy food and ways to connect with the other people who live there
- families and friends
- the local area
- carers and staff

Families and social care staff know the people in the care home well and can recognise changes that could mean they are not well.

People living in a care home must be assessed and regularly checked by a healthcare person when this is needed.

Recommendations - what we want to see happen

- we must recognise and value the important role of all care home staff
- the care home team should have the main role in the healthcare of people living in care homes

- health and social care staff must work together to look after people's needs
- everyone living in a care home should be able to get nursing care

The multidisciplinary team

A multidisciplinary team is a group of healthcare and social care staff with different skills who work together to get the best life for the person living in the care home.

Care home teams must:

- know how to get help from members of the multidisciplinary team without having to check with a GP first
- know how to refer people to get healthcare services

Recommendations – what we want to see happen

- regular multidisciplinary team meetings could happen face to face, online or a mixture of both

Administration and support of the meetings should be done by both the health and social care partnership and the care home.

- people living in care homes should be able to have a family member, welfare guardian or power of attorney with them at multidisciplinary team meetings

- multidisciplinary teams should look for ways to:
  - share what they have learned
  - develop their knowledge, skills and experience

- if possible, each care home should be linked with a named GP practice
- people should be given the choice to register with the GP practice linked to the care home they live in

They should not be made to change GP practice.

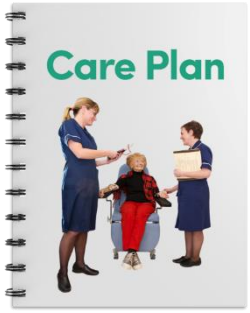
- Health Boards should check how organisations get contracts to provide services and change them to make sure they follow the recommendations in this framework

- Health and Social Care Partnerships must make sure people can get the specialist healthcare they need

Prevention - stopping an illness before it starts by keeping people well

People can stay well with support:

- to eat healthy food and drink lots of water
- with movement and activity to keep their minds active
- by staying connected to people
- with hearing and eye care
- with support for continence and bowel care
- with skin and wound care
- with emotional and spiritual support



Every person living in a care home should have a personal plan giving information about how care and support will be provided.

Recommendations - what we want to see happen

- people living in care homes must be supported to go to any public health programmes that are right for their age such as:
    - bowel cancer screening
    - immunisations against flu, COVID-19, pneumococcal and shingles infections

- staff must be able to get advice, education and guidance about infection, prevention and control in care homes

- everyone living in a care home will have a personal plan that is checked regularly

There must be good ways to develop these plans and put them in place.

- a medication review should take place when someone first moves into a care home, and then at least once a year after that

- regular dental, sight, and hearing checks should continue to be part of an individual's personal plan when they move into a care home

- there should be a named dentist for each care home and contracts with local optometry and hearing services

- staff should use resources to look after all people's needs, not just their medical needs

- care home staff should ask people about their religious and spiritual beliefs and their needs should be looked after

These needs should be checked regularly as part of care plans.

- people should be supported to keep links in their local community to support their mobility, independence and communication

Anticipatory care, supporting self-management and early intervention – stopping health problems from getting worse

anticipatory care planning encourages meaningful discussions with the person living in a care home about ‘What Matters to Me’.

This can then move to a conversation about planning ahead.

Every person living in the care home should get to develop an anticipatory care plan.

Anticipatory care plans must be available to anyone involved in the person’s care.

supporting self-management is a way of working that supports and enables people living in care homes to look after their own health and wellbeing.

This supports their confidence, self-esteem and feelings of self-worth.

It is important to agree how someone’s health will be managed and what treatment they will have.

Recommendations - what we want to see happen

- meaningful conversations should take place as soon as possible – ideally before someone goes into a care home

- a GP should be involved in discussions if someone has a complicated health condition or needs different treatment options

- all health and social care staff must get support and training to have meaningful conversations about people's care

- everyone living in a care home should have the opportunity to make an anticipatory care plan

All Health Boards should agree a way to do this.

- anticipatory care plans should be shared with everyone involved in the person's care

- there should be healthcare community services that support self-management programmes

- people living in a care home should have regular checks from their primary healthcare teams of medical conditions they have had for a long time

- reduce investigations and treatment that is not needed or that is not right for the person

- where possible, people with complicated medical conditions should be supported to attend hospital clinics

Urgent and emergency care

People living in care homes can become unexpectedly unwell, needing urgent care and attention.

Many urgent care services will only see people who can go to the GP practice.

Getting urgent treatment and care can sometimes be complicated and difficult.

It is important that people can get the care that is right for them at the right time.

Medical information should be shared with care homes after someone has been in hospital.

Care home staff need a better understanding of how to get help from resources like NHS 24 and NHS Inform.

