Explaining the barriers to and tensions in delivering effective health care in private UK care homes: a qualitative study

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ABSTRACT

Objective: To explain the current delivery of healthcare to residents living in UK care homes.

Design Qualitative interview study using a grounded theory approach.

Setting Six UK care homes, and primary care professionals serving the homes.

Participants 32: 7 care home managers, 2 care home nurses, 9 care home assistants, 6 GPs, 3 dementia outreach nurses, 2 district nurses, 2 advanced nurse practitioners, 1 occupational therapist.

Results Five themes were identified: complex health needs and the intrinsic nature of residents' illness trajectories; a mismatch between health care requirements and GP time; reactive or anticipatory health care?; a dissonance in health care knowledge and ethos; and tensions in the responsibility for the health care of residents.

Care home managers and staff were pivotal to health care delivery for residents despite their perceived role in social care provision. Formal health care for residents was primarily provided via one or more general practitioners (GPs), often organised to provide a reactive service that did not meet residents' complex needs. Deficiencies were identified in training required to meet residents' needs for both care home staff and GPs. Misunderstandings, ambiguities and boundaries around roles and responsibilities of health and social care staff limited the development of constructive relationships.

Conclusions: Health care of care home residents is difficult because their needs are complex and unpredictable. Neither GPs nor care home staff have enough time to meet these needs and many lack the prerequisite skills and training. Anticipatory care is generally held to be preferable to reactive care. Attempts to structure care to make it more anticipatory are dependent upon effective relationships between GPs and care home staff and their ability to establish common goals. Roles and responsibilities for many aspects of health care are not made explicit and this risks poor outcomes for residents.

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ARTICLE SUMMARY

Article focus

- Care home residents suffer from long term co-morbid conditions, with acute deteriorations, rendering them disabled and vulnerable.
- There is a growing body of evidence that care home residents have unmet health needs and may be admitted to hospital unnecessarily.
- This study aimed to understand health care delivery to care home residents from both the care home and primary care perspectives, in order to explain why hospital admissions occur and to identify where the barriers and solutions to improving health care lie.

Key messages

- Both general practitioners and care home staff described that care for residents was affected by inadequate training, insufficient time and uncertainty about who from health and social care sectors held responsibility for key aspects of health care provision.
- Care home staff played an important, yet little recognised, role in delivering health care to residents. They did this through contributions to observation, shared decision making and by mediating access to both primary and secondary healthcare.
- Primary health care was not organised to deliver effective health care to meet the needs of care home residents. It was predominantly ad hoc and reactive and, as such, was poorly placed to anticipate either gradual or acute deterioration in a way that would facilitate proactive management.

Strengths and Limitations

- The study considered accounts from both health and social care staff. This allowed us to recognize the commonalities in the challenges described by health and social care staff and their shared understanding of the role that social care staff play in health care delivery.
- Patient and family carer perspectives were not explored and the study was therefore unable to comment on the patient-user perspective of health care for care homes.

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INTRODUCTION

Around 423,000 care home places are provided by the private and voluntary sector in England and Wales[1]. Ninety one percent of residents are over 70 years old, 78% have at least one form of mental impairment and 76% require assistance with mobility or are immobile[2]. There is growing evidence that care home residents have unmet health needs[3-7], may be admitted to hospital unnecessarily[8] and that their dignity may be affected by poor access to health care[9].

Primary health care provision in UK care homes is co-ordinated by general practitioners (GPs), supported by district nurses and a team of community-based allied health professionals. This provision should be identical to that for individuals living in their own homes, but is in contrast to the situation in the USA and The Netherlands where there is care home-specific health care provision[10]. Existing mechanisms for quality assurance of health care may fail to meet the needs of care home residents. The Quality Outcomes Framework (QoF), used by the National Health Service to ensure that primary care across the UK is systematic and evidence-based, does not address residents' needs[11]. Meanwhile, the regulator of care homes, the Care Quality Commission (CQC), has primarily focused on the quality of social care provision[12]. When the CQC did turn its attention to healthcare, with a recent national survey, it reported that residents were often not informed of the health care arrangements for the home, and that for nearly half (44%) there was no regular GP visit to the home[13].

