**LEVEL 1 – Core Essentials – Internal General Practice Systems to enable consistency of care**

Practice

Shared Vision

Systematisation of Processes

Leadership

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| **LEVEL 1 – Core Essentials – Internal General** **Practice Systems to enable consistency of care** | | | | |
| **The General Practice commits to meet the Standard by** | **Self-Assessment** | **Responsible Team Member** | **Completion** | **Notes** |
| 1. **Leadership** for care home daffodil standard | * 1. Confirm practice clinical lead (this does not necessarily need to be a GP) |  |  |  |
| * 1. Confirm practice non-clinical lead |  |  |  |
| * 1. Confirm lead at care home contact details including NHS/secure email |  |  |  |
| * 1. Confirm route for seeking specialist palliative care advice |  |  |  |
| * 1. If not already, invite Care Home representative to regularly attend care home ward rounds & MDT |  |  |  |
| * 1. Consider developing dedicated PCN/cluster/GP federations clinical specialist EOLC role (this does not necessarily need to be a GP) |  |  |  |
| 1. Share practice vision | * 1. Practice meeting/event * communicate and engage all practice staff to ensure all understand goals and can be involved, at an appropriate level * Reinforce a culture of continuous learning and improvement in the practice * Clarify any learning needs of staff |  |  |  |
| 2.2 Share with MDT/ ward round team, if not currently engaged with wider MDT then consider increasing engagement (See other Daffodil Standards for support with this) |  |  |  |
| 2.3 Share with patient groups + PCN/GP cluster / federation |  |  |  |
| 2.4 Share with Care Home |  |  |  |
| 1. Review of your practice system PROCESSES to ensure consistency to allow easy monitoring | **For example:** |  |  |  |
| 3.1 General  Consistent, clear coding e.g. identified care home resident, care plan in place, NOK/family contact details: consider using a template to aid this |
| 3.2 Admission  Full registration details inc discharge summary if coming from hospital  Face to face or remote alternative where this is not safe or possible - note [GMC guidance for remote consultation decision making](https://www.gmc-uk.org/ethical-guidance/ethical-hub/remote-consultations)), medication review and care planning discussions involving NOK/ key contacts and care home staff within agreed set timeframe  Personalised care and support plan with ‘what matters most’ discussions, including preferences for care and support and DNACPR status within 28 days (or sooner if clinically indicated).  NB: [RCGP joint statement on advance care planning](https://www.rcgp.org.uk/about-us/news/2020/april/joint-statement-on-advance-care-planning.aspx)  Ensure no blanket DNACPR policies and avoid DNACPR decisions in isolation and are part of wider ‘what matters most’ discussions. |
| 3.3 Ongoing Care and Support  Face to face or remote alternative where this is not safe or possible - note [GMC guidance for remote consultation decision making](https://www.gmc-uk.org/ethical-guidance/ethical-hub/remote-consultations)), and MDT/ward round review within agreed timeline if stable  Involve patient and NOK/LPA/ Family/ Advocate in Care Plan decision making & updates  Clear process for escalating concerns of nurses/ care staff/ family to promptly assess need for review  Encouraging reporting of significant changes in health such as sustained reduced intake, weight loss, high or low BMs, reduced interaction or mobility |
| 3.4 Dying  Early recognition of deterioration and dying  Consider example tools: [SBARD](https://www.westsussexconnecttosupport.org/s4s/api/FileManagement/GetFileContent?id=/6/21/) and [Restore2](https://www.weahsn.net/our-work/transforming-services-and-systems/keeping-people-safe-during-and-after-covid-19/care-homes-during-covid-19/training-resources-for-care-homes/) |
| 3.5 Family Support + Bereavement  Collect key family/ NOK/ LPA/ advocate or allocated SW contact details within 28 days of admission  To involve those important to the patient in care planning discussions with their consent  Contact family on death of resident |
| 1. RCGP MDT template | * 1. Use RCGP MDT template for all care home residents to enable consistent care and support |  |  |  |

Guidance for managing the COVID-19 pandemic in care home for older people

<https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes>