NHI nursinghomesireland

SUBMISSION TO INDEPENDENT EXPERT REVIEW OF DELAYED DISCHARGES

JULY 2018

Introduction

Nursing Homes Ireland welcomes this opportunity to inform the Working Group's Expert Review of Delayed Discharges. Timely discharge of patients from our acute hospitals is of fundamental importance to ensure the most appropriate placement for the person and 'free-up' capacity within our acute hospitals, to enable them facilitate admissions and to alleviate overcrowding.

Over 400 private and voluntary nursing homes operate within communities spread across the country. These dedicated, home-from-home healthcare settings fulfil a vital role in meeting the healthcare needs of a significant cohort of our population and are essential for a proper-functioning health service. In providing specialist healthcare within our local communities and removed from acute settings, private and voluntary nursing homes fulfil Sláintecare and cross-party objectives for our health service.

We note from your correspondence that "Delayed discharges are currently defined as 'a patient who remains in hospital after a senior doctor (consultant or registrar grade) has documented in the medical chart that the patient can be discharged'. Figures are only obtained from acute hospitals. The reported measurement is based on patient numbers (as opposed to bed days lost as a % of available bed days, etc) and has recently been reported as between 500 and 600. Of the reported figures, patients awaiting "long term nursing care" are the most significant group at approximately 60%, with both patients awaiting discharge "home" and "other" each accounting for approximately 20% of patients experiencing delayed discharge. It is obvious from these figures that reported numbers of delayed discharges (outside of long term nursing care) within the system are low."

44% of the 9,911 applications in 2017 for the Nursing Home Support Scheme (Fair Deal) were from patients in acute hospitals. 48% of the applications during the month of December 2017 were from same source.

In 2017, 8,930 persons availed of transitional care funding to facilitate their discharge from an acute hospital into private and voluntary nursing home care. This averages 744 people per month. The number availing of the funding increased by 22% year-on-year (7,342 in 2016).

At year-end 2017, 58% of the 480 persons awaiting discharge (278 people) were awaiting long-term nursing care. 191,898 bed days were lost through delayed discharges over the year 2017. Applying the end-of-year percentage of 58%, this would equate to 111,300 bed days being lost within our acute hospitals through non-ability to access long-term nursing care.

An Taoiseach Leo Varadkar recognised the fundamental and essential role of nursing home care in alleviating pressures upon our acute hospitals when he was Minister for Health. Speaking in Dáil Éireann in November 2015[1], he pointed to a 31% reduction in the number of persons delayed discharged year-on-year. He informed of a headline initiative undertaken the

[1] Dáil Éireann, Private Members Motion - Hospital Emergency Departments, 10th November 2015

previous April to address the perennial issue of winter overcrowding when €74 million was committed by the Government to support an extra 1,600 people to avail of Fair Deal and to avail of transitional care. Then Minister Vardakar said the measure resulted in the 'freeing-up' of approximately 265 hospital beds every day, "a capacity increase equivalent to a medium-sized hospital".

30,905 discharges from our acute hospitals in 2016 were to 'long-stay accommodation'[2]. One-in-five (18.2%) in-patient bed days – 301,125 – were for patients aged 85+. Hickey, Clinch and Groarke (1997) found that 19.3% of acute medical beds are occupied by patients with persistent cognitive impairment, which would include people with dementia. Private and voluntary nursing homes are the majority providers of specialist dementia care within the nursing home sector[3].

Over 23,000 persons avail of care in private and voluntary nursing homes. They are provided with access to 24/7 nursing care and are supported by a diverse team of healthcare specialists. The care provided within nursing homes is holistic. They meet a person's day-to-day living requirements. Activities and therapies fulfil a fundamental role within nursing home care in supporting rehabilitation and providing stimulation, therapy, improving wellbeing, and enhancing the day-to-day life of the resident.

Private and voluntary nursing homes fulfil an essential role in facilitating a patient's discharge back to the community through the provision of short- and long-stay care. They are the majority providers of specialist dementia care. HSE data informs of the hundreds who are ready for discharge within our acute hospitals on a day-to-day basis, circa two-thirds are awaiting long-term nursing care. Nursing homes specialise in the provision of long-stay and also transitional, respite, rehabilitative and convalescent care. They also excel in providing palliative care, with an increasing number of people receiving this specialised care within the homely settings that are nursing homes. Palliative care patients are often discharged from acute hospitals into nursing home care, a more suitable setting to meet their care needs.

To inform this submission, we undertook a snapshot survey of NHI Members. We asked of the issues arising 'on-the-ground' with regard to discharges from acute hospitals to nursing home care. The feedback from Members provides valuable insight into issues arising at national and local level and those preventing the timely and appropriate discharge of patients from acute hospitals.