This study set out to contribute to the debate on how to improve health care in care homes by understanding why health care provision is such a cause for concern when commissioners believe that they have put adequate services in place. In order to do this we needed to find out what actually happens when a care home resident needs health care and why the processes that take place occur. We needed to understand the underlying facilitators and barriers to achieving the best and most appropriate health care for patients. From such an understanding, recommendations could then be made for the design of future provision.

METHOD

Methodological approach

With the existing paucity of knowledge concerning how health care is delivered in care homes, a grounded theory approach[16] was adopted.

A phenomenological interview study was used to understand how formal health care was delivered in care homes. The perspectives of care home staff and primary care services were sought using qualitative interviews which aimed to provide a description of context,

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different cultures of work, concepts and behaviours[16,17] and to give parity to accounts from different professional and organisational perspectives.

Semi-structured interviews were used, expecting respondents' time to be limited. In light of the media and regulatory scrutiny, it was anticipated care home staff might feel defensive and that their care was being judged. Therefore a hypothetical case vignette (box 1) was used to help elicit talk and to generate valid data.

Sampling strategy

The initial intention was for both residential and nursing homes, with and without dementia registration, to be sampled. The aim was to sample participants from the typical range of care staff who work in care homes and from primary care. Initial interviews were therefore planned with managers, nurses and care assistants employed in care homes and GPs, district nurses and allied health professionals providing services from primary care. The data-driven grounded theory approach required theoretical sampling whereby sampling decisions could change as the study progressed in order to test evolving theoretical constructs.

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Ethics

Ethical approval was gained from the local NHS ethics committee (REC 09/H046/82).

Recruitment

As part of the NIHR-funded Medical Crises in Older People research programme (http://www.nottingham.ac.uk/mcop/index.aspx), the managers of all care homes within Nottinghamshire and a 10 mile radius of the University of Nottingham Medical School (n=131) were invited to a care home educational event. Of these, 18 care homes accepted an invitation to take part in a cohort study (published elsewhere) from which 11 were selected to provide a representative sample on the basis of nursing and dementia registration. From this sample, homes were invited to participate in this study representing nursing and residential registration status, and suburban and rural locations. Once the home was recruited, individual care home staff were invited to participate through a circular letter and posters placed in staff rooms and on notice-boards. Data saturation was reached after 7 homes were recruited.

GPs were approached after recruitment of the care home. One practice attached to each home was identified and the GP who most frequently provided care was approached. Allied health professionals and district nurses were recruited from contacts made during the conduct of research in GP practices and care homes, or sought-out by telephone and letter where their participation was considered to be important to the emerging theoretical framework.

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Interviews

The interviews were completed at a time and place to suit the participants and lasted between 20 and 90 minutes. An interview guide (Appendix) and case vignette (Box 1) guided the interview. Recordings were made using a digital recorder and transferred to compact discs, transcribed and anonymised. The recordings were erased as soon as the anonymised transcription was verified as a true record by the interviewer.

The interviews were undertaken by IJR, (female, a registered nurse and post-doctoral sociologist with qualitative expertise) and ALG (male, academic geriatrician undertaking doctoral studies). Neither had direct clinical responsibility for the residents in the care homes, but ALG worked as an NHS community geriatrician in the same region.

Box 1 The vignette

Imagine a resident who is short and stooped with a curved spine. She suffers from stiff, painful joints. She is thin. She becomes muddled and disorientated from time to time. She usually needs some help with personal care and wears a small pad for urinary incontinence – a little leakage. She keeps getting urinary tract infections. She has long spells when she is well, but when she gets an infections, staff notice changes in her. She starts to become more confused, so that she needs more help with her personal care than usual. She becomes a bit more unsteady on her feet. The last time that this happened, she had a brief emergency visit to hospital and it took a week or two for her to get back to normal. Can you think about your own experience and recount a similar case?