Recommendations - what we want to see happen

- people living in care homes should have support at any time when urgent or emergency care is needed
- community healthcare teams should have staff who can visit people in care homes when they need urgent assessment

Support and advice should be easy to get from the GP practice by phone.

- care home staff and healthcare staff should know how to use the SBAR format when talking about urgent or emergency care

The SBAR format is a way for people in a healthcare team to communicate about a person's healthcare.

All staff should use the same form for these conversations.

- care home staff should be able to contact healthcare staff quickly in an emergency

- we need ways to make it easier to get medicines in an urgent situation

- people living in care homes should never be stopped from going to hospital because they live in a care home

- we should look at ways to do tests and investigations in the care home rather than in a clinic or hospital

- health boards should develop services that give people hospital-level care in the care home

- quick and safe travel to and from hospital for people in care homes should be provided

- all parts of the healthcare system should be able to get someone's health records online

Palliative and end of life care

Palliative care supports people to have a good quality of life when they have serious health conditions that will not get better.

End of life care is an important part of palliative care which looks at the needs of people who are close to dying.

Health and Social Care Partnerships must make sure that advice and support from primary care and specialist palliative care services is easy to get.

It is very important that families and friends are kept informed, involved and supported as their loved one comes to the end of their life.

Recommendations - what we want to see happen

- care homes should find ways to:
  - help identify people who may need palliative care
  - support the person as their health needs change

- make sure people living with dementia get the care and treatment they need

- anticipatory care plans should be reviewed as people are nearing the end of life

- care home providers should plan their staff's learning and development when working in palliative and end of life care

- care home staff and specialist palliative care teams should work together and share information

- the GP and members of the multidisciplinary team should be available to support the care home staff with end of life care and speak with relatives when needed

- there should be a specialist palliative care service that is easily accessible to the multidisciplinary team
- all Health and Social Care Partnerships should have palliative care phone lines, giving quick access to community nursing and medical staff

- staff should be able to get quick access to appropriate medication and equipment

- Scotland's bereavement charter should be used by staff working in and with care homes

It guides the support that is offered to those who are bereaved.

A skilled workforce

This framework will only happen if there is a skilled workforce.

We must look at:

- recruitment – the way we advertise jobs and choose people to do them
- training and leadership
- ways for staff to progress in their jobs

The health and wellbeing of staff working in care homes is very important.

Staff should be supported when dealing with difficult and upsetting experiences.

Recommendations - what we want to see happen

Data is facts, figures and information.

- improve the data about the workforce to support:
    - workforce planning
    - how we advertise jobs and choose people to do them
    - how we encourage people to stay in care home work

- make sure registered nurses are key members of the care home team

- find ways to recruit workers from the local community

- organisations should:
  - look after the wellbeing of their staff – that they feel happy, comfortable and healthy
  - make sure staff have time for the learning and training that is needed
  - find ways for support workers to progress in their job

- make sure all care services use the induction framework - a way to welcome new employees and give them information they need when they start a job

- have learning and training that gives care home staff the knowledge and skills they need

This must include practical training in real life, as well as online training

- look at ways of working where multidisciplinary teams work alongside the care home team to build their skills, abilities and confidence in meeting the needs of the people living in the home
- encourage learning and development between staff

- look at ways to develop a space for information and resources that all staff can use

Data, digital & technology – ways of using the internet, equipment and information

There are big differences across care home services in the way they use digital technology to care for people.

We must have ways to get better data from NHS services and to make sure national services work better together.

This will help us better understand the needs of those living in care homes and the staff who support them, and to get information about the best ways to support people.

Recommendations - what we want to see happen

- there should be a review of the data collected from care homes to make sure it is being used for the good of people living in care homes

- data standards should be introduced to make sure that data from different organisations is understood to mean the same thing

- the Scottish information sharing toolkit should be used to help organisations know how to share or use NHS Scotland data

- people living in care homes should have support to use technology to connect with the world outside the care home

This includes access to good Wi-Fi and broadband connections.

- there should be access and support for people living in care homes to use video call technology with healthcare staff
- care homes must have the technology to support virtual multidisciplinary team meetings

- all care home staff should be able to get resources to improve their digital skills
- we should look at ways to support online learning

Making this happen

After this framework is published we will ask people living and working in care homes what they think.

To do this we will:

- start a group to check if work is going well and make improvements when needed

It will have members from all areas of health and social care as well as people living in care homes and their families.

- decide the best way to make the recommendations happen
- make sure we link with other Government plans
- make sure care home staff:
    - understand what work we want to see happen
    - understand the opportunities and what will be difficult when working to make the recommendations happen

- produce an annual progress report

This publication is available at **www.gov.scot**

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