Given the central role the private and voluntary nursing home sector we look forward to meeting with the Working Group in the coming weeks to further inform its review.

[2] Healthcare Pricing Office, Activity in Acute Public Hospitals in Ireland, 2016 Annual Report
[3] Dementia Services Information and Development Centre, An Irish National Survey of Dementia in Long-Term Residential Care, 2015

Terms of Reference of Working Group

1. **To assess current data collection, collation and reporting systems on delayed discharges at local and national level and make recommendations to improve such systems, as appropriate;**

The HSE performance reports provide 'moment-in-time' data regarding the numbers delayed discharged nationally. Similar to the trolley-watch figures, it is our view that detail regarding the numbers awaiting discharge from our acute hospitals should be published on a daily basis and be identifiable on a hospital-by-hospital basis. The number of delayed discharges can correlate with the number of people on trolleys awaiting full admission to the acute hospital. Publication of the data can provide a greater level of scrutiny with regard to individual hospital management with regard to facilitating timely discharge of patients and would provide 'real time' information to patients and nursing homes with capacity/ empty beds.

The HSE previously launched a community bed bureau initiative to enable hospitals be immediately provided with critical data that identifies nursing home beds available to facilitate discharges. It is a simple web-based system that enables nursing homes log their vacant beds on a day-to-day basis and to provide detail regarding their capacity. Nursing homes can inform the hospital of the type of bed available and the specialist care available to prospective residents.

However, it is the understanding of NHI that the bed bureau is not being utilised by either the HSE or nursing homes themselves. NHI continues to facilitate requests from the HSE seeking to identify the availability of beds at local or at national level. The bed bureau should become a key priority and tool for the HSE to support it in facilitating timely discharges from acute hospitals to nursing homes. Concerted promotion of it should be undertaken and it requires the HSE to drive it on a day-to-day basis. An effective bureau should be a dependable, day-to-day resource that is utilised within our acute hospitals and nursing homes on a daily basis. It can expediate hospitals matching patients requiring nursing home care with available beds within nursing homes.

2. To identify and evaluate the factors and trends that impact on the length of stay of patients who experience a delayed discharge;

Discharge Planning

Research evidence highlights good discharge planning commences from the moment of admission. Discharge planning should be implemented at the earliest possible opportunity, following admission, to engage with the patient / their next of kin with regard to planning their care pathway, assessing their current and future biopsychosocial needs and agreeing their discharge destination.

From the moment of a patient's admission to an acute hospital – be that via A & E or for inpatient services – there is requirement for the HSE to start considering and, where appropriate, planning the care pathway. Engaging with patients in acute hospitals at the earliest possible opportunity of their care with regard to the next step / prospective options in their care pathway can fulfil a key role in facilitating timely discharges from hospitals. Briefing the patient / their next of kin regarding the prospective care options supports and prepares them for the next phase and enable them take appropriate measures early.

The 'next phase' is potentially life-changing and can present a seismic decision for the patient. People requiring nursing home care should be informed with regard to the specialist care that nursing homes offer and how this specialist care is best positioned to meet their health and social care needs and can be tailored to maximise each individual's potential. At the earliest possible opportunity the HSE should commence engagement with suitable nursing homes, assess the financial supports available to enable timely discharge, and discuss this care pathway with the patient / their next of kin.

An underlying principle within the Fair Deal scheme is the right of the person approved for it to avail of care within a nursing home of their choice. Nursing home care entails 24/7 care so it is essential a person availing of such care, on a temporary or long-term basis, is enabled to choose the nursing home that best suits their individual needs. Discussing a person's care plan at the earliest possible stage presents opportunity for the patient / their family to consider, research, decide upon and agree to the preferred destination. The patient must be central to the decision-making process and involved throughout the planning and deliberative stages. This sadly is often not the case but is essential for autonomous care and is now also a legal requirement under the Assisted Decision-Making (Capacity) Act 2015. Independent research, commissioned by NHI and undertaken by Ulster University (UU), *The Lived Experience of Residents in the Context of the Nursing Home as 'Home'* (2017), found that many residents were not involved in the decision-making process within the hospital. Some did not participate in the choice of nursing home and a small few were led to believe that the nursing home admission was a temporary rather than a permanent arrangement. The research highlighted a number of relevant recommendations which relate to the hospital management of such patients and the need to involve them in decisions about their care (extracts follow):

- *Moving into a nursing home is a major life event. Potential residents, their families and nursing home staff should work honestly and collaboratively, with due regard to the centrality of the resident in the decision-making process, to ensure a smooth transition for all concerned.*