Analysis

To understand the complexity of health care delivery, an iterative process ran in parallel with data collection. After each interview IJR and ALG discussed the interview content which they checked against interview schedules. The schedules were adapted, with emerging themes to be used in later interviews. Memos were written after interviews, recording ideas and initial analysis. Contradicting evidence was sought in the emerging theories. Recruitment was stopped when data saturation was felt to have been reached. Further analysis was performed using NVivo 8 to organise the interview data and memos. Coding of all the data was carried out by IJR and ALG, independently initially, to develop subthemes. The final analysis was triangulated by all authors through team discussions, literature review, and the writing phase of this process.

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Quotes from participants are identified using the following abbreviations: CHM - care home manager; CA - care assistant; GP - General Practitioner; TN - trained nurse; ANP – Advanced Nurse Practitioner; Res - residential care home; Nurs - care home with nursing; and Dual - Dual Registered home (residential and nursing)

RESULTS

Sample

The participating care homes are described in Table 1. All of these were dementia registered. Two had formal health care provided by a single GP practice, with whom all residents were registered. The remaining homes had relationships with multiple practices. None of the homes had private contractual arrangements with GPs.

Early in the course of the analysis, the relationship between care home managers and GPs emerged as pivotal in the delivery of all aspects of health care and in line with theoretical sampling we therefore recruited more participants from these two groups in an attempt better to understand these relationships. Thirty two interviews were conducted: 7 care home managers (one home had a different manager for its residential and nursing and both were recruited); 2 care home staff nurses; 9 care assistant; 6 GPs (one for each home); 3 members of dementia outreach teams; 2 district nurses, 2 advanced nurse practitioners; and 1 occupational therapist.

Table 1. Profile of participating care homes

	Type of care home	Type of ownership	Number of residents	Location
1	Residential with dementia care	Charity	38	Urban
2	Nursing and residential with dementia care	Private Small chain of homes	42	Suburban
3	Residential with dementia care	Owner/manager	25	Suburban
4	Nursing with dementia care	Owner/manager	40	Rural
5	Nursing with dementia care	Owner/manager	27	Rural
6	Residential and nursing with dementia care	Private	30	Suburban

Coding framework

The accounts offered by participants helped build a picture of health care that took place as a composite of the formal contributions of health professionals and the less formal work of care home staff. The provision of formal health care was, for the most part, driven by unanticipated deterioration in residents' health status, rather than being anticipatory or preventative. The care given by the care home staff, although often labelled as social care, was commonly targeted at health problems or at the maintenance or restoration of health. All participants expressed concern for residents and patients, acknowledging the considerable challenges of caring for frail older people at the end of

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their lives but attributing shortcomings to aspects of the system, rather than the residents or patients themselves.

The main themes of the analysis (Table 2) explain why there are such shortcomings and uncovered barriers to providing effective health care in care homes.

Table 2 Coding and analytic framework

Main themes	Subthemes
Healthcare issues	Acuity of residents, complex co-morbidities Best interests: dementia and capacity Deterioration or rehabilitation Emergency care Access to medical care Anticipatory care Frailty Residential versus nursing status
Professional boundaries as barriers to delivering care	Not calling the GP Deference Expert vs. tacit knowledge Role and disempowerment Recognising change Best interests Relationships/family Social care
Risk	Distinguishing between minor and catastrophic symptoms Moral and legal tensions: who takes responsibility for health care decisions
Responsibility	Care homes as the last refuge when neither family or the NHS can/will take on care An ethic of care (moral ought) Care staff skill, disempowerment and responsibility
Home or hospital - where should the care be delivered?	Stranger at the bedside – hospital care that inevitably means people who do not know the residents caring for them. The absence of end of life planning and care “Give her a chance” Substandard care (hospital): the experience of care home residents

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	sometimes returning to the care home more ill than when they went "We're not short of work" (GPs) Support for care home staff in caring for ill residents
Expectations and tensions:	Normative assumptions of care homes as businesses/poor care (NHS staff) Care homes held at arm's length Dealing with end of life "Oh God you know they've got septicaemia" (social care practitioners as health care practitioners)
Contradictions:	The economy of care: untrained staff in care homes and GP time Ethic of care vs. business ethic (both care home managers and GPs refer to the economy of their work) Deontological ethics vs. consequentialist ethics: end of life (moral and legal tensions)
Consequences:	Care homes in isolation Formal health care at a distance Care homes as a last resort, "picking up the pieces" Residents waiting for health care Reactive health care Quality of life?