- *Accepting the sensitivities associated with families addressing the issue of long-term care, it appears that health and social care professionals have a key role to play in this regard. As objective professionals, they are ideally placed to initiate discussions with the older person without fear of reprisal. Such discussion should not be deferred until the older person becomes ill but rather comprise part of the regular contact with GPs or public health nurses in a proactive manner.*

- *The assessment of older people in acute care settings should also address these issues as an integral part of the assessment process. Questions such as 'Where would you choose to live if you were no longer able to manage on your own'? Could be used to 'sow the seed' about long-term care arrangements.*

- *Shared decision making should begin prior to the nursing home placement and every effort must be made to ensure that families and staff are guided by the Nursing Homes Support Scheme Act (2009). This advocates that the applicant (resident) may select the relevant facility or approved nursing home in which to receive care services. In light of the findings of this study, Fair Deal Placement Officers should ensure that residents are central to the decision-making process about their choice of nursing home. It is also recommended that these officers should provide nursing homes with all the information they require in order to meet the resident's needs and in doing so to facilitate a positive transition.*

- *As the transition from an acute hospital was particularly stressful for the residents in this study, there is an immediate need to put effective systems in place to ensure greater communication and cooperation between HSE staff and nursing homes.*

Nursing Home Support Scheme (Fair Deal) Application Process

As presented further within this submission, a key detriment to timely discharge can be the lack of availability of financial support for their next care phase. Presenting the support options at an early stage can facilitate consideration and, where necessary, early application for the appropriate funding support. Persons applying for Fair Deal funding must complete a two-step process, a financial needs assessment and a care needs assessment, currently referred to as a Common Summary Assessment Record (CSAR).

Similarly, the advance planning must entail engagement with identified nursing homes (public, private or voluntary) to brief regarding the prospective discharge of a patient to nursing home care and with regard to their specific care requirements. Early engagement can entail preliminary discussion regarding the capacity of the nursing home to meet the specific needs of the patient. The Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) specifically require of nursing homes:

> *"5 (2) The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre."*

Nursing homes are therefore legally required to ensure that they can meet the assessed biopsychosocial needs of every resident prior to or on their admission to the nursing home. Due to the complexities of care needs for residents being discharged from hospital, many nursing homes would arrange to do a pre-admission assessment of the resident whilst in hospital. It is our members' experience that it is increasingly difficult to access the level of detail required to do a comprehensive assessment without a visit to the hospital. New and strengthened data protection legislation under the EU General Data Protection Regulations 2016 adds a new dimension to the accessibility of this patient information as healthcare professionals are concerned about the risk of a data breach of this sensitive personal data. Therefore, if a nursing home staff member assesses a patient in hospital and then (for whatever reason) cannot meet that persons' individual needs or the person expresses a wish to go to another nursing home the process will need to be repeated by another nursing home, and so on. Careful and planned co-ordination and communication with all potential nursing homes, in conjunction with detailed referral information provided to the nursing home in advance, can assist with delays experienced in this regard.

A working group under the National Clinical Programme for Older People is currently in the process of developing a validated National Nursing Transfer Tool. The Terms of Reference of this working group highlights that the primary scope of this project is for a tool to be used for when older persons are being admitted to hospital from long-term care. It is our contention that any tool developed could and should be used to enhance the communication between both services both on admission and on discharge. This tool could be used as the

basis for referral to nursing homes to assist the triage of potential new admissions and thereby reduce the number of ‘failed’ pre-admission assessments.

In the interim and in addition, the roll out of the Single Assessment Tool (SAT) to replace the CSAR, which commenced in four pilot sites, needs to be expedited and implemented in all hospitals in partnership with the nursing home sector. A copy of the SAT or the CSAR on referral to nursing homes could assist with the triage of admissions and assist in the nursing home decision-making process.

On an ongoing basis, it is essential staff who liaise with patients, such as discharge coordinators, social workers, gerontologists, etc. are actively engaged with nursing homes. They should be informed and knowledgeable of the specialist care provided by surrounding nursing homes and have a detailed awareness of the unique care options provided by each nursing home.

They fulfil a critical role in informing and providing reassurance for a person requiring discharge back into the community via nursing home care. Where necessary, they can lead in supporting a person to undertake and fulfil the financial and care needs assessment, required for a person availing of the Fair Deal scheme.

Education / training should be provided to ensure such personnel have the relevant knowledge, skills and competencies to fulfil this role.

3. **To identify and evaluate causes and trends of delayed discharges at national and Hospital Group level, including patient profiles, demand and availability of services and the funding structure, in order to assess the implications for policy, operations, planning and service delivery;**

Patient Profiles

Nursing home residents have multiple co-morbidities and present with high dependency care needs. The average age of a nursing home resident is 82.9 years[4]. Half are aged 85+ (49.4%)[5]. The *National Dementia Strategy* estimates the numbers with dementia in the 85+ age category is more than six times the number within the 65-69 category. It is projecting a 46% increase in the numbers with dementia within the 85+ category over the ten-year period 2016 – 2026[6].

Creating Excellence in Dementia Care (Cahill, O'Shea, Pierce; 2012) states: "In the USA and Europe, between one-half and two-thirds (50-66%) of nursing homes residents are said to have dementia (Cahill and Diaz-Ponce, 2010). Irish studies support the view that the prevalence of dementia in nursing homes is likely to be higher than the official estimates in Ireland. In a recent study Cahill and Diaz-Ponce (2010) screened a sample of residents in four nursing homes in the Dublin area to assess cognitive impairment (CI) and found that 89% of participants surveyed were cognitively impaired, of whom 42% were severely and 27% moderately impaired."

Private and voluntary nursing homes are the majority providers of specialist dementia care[7].

Residents with a dementia often have perceived lower dependency needs as the CSAR/ SAT used in their Fair Deal assessment focuses predominantly on physical dependencies and therefore does not adequately assess the psychosocial elements of care required. This can have significant implications for staffing and other allied health services within the nursing home setting in order to deliver person-centred and therapeutic care to a high standard. Given the large numbers of patients likely to need assistance with decision-making in line with the provisions set out in the Assisted Decision-Making (Capacity) Act 2015 when commenced, there is potential for further delays therefore in decisions regarding acceptance of long-term care as a placement option and then subsequently in their preferred nursing home.

It is often quoted that public nursing homes admit higher dependency residents however a national study undertaken by the Dementia Services Information and Development Centre (DSIDC) dispels this myth. *An Irish National Survey of Dementia in Long-Term Residential*

[4] Department of Health, Health in Ireland Key Trends 2017
[5] Department of Health, Health in Ireland Key Trends 2017
[6] National Dementia Strategy, Estimated number and projected growth in the number of people with dementia in Ireland by age group, 2011-2046: 2016 – 85+: 21,260; 2026 – 85+ - 31,085
[7] Dementia Services Information and Development Centre, *An Irish National Survey of Dementia in Long-Term Residential Care* (2015)

Care (2015) states: "Curiously, HSE operated facilities which receive the highest payments for care from the Nursing Home Support Scheme (Fair Deal) because they are said to accommodate those with highest dependency needs were more restrictive than other providers in relation to admission criteria and were more inclined to refuse admission to those not independently mobile."

Persons availing of nursing home care are presenting with increasingly high-dependency healthcare requirements. This is reflected in the average length of stay in a nursing home considerably reducing, with those presenting having higher dependence and acuter care needs. The Review of the Fair Deal scheme, published July 2015, states: "When the scheme first commenced the average length of stay was approximately 4 years and at end 2014 had reduced to 1.9 years in private and in public facilities for those who had entered long-term residential care since the scheme commenced." In March 2017 Pat Healy, HSE National Director of Social Care, informed the Oireachtas Public Accounts Committee regarding people supported by the Fair Deal scheme: "The figures bear out the fact that the number of years for which people are staying in long-stay care is reducing. That means that they are older and closer to end-of-life care as they go into nursing homes."[8]

Nursing homes also provide short- and long-stay care to younger people with neurological conditions such as young onset dementia or acquired brain injury. In March 2017 Minister for Health Simon Harris informed the Oireachtas Health Committee 1,064 people under the age of 65 were residing within nursing homes, while the Disability Federation of Ireland has estimated the number to be circa 1,200 people.

Patients that require nursing home care often require a number of additional allied health services, for example physiotherapy, occupational therapy, speech and language therapy. These residents also often have unique and complex care needs, including the need for aids and appliances, particularly post-surgery or for those who are frail or have neurological deficits, such as a severe stroke or Acquired Brain Injury. Access to these allied health services and aids and appliances is severely restricted or indeed non-existent for the majority of private and voluntary nursing home residents for reasons which are detailed in the resources section that follows.