Analytic themes were finally expanded and organised under the following headings:

- **Complex health needs and the unpredictable nature of residents' illness trajectories**.
- **A mismatch between health care requirements and GP time**
- **Reactive or anticipatory health care?**
- **A dissonance in health care knowledge and ethos**
- **Tensions in the responsibility for the health care of residents**

Complex health needs and the unpredictable nature of residents' illness trajectories

Care homes residents were perceived to experience complex illnesses with high levels of health and social need. Although the vignette used in the interview referred to a minor illness in a presumed long-standing resident, participants often raised admission to the care home as a particularly difficult time.

"We've got a lady about to be admitted to us, she's obese, lymphodema, chronic obstructive airways disease, continuous oxygen, they've put in a caecostomy tube, she's catheterised, she's in bed, she's feeling nauseous all the time, she's hasn't been out of

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bed for 5 months, as far as I'm aware she hasn't got any pressure sores but she does tell me that her bottom's very sore". (CHM4Nurs)

On-going health care of residents, of the sort discussed in the interview vignette, was recognized as part of the core work of both care home staff and GPs. All participants, from both health professional and social care backgrounds, found it difficult and challenging at times to interpret the significance of changes in the symptoms of residents who usually had multiple and chronic health conditions.

"I had one of my residents admitted last week to hospital with, and we thought she'd had a stroke. It was a UTI". (CHM1Res)

Participants also frequently spoke of death and dying as being difficult to predict.

"Because one day, they can be fine, the next day, they stop eating, and then they could linger for months, or the next day, they could die." (GP3)

"She seemed alright, and all of a sudden she had a funny turn during tea, and so we put her in a wheelchair as quick as we could to get her out of sight from the others you know, because they can't understand what's happening and it upsets some people, and we put her in her bedroom, and we had to dial 999 and the lady actually died before she got to hospital." (CA5Res)

Participants reported the negative effect of poor information transfer to care homes, particularly around admission and discharge from hospital. There was a mistaken expectation held by hospital staff that further management and additional health care such as speech and language therapy, occupational therapy, and physiotherapy would be easily accessible to care homes.

For newly admitted residents, transfer of patient notes from one GP to another could be delayed for weeks, delaying crucial information for safe care and management.

"... Complete disaster, when she moved into the home, took us ages to get hold of ... her old records. And the staff at the home thought she'd got diabetes. But in fact she had diabetes insipidus ..." (GP1)

A mismatch in health care requirements and GP time

GPs described visits to care home residents taking up a substantial amount of their workload.

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"10% of our elderly patients are in care homes, and 10% of our population are over 75... we have at least two to three out of the average of 10 visits a day are to care homes" (GP3)

Two patterns of primary care organisation were evident in our data. The residents of the two rural care homes were served by single GPs, whereas the urban homes were served by several GPs from local general practices. Having a one-to-one relationship with a single GP in the rural care homes arose out of geographical necessity and was praised by all respondents for one home whilst being roundly criticised in the second example. For the former, a constructive working relationship was described, defined by frank and open discussion of differences around patient care and a history of joint initiatives between the GP and care home to improve healthcare for residents.

"Because we do it that way, we do get to know the patients.....one GP practice covering the whole nursing home, I think also works because the nurses know what to expect when they call the doctors. I mean, they know us and we know them." (GP4)

The relationship at the second home was defined by mistrust, conflict and reluctance on behalf of both care home staff and GP to engage with each other. The sense was that a one-to-one relationship would not have been chosen were it not for the geographical necessity.

"Yes they [the care home] are hard work ... all the other GP's have said, 'No,' so we are lumbered with it. What we did propose was that we have half the patients in [the village] and let's have half the nursing home people, but no, all the practices have turned round and said, 'No, it's not in our area'. Of course it's in their area....."(GP5)

Multiple GPs assigned to each care home, and reports of the variable attitudes and skills of GPs, made communication and developing relationships problematic.