It is common for older nursing home residents to be admitted to hospital for IV (intra-venous) antibiotics for acute infections. These services are only available in hospital or for private health insurance owners in the greater Dublin area alone (CIT/ OPAT nursing). However, the use of IV antibiotics in the private and voluntary nursing home sector is largely not supported for a myriad of reasons linked to knowledge and skills gaps of nursing staff; significantly reduced access to medical support and oversight and resource implications in relation to access and funding of medical equipment required to deliver the antibiotics

[8] Public Accounts Committee meeting, HSE Financial Statements 2015: Note 13 re Fair Deal Scheme, 9th March 2017

It is our recommendation that the CIT/ OPAT teams are extended on a national basis for the provision of IV antibiotics to residents of all nursing homes public, private and voluntary to prevent un-necessary hospital admissions and to expedite timely discharge of patients requiring IV therapy who are otherwise medically fit for discharge. The benefits of this to residents would be multi-faceted, as they would receive the care required in the comfort of their home and would avoid the negative consequences of hospital admission on their overall health and well-being.

A Dublin Mid-Leinster NMPD quality improvement project entitled "Reducing Admission Rates & Length of Stay for Older Persons >65yrs into the Acute Hospital Services (AHS) from Residential Community Nursing Units (CNU's) & Nursing Homes" was commenced in 2017 and included 12 nursing homes (2 private) and four hospitals. This project had a number of interventions including the administration of IV medication with the support of CIT/OPAT and highlighted some of the barriers that prevented nursing homes from adopting this service with these supports.

Resources

As discussed above, residents in private and voluntary nursing homes are significantly restricted or prevented from accessing allied health services, aids, adaptations and medical equipment that they require. NHI attests that this is discrimination on the basis of where they reside as these services/ equipment would be made available to persons living in their own homes or in a public nursing home. This is, in our view, one of the most prevalent and yet easily reversible reasons for the majority of delayed discharges today.

An unpublished HSE audit undertaken October 2012 to January 2013 that assessed access to primary care services concludes: "Private and voluntary LTRU [long-term residential units] residents who are medical card holders experience a deficit in access to PCT [primary care team] services." It further concludes: "Public LTRU residents experience comparatively less difficulty in accessing PCT services."

Nursing Homes enter into a 'Deed of Agreement' with the National Treatment Purchase Fund (NTPF) under the Fair Deal scheme. Fair Deal's definition of long term residential care services specifically excludes and does not fund a wide array of activities and services that are provided by nursing homes to enhance residents' health and wellbeing. Excluded, for example, are, physiotherapy, occupational therapy, specialised equipment and other health and social care services.

The 'Deed of Agreement' expressly excludes a number of items including dressings and oxygen (which is a prescribed product and in essence is therefore a medicine). Appendix 1 provides the detail of what is covered / not covered under the Deed of Agreement with private and voluntary nursing homes. You will note that the agreement covers only basic aids and appliances and therefore does not constitute pressure relieving equipment, seating,

individualised hoist slings, etc. In addition, all therapies, chiropody, ophthalmic and dental services are not receiving to residents in private and voluntary nursing homes.

Conversely, the public nursing homes do not enter into a Deed of Agreement but instead are funded without negotiation. Appendix 2 highlights the items and services which are funded for public nursing homes. Under the Non-Pay related Goods and Services there is a detailed breakdown of basic clinical consumables which are funded for public nursing homes. These items are not covered under the 'basic aids and appliances' for private nursing homes as they are deemed to be supplied under the Primary Care Reimbursement Services (PCRS). However, recent HSE policy documents and circulars provided by the PCRS have highlighted that these items will no longer be reimbursed to residents of private and voluntary nursing homes either. See appendix 3 (The Provision of Non-Standard Equipment For Residents in Designated Centres for Older People, 2012) and page 8 of appendix 4 (Circular 48/16 to Pharmacists re National Framework including items not reimbursable).

There is, therefore, a significant funding gap for therapies, allied health services, basic medical consumables, dressings or other aids and appliances, for private and voluntary nursing home residents. Given that 80% of people availing of nursing home care under Fair Deal are residing within private and voluntary homes, this inequity places a severe strain upon the capacity of these nursing homes to meet the care needs of persons with higher physical and medical dependencies. It is the experience of members that disputes surrounding availability and funding of supports can be resolved by hospitals; however, this is on an ad-hoc, case-by-case basis. Effectively it is postcode lottery, with people in private and voluntary nursing home care being discriminated against.