"We have seven GP surgeries looking after our residents.....well sometimes I'll pick up the phone and I'll speak to a GP, I don't recognise your name doctor, are you new there?"(CHM2Dual)

The suburban GPs in our sample could see some advantages to organising a one-to-one relationship in terms of facilitating a relationship with care home staff and getting to know their patients better. But they also perceived barriers to this approach in the form of patient choice and organisational issues with neighbouring practices.

"it's a relatively new home that….started about three or four years ago in the area, and what we're doing with them is we've actually said to them, we're prepared to take on ten of your patients but after that, it becomes too much of a sort of, too much of a burden

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really, because it's a, it's a specialist dementia home and they're very difficult management-wise" (GP1)

Reactive or anticipatory health care?

The rural care home in our sample with an effective one-to-one relationship with the GP had regular scheduled visits to the home. These were perceived to enable efficient, anticipatory care and reduce out-of-hours care. However, the remainder of the homes studied did not have regular scheduled visits from their GPs. Two of the urban GPs had previously attempted to establish these types of arrangements with local care homes but had abandoned the custom, concluding that it had no effect on calls from the home between scheduled visits.

"In the past, we used to try and do anticipatory things like a little ward round once a week. And I think we just found that it wasn't making a lot of difference to just letting the staff call us when they needed help. So we were putting more hours in without seeing very much for it."(GP1)

For some care home managers the concept of weekly visits was unhelpful because they considered that their residents sometimes fell ill without warning, and it was at these times they required support.

"two weeks ago one of the doctors sent a letter…saying that the doctor gets called out on numerous days for minor issues, and they want to come just once a week, so I phoned up the practice manager and said, 'I cannot tell you when a resident is going to be ill, that's fine, I'll call an after hours' doctor out, you'll get charged.' So they know they have to visit, when I want a doctor, a doctor comes."(CHM6)

Given the reliance on a system where care homes called GPs reactively, care home staff were concerned when access to primary care was poor and slow.

"There is always a time limit sometimes you have to call before 10, but if something like that after 10 I have to do it myself because I have to use my charm again with the [receptionist] there, so that they can book it immediately. So I just have to say, 'I know I'm a bit late, but you see it's a bit of an emergency here'. " (CHM2Dual)

Efforts to protect GP time were made. For example, some homes accumulated individual issues for the GP to attend to in one visit and one care home manager took residents to the surgery if their condition allowed. Although well intentioned, these practices could have serious implications for resident wellbeing.

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"Somebody was almost moribund when I went to see them, and you know, the visit had been put through to reception as just a routine sort of unwell sort of thing, the receptionist hadn't realised quite how unwell, just put it down for a routine visit." (GP2)

A dissonance in health care knowledge and ethos

Staff in care homes, which are social care institutions, are trained at least to meet the minimum standards of social care required by regulation. It was obvious to care home staff that this did not equip them to deal with the health care needs of their residents.

"Some of our residents do have some really complex healthcare needs and, and obviously, because we're not a registered nursing home and we're not healthcare professionals, we're really dependent on the service we get from GPs," (CHM1Res)

Some GPs highlighted a link between social care training and the inability to identify health care problems, with consequences upon resident wellbeing and GP time.

"The staff particularly in a residential home, are not trained medically so they, they might see there's a bit of a change in a resident but think, 'Oh well, they're just having a bad day today, we'll wait a little bit longer.' And that, you know, we kind of want them to do….It's difficult to get the balance right….very difficult....for them to try and anticipate when people are becoming ill and call us in to pick things up earlier". (GP1)

Health care staff often attributed what they considered to be inadequate training of care home staff to the "profit motive" of care homes operating in the private sector.

"But they're privately employed and there's always, there's always these issues, isn't there, about, I suppose, well, as a, what you read in the papers, there's always the issue about owners wanting the maximum profit, and therefore the minimum staffing and all the rest of it". (GP2)

Despite this, GP training and skills were also felt to be inadequate, or as one GP candidly put it.

"The average General Practitioner isn't experienced enough.....and you need a, basically another specialism going in and I think that would deliver better care to the patient."(GP5)

Despite the concerns of GPs that care home staff lacked health care skills, care home staff revealed a body of experientially-derived health-related knowledge. Examples included nutrition, rehabilitation or the identification of new illnesses.

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"so we've got him on the, we tried the hoist and he was okay and then, they had to stand him, and I said, 'Could he stand?' and they said 'Yes.' I said, 'Right, don't use the hoist, get the rotunda out, two of you, and do him on that.' So he's going to gain that little bit of strength, isn't he?"(CHM3Res)

Tensions in the responsibility for the health care of residents

A recurring issue in both the nursing and dual-registered homes was the ambiguous nature of what care should be provided by care home nurses and what should be provided by NHS district nursing services.

"As a district nurse is a bit of an issue, because there are times when we have to go into a residential home to administer insulin when there are nurses there, trained nurses, and they will not administer the insulin because they're saying we're not insured, so that piles even more pressure, even more visits onto the district nurses."(DN1)

Some care homes recognised that they could provide more health care and that it would be beneficial to residents if they did so, but expressed a strong fear of being blamed for mistakes.

"At the back of your mind you always know that if there's a deterioration in somebody's condition, if there's a medical change, we would be neglectful if we just sat there and recognised that, and thought oh we'll get the doctors to see it next Tuesday." (CHM2dual)

Legislation and regulation sets out standards for care home managers. There was an understanding by managers that, as part of their responsibility for residents' well-being, they would ultimately be held responsible for residents' health as well as their social welfare. They therefore saw mediating access to health care as part of their role.

"Obviously, being a registered manager, you're legally responsible for an awful lot for, under the care homes regulations act, care standards act". (CHM1)

This perceived responsibility for health care decisions extended to end of life issues, which were universally considered to be difficult. Some care home managers described tackling the issue of DNAR orders directly with residents and families and having to take important decisions about advance care planning without support from health care professionals.

"Social services don't want the family to make that [do not resuscitate] decision. So I'm in the middle here, because if you don't do it means you're neglecting it, you're not a

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good nurse, you're not a good home, but the GP does not want to take responsibility for that." (CHM2)

There was a mismatch between care home managers' expression of responsibilities bounded by duty of care and fear of regulation and NHS staff's frequent assertion that fear of litigation influenced how care homes undertook their work.

"Although they're writing 'today Bill', for example, 'refused a bath, was too ill to get in the bath and just wanted hands and face washed', documenting it but the care plan says Bill is able to make a, is able to have a bath or shower each day. So that would not stand up in a court of law if it had to". (ANP1)

GPs often reported not liking this work. One of their main concerns, attributed to poor staff skills and hence risk assessment, was that some patients were referred to them for what they considered to be trivial reasons.

"....the leg's a bit red, or something like that, and you know you can see from looking at the notes that your colleague's been that week, said it might be a mild cellulitis, not too bad, probably give some antibiotics, but you know let's not worry too much about it, leg's not better come back and visit again. Hang on a minute you haven't given it long enough"(GP4)

GPs also expressed concern regarding the value of medical intervention in many of the residents.

"A person who's in a home, it's the end of their life. They become ill, they get a chest infection, are we going to treat them? Are we going to bother? Do they want to go into hospital, be messed around, needles stuck in them, people messing them about? You know, isn't it better they just died? "(GP1)

Despite their limited health care skills, care home staff were responsible for accessing health care and felt they have important contributions to make to health care decisions. However, inadequate working relationships with primary care staff prevented them from doing so. This was particularly evident in their role as advocate for the residents, most of whom they knew well and with whom they had close relationships - at times accepting a role comparable to kinship for those with no family. The particular contributions they described related to assessments of mental capacity for medical decisions and in establishing the best interests of residents.