There is requirement also for flexibility in the funding of persons with high dependency care needs who can be discharged from the hospital into nursing home care. Members that informed our survey, replying to a question that asked what 'barriers' emanate from acute hospitals that prevent timely discharge of patients from acute into nursing home care, highlighted the failure of the HSE to financially support residents with extremely challenging care requirements. As an example, one member stated,

> *"The failure of the HSE to fund extremely high dependent people who require care which is, in some cases, one-to-one care. The HSE state these people require one-to-one care in the acute setting however they expect the nursing home to accept them and pay a Fair Deal rate that is not commensurate with their care needs. This is certainly preventing the discharge of one patient from [identified hospital] at present."*

This is particularly prevalent for persons with an advanced dementia or neurological deficit that display responsive behaviours and require tailored, intensive and person-centred and therapeutic care to prevent and manage these behaviours. This requires a significant input from highly skilled and experienced staff and goes above and beyond what may be referred to as 'basic nursing care'.

Independent analysis of nursing home care in Ireland has highlighted the Fair Deal scheme's lack of recognition of costs incurred to meet very high dependency and complex care needs of persons requiring nursing home care.

The aforementioned DSIDC analysis concluded: "Our findings would lead us to conclude that the complex and high dependency needs of PWD [persons with dementia] in SCUs [specialist care units] now need to be more realistically reflected in fairer resource allocation, in recognition of the skill mix of staff employed in SCUs, their training needs and the level of care expected to be delivered to residents with dementia."

The Department of Health commissioned analysis undertaken by DKM Economic Consultants, *Potential Measures to Encourage the Provision of Nursing Home and Community Nursing Unit Facilities* (2015) concluded: "It is untenable that the State quality regulator [HIQA] can assess differentiated dependency levels and in doing so impose costs on nursing homes, while the State price regulator claims it is unable to reflect the same factor in its pricing decisions."

It further stated: "The lack of reference to the level of dependency of residents within the pricing model is discouraging the development of more specialised facilities where more expensive care is required."

There is requirement for the HSE to recognise that particular individuals being discharged from hospital have severe and very complex clinical and healthcare needs. Funding must be provided to recognise the complexity of care presented to the nursing home and ensure it is enabled to provide the high-intensive, complex, specialist care presented by the patient.

The review of the Fair Deal pricing mechanism, which was due for publication June 2017 but remains outstanding, presents prime opportunity to advance the requirement for a fit-for-purpose funding model that provides real recognition of the costs incurred to provide high-dependency 24/7 care.

Access to Medical Support and Oversight

Nursing homes are nurse-led services that rely on inputs from community services such as GPs and Pharmacists to meet the clinical needs of every resident. The Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) require, at a minimum,

- that there is a record of each residents' medical condition at the time of admission;
- that a medical practitioner of the residents' choosing is made available to them;
- that appropriate medical healthcare and any recommended treatments are provided.

Access to GP services and the fulfilment of regulatory requirements is a growing crisis for nursing homes nationally. The GMS contract negotiations and the impact of FEMPI legislation on the funding of GP services has significantly impacted on the availability and willingness of GPs to provide services to residents in nursing homes. The IMO issued a communique in 2016 (see appendix 5) which outlined a number of tasks they believed were

not covered by the current GMS contract. On 5th July 2018, the NAGP issued a document highlighting the services that are not covered by the medical card or GP card. Many of the services highlighted as not covered are essential elements for nursing homes to achieve regulatory compliance with HIQA or may be required for the diagnosis, assessment and treatment of residents e.g. phlebotomy. An article by Muiris Houston in the *Irish Times, Health & Family,*16th July 2018, cited that 70% of GP practices are no longer taking new patients. The effects of this are now being felt by nursing homes, particularly when admitting residents that are outside of their GP's normal catchment area. This is therefore impacting on nursing homes being able to admit both long-term and short-term residents and will only worsen if not resolved in the immediate future. In some cases, GPs are seeking additional payments from the nursing home to provide these services that are 'not covered' under the GMS.

Furthermore, as presented within the feedback from our Member survey, nursing home residents who are denied or unable to access nursing home care within their local community can then have difficulty accessing a GP, giving they are no longer within the catchment area of their previous GP.

The current review and negotiations under the GMS presents the opportunity to address such matter. It has to be expedited, with an increasing number of nursing home residents being denied GP services that are required to assess their health on an ongoing basis and, where required, provide treatment to improve their wellbeing and prevent admissions to hospitals.