"A lady...with advanced dementia, a succession of chest infections and asthmatic. GP wanted [this lady] to be admitted into hospital. The nurse didn't think it was in this

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lady's best interests....she was treated with IV antibiotics, she came out of hospital. She died eight days later". (TN2)

DISCUSSION

The study set out to describe facilitators and barriers to providing best quality health care for care home residents. The findings presented under the five main headings provide a summary of these but also contribute to an understanding what might be seen to comprise good healthcare in this setting.

The findings presented under complex health needs and the unpredictable nature of residents illness trajectories, suggest a patient cohort defined by complexity and considerable clinical fluctuation, which it is difficult to predict. Respondents from all disciplines found this challenging. This recognition, that much of the difficulty in dealing with residents comes from the complexity of their conditions, represents an important starting point for constructive approaches to health care provision. The failure to provide timely and comprehensive medical information was a recurrent observation which seemed to confound these difficulties and is a legitimate target for quality improvement.

Under mismatch between health care requirements and GP's time there was a broad consensus that good care for such complex residents takes time, which many GPs were unable to make. Further discussions focussed on how care is, or ought to be, structured. The most positive descriptions of health care came from a home with a 1:1 relationship with a GP but so did the most negative. Such relationships would seem to be able to facilitate high quality care where the home and GP are suitably and mutually engaged and can establish common goals. They can clearly be destructive when these conditions are not met.

Considering reactive versus anticipatory care, the latter seemed to be an ambition for most respondents. For many, this was fostered out of frustration at the negative consequences of reactive care, rather than experience of anticipatory care models which had been seen to work. Some spoke positively of the role that regular scheduled GP visits could play but it was clear that this should not be proposed at the exclusion of rapid response between scheduled visits, given the unpredictable illness trajectories already discussed.

The dissonance between healthcare knowledge and ethos seemed to be located as much in perception as reality. Once again health and social care staff seemed to describe common, rather than separate, challenges. Both described deficiencies in their own and each other's training. It was clear that, with very few exceptions, staff from all sectors

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felt inadequately prepared and resourced to care for residents and that more expertise was desired.

Finally, under tensions in the responsibility for healthcare of residents, care home managers and staff described vividly how they often played a co-ordinating role in both delivering and mediating access to health care for residents. They also described uncertainty as to where this role sat within existing regulatory frameworks, being driven more by duty of care than specific guidance. This uncertainty could lead to deficiencies in care, where neither health care staff nor general practitioners were clear on who should take primary responsibility for, as an example, anticipatory care planning.

Wide variation in GP provision to care homes[5-8] and difficulties in delimiting the role of care home staff[18] have both been described in previous studies. However, by considering the question of health care delivery to residents from both perspectives we have added to this understanding by recognising the commonalities in many of the challenges described. These commonalities were not often recognised by interviewees. Failure to recognise common ground contributes to the difficulty of relationships between care home managers, senior care home staff and GPs. This may be a consequence of inadequate partnerships and integration between the (publically-funded) health service and the (private) care home sector.

The main strength of this study is that it considered the perspectives of both health and social care staff and studied dyads of health and social care providers. This allowed a balanced account of the provision of health care to care homes to be established. There were a few limitations. The study was conducted in a single region and so cannot be taken as representative of the situation across all of England, or the UK as a whole. It also did not take account of the perspective of patients or family carers. Whilst this was rationalised on the basis that these groups would have a limited insight into the practicalities of health care as negotiated between health and social care providers, it does mean that a potentially useful perspective was omitted.

In conclusion, on the basis of these findings, a large part of the challenge of providing effective health care to care home residents comes from the complexity of the medical problems presented by the residents themselves. Their health care needs would be more effectively met by models of care which: provide health and social care staff with specific training in anticipating and managing fluctuations in health status; ensure effective transfer of adequately detailed information at the point of arrival to and departure from a care home; provide sufficient time for assessment and management of health problems as a routine; and provide explicit lines of responsibility for particular aspects of health care management.

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CONFLICT OF INTERESTS

All authors have completed the Unified Competing Interest form at http://www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare: no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years [or describe if any], no other relationships or activities that could appear to have influenced the submitted work.