4. To map current patient pathways to identify connections of care and bottlenecks in discharge planning, coordination and administration;

Our survey of Members also identified issues at a 'local level' that defer discharges from the hospitals back into the community via the nursing home. These included:

- No specific discharge coordinator within hospital. Nursing homes recommended a named particular person / personnel to take responsibility for managing and facilitating discharges and to liaise with nursing homes. A more structured approach, whereby responsibility is assumed for collation of the required information to facilitate the discharge (medical, clinical and healthcare needs of the patient) will support more timely discharges.
- NHI recommends the introduction of geriatric teams who focus upon ensuring timely discharge of patients back into the community. One respondent stated they have experience of acute hospitals in the UK and Australia and within these countries the discharge coordinators are meeting the inpatient virtually upon admission with view to planning ahead.
- Preferred nursing homes being pushed by hospital personnel from which the person continues their care pathway. The nursing homes are not necessarily preferred by the resident / their next of kin, often being far removed from the resident's home and local community. The stance taken by the HSE leads to a delay in the discharge being facilitated, with the patient / their next of kin presenting they wish to avail of care within a nursing home differing to those presented. Such actions disregard the principle inherent within the Fair Deal scheme of resident choice.
- A resident who chooses a nursing home removed from their local community can then have difficulty accessing a GP. HIQA's *National Quality Standards for Residential Care Settings for Older People in Ireland* stipulate nursing home residents must receive "a high standard of service from the general practitioner with whom he/she is registered (or a suitably qualified appointed deputy) including regular and timely consultations and an out-of-hours service that is responsive to his/her needs". By consequence, the requirement to identify a GP can lead to a prolonged delay in the nursing home admitting the patient from the hospital.
- Delays in accessing transport, usually an ambulance, to transfer the patient as recent HSE policy decisions have prevented access to these services for residents of private and voluntary nursing homes
- Appropriate equipment to meet the residents care needs not being made available. This can lead to people remaining within the hospital while the nursing home sources the appropriate equipment. The HSE has access to such equipment and should make available with immediacy to the nursing home, thus facilitating the discharge with immediacy.
- Delays in the completion of the prescription by GP within the hospital or inaccuracies with such.

- Family indecision. Nursing homes informed the decision to discharge is often undertaken minus previous consultation or engagement with the resident or their next of kin regarding the next step in their care pathway. Residents and the next of kin are ill-informed, worried and have not had time to assess or consider the next care pathway. Please see our comments under TOR 2 - Discharge planning should be implemented at the earliest possible opportunity to engage with the patient / their next of kin with regard to planning their care pathway.
- Financial support. Delays in securing financial support under the transitional care initiative or the Fair Deal scheme leads to an unwillingness by the patient / their next of kin to facilitate the move from the acute hospital to nursing home care. Nursing homes informed patients and / or their next of kin are often not amenable to discharge if Fair Deal financial approval is still awaited. Often the application process for financial support is delayed and the required steps should have been taken earlier.
- Inefficiency in the reviewing of a patient's medical, clinical and healthcare needs by medical and nursing staff and discharge coordinators. Delays are arising with the undertaking of required scans and in clinical assessments which slow-down the discharge process.
- Late contact by the hospital to the nursing home on behalf of a patient ready for discharge. The nursing home is contacted to inform a patient is ready for discharge but the nursing home is required to undertake a care needs assessment. Such a procedure could have been undertaken at an earlier time. Delayed notification can also lead to difficulties in securing the medication and medical equipment particular for the resident. Furthermore, a late decision by the hospital delays the patient in applying for financial support to enable them avail of care within a nursing home. Again, note our comments under TOR 2.
- The timing of discharges was cited by some nursing homes. While it is appreciated it is difficult to plan the timing of a discharge, nursing homes presented hospitals make contact late in the afternoon or in the evening, when access to the patients required medication is difficult / impossible to avail of. Some nursing homes also informed of a pattern whereby the hospitals would seek to discharge late Friday, obviously to alleviate beds for the upcoming weekend. This again places extreme pressure upon nursing homes to be equipped medically to facilitate the person's particular medical needs and to undertake a care needs assessment where required. It is often not feasible for the assessments to be undertaken within the hospital's desired timeframe, hence the patient's discharge is delayed.
- If a person is waiting for a bed to become available within a particular nursing home, they should be encouraged to avail of a bed within another nursing home on a short-term basis.
- Difficulties in accessing information from the hospital regarding the particular medical, clinical, healthcare care needs of the patient ready for discharge.

One of the recommendations of the UU research was the immediate need to put in place systems for better communication and cooperation between HSE staff and nursing homes due

to the stressful impact of transitions on the older person. A number of best practice examples that have been in operation and have worked well include the Connolly and Tallaght Hospital Geriatrician out-reach services and the newly developed Waterford Integrated Care for Older People service. All of these services work with their local nursing homes in developing the knowledge, skills and competencies for navigating and accessing the services required to maintain a high level of specialist care within the nursing home. This contributes to better preventative medicine and recognition of early indicators/ signs of the deterioration in the patient. This means they can be treated before they become acutely unwell. These services have been shown to prevent un-necessary hospital admissions and also contribute to facilitating earlier discharges from hospital. Outreach services should become a health priority and teams should be put in place within all CHO areas.

5. **To examine current processes, practices and measures by Hospital Groups and Community Health Organisations to manage and support safe and timely discharges, including integrated IT systems, having regard to reviews completed or underway;**

Access to community healthcare professionals can fulfil a critical role in facilitating timely discharges from acute hospitals to nursing home care and also in deterring admissions. Enabling residents to have regular and timely access to healthcare professionals such as GPs, gerontologists and therapists will enable treatment to be provided in the community, away from the acute hospital. It will also lead in identifying and treating ailments in advance and in facilitating medical or therapeutic intervention at an early stage removed from the acute hospital.

However, very serious issues are arising for private and voluntary nursing home residents with regard to accessing healthcare professionals operating within the community.

Good GP and nursing care is essential for reducing acute hospital admissions. Given severe pressures upon acute hospital services on an ongoing basis, regular and timely access to GP services can play a lead role in deterring unnecessary hospital admissions. Given the frailty and ailments of many older persons in nursing home care, ensuring they have continuous access to GP care will support Government and cross-party objective of enabling healthcare to be provided within community and removed from acute settings, where possible.

Ongoing and timely access to GP services is imperative for persons in nursing home care. Yet access to GP cover is becoming increasingly difficult. The provision of such must be achieved through ensuring a collaborative approach between GP services, primary care services and nursing homes.
Timely access to GP care can support the clinical care already being provided to persons within nursing homes by ensuring continuous assessment by a GP is available to them to identify and treat health issues at an early stage.

The revision of the GP contract must not overlook the necessity for nursing home residents to be provided with regular and timely access to GP care. The contact must state categorically the obligations and duties of GP's in the context of care provision to nursing home residents. It must encompass the requirements for access to GP care under HIQA's National Quality Standards for Residential Care Settings for Older People in Ireland. The Standards stipulate every nursing home resident must be provided with "a high standard of service from the general practitioner with whom he/she is registered (or a suitably qualified appointed deputy) including regular and timely consultations and an out-of-hours service that is responsive to his/her needs". The revision of the contract presents opportunity to reinforce the intrinsic role doctors fulfil in providing GP services to persons in nursing home care.

Pressures can be alleviated upon GP services by addressing significant barriers with regard to enabling nurses in the private and voluntary nursing home sector to become nurse prescribers.

A number of staff have successfully completed their training and are Registered Nurse Prescribers with the Nursing & Midwifery Board of Ireland; however their practice is being restricted due to the HSE decision not to provide these nurses with a GMS prescription pad. This inability of Registered Nurse Prescribers to obtain a GMS prescription pad means a resident with a medical card within a private and voluntary nursing home setting may experience a time delay in accessing medicines as they are reliant on their GP to visit them within the nursing home.

Timely and regular access to therapeutic services is also essential to improve the health and wellbeing of nursing home residents and, by consequences, alleviate admissions to acute hospitals. Therapies such as physiotherapy, occupational therapy and chiropody have particular significance in supporting and improving the physical wellbeing of a nursing home resident. Yet, residents of private and voluntary nursing homes are being denied access to such essential services. The previously referred to unpublished HSE audit revealed the majority of nursing home residents do not have access to essential therapies provided by the HSE. Half of the residents in HSE nursing homes have access to therapies but just a third in private and voluntary nursing homes have access to such, it found.

Access to multidisciplinary healthcare teams will also support the timely discharge of patients from the acute hospital to nursing home care.

Furthermore, as presented within this submission, the HSE should lead in the development of community case management teams that would provide care within the nursing home for specific health conditions.

6. To review practice and identify initiatives to improve the management of delayed discharges, in light of international practice;

In order to review international best practice in this area it is recommended that the working group consider the 'Systematic Literature Review On Tackling Delayed Discharges in Acute Hospitals Inclusive of Hospital (Re) admission Avoidance' undertaken by a team of researchers in UCC in 2015.

7. **To improve performance and monitoring by recommending appropriate performance metrics, targets and accountability arrangements to support improved performance and better outcomes for patients;**

Any measurements or metrics recommended for use must not lose sight of the 'lived experience' of the patients using the service. There needs to be careful consideration of what constitutes an 'appropriate' admission to hospital, taking into consideration all of the various factors involved and notwithstanding the residents own decision-making in their plan of care. All too often policy decisions are made within the HSE or at hospital level without the requisite knowledge of the day-to-day workings of a private and voluntary nursing home. Any such metrics or performance monitoring should be open for public consultation prior to their implementation.

ENDS