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Appendix: Interview guide - Explaining the barriers to and tensions in delivering effective health care in UK care homes: a qualitative study:

Themes	Example question	Prompts
Consent and confidentiality issues		Thank you Confidentiality/anonymity Recording Explain interview structure, some questions first and then the vignette Any questions
Adapt questions to work/role/place of work		
General questions about role	How long have you been a care home manager? How long have you worked here? Can you tell me what you think are the most important parts of your job?	
	Tell me about the kind of jobs you do on a typical shift?	What proportion of your time do you spend doing that? Is that something you regard as important? Why/why not?
	What sort of training did you have to do in order to get to where you are now?	Do you feel that you training has prepared you adequate for your role? Do you have ongoing training? Who takes responsibility for that? How do you identify your training needs?
Vignette	The purpose is so that everyone we are interviewing has the same story to help us explore some of the important things we need to	Does this make sense to you?

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	know about residents and their help. After we have given you time to read it we shall discuss it with you. It is not going to be a test or anything like that!	
	Can you think about your own experience of caring for residents and recount a similar case?	Does this kind of situation sound familiar to you? Tell me more about that. How did you feel about that? What did you do next? Who did you tell about it? Was the nurse/manager/GP/district nurse involved? What are the issues that this case raises for you? Were you happy with how this went?
Day to day life in home	Are there jobs that you do that are not directly involved with the care of the residents? How well would you say you know the residents? Do you look after the same residents every day? If so, does this ever change? Could you tell me what a typical day for a resident is like? Tell me about how much time you spend with each resident on a shift? When the residents are sitting in the dayroom, how do you decide who accompanies them to the toilet?	

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Changes in health status	Can you tell me about the overall health of the residents? When a resident isn't well, how do you manage that? How would you tell if one of the residents seemed unwell? What is the role of the resident/their family in identifying changes? Do you do any regular checks on the health of residents?	Tell me more about that. How would you spot that? Is there any other way that you could tell they were unwell? How do you respond if approached by the family? How do you know when/what to check.
Communication of health status	If you notice change in a residents' wellbeing, who might you tell? How do you decide who to tell within the home/outside the home? Would you contact NHS staff/GPs/district nurse? How would you document changes in health status?	Why that person? How would you communicate your concern? Who would you contact? If not, who would? How would they make contact? Is that an easy decision to make? How could it be made easier? Written in notes? Verbal/written handover? Computer records?
Role in health management	What do you see the HCA/nurse/manager/GP/hospitals role in managing changes in	Why is that their/your responsibility? Is there any other way that

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	health? How are lines of responsibility defined?	could work? Is that written down anywhere? Policy vs practice
Strength/weaknesses of the system	Does anything get in the way of indentifying changes in residents' health/wellbeing? How do you get around these problems? Can you think of a way to change things for the better?	Can you explain that for me? Who does that? Could that be easier?
Structured assessment	If we were to introduce a more structured way of assessing and managing residents to improve their health, what do you think that we would need to do? If we were to ask for changes to the way care were documented, what sort of things should we be suggesting? If we were to change the type of medical support provided to care homes, what do you think we would need to do in order to address the issues you raise?	…..and how would we go about that? What might get in the way of that? Whose support would we need for that? Thinking about your previous experience, why do you say that? Can you give me an example from your own experience of why you think that would be useful? What might get in the way of that? How could we make that work from your perspective?
Wrap up	*Are there any questions you would like to ask me?* *Thank the participant for their time and help.* *Reiterate confidentiality and anonymity issues.*	

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Explaining the barriers to and tensions in delivering effective health care in private UK care homes: a qualitative study

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Explaining the barriers to and tensions in delivering effective health care in UK care homes: a qualitative study

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2. Delivery of Health Care
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ABSTRACT

Objective: To explain the current delivery of healthcare to residents living in UK care homes.

Design Qualitative interview study using a grounded theory approach.

Setting Six UK care homes, and primary care professionals serving the homes.

Participants 32: 7 care home managers, 2 care home nurses, 9 care home assistants, 6 GPs, 3 dementia outreach nurses, 2 district nurses, 2 advanced nurse practitioners, 1 occupational therapist.

Results Five themes were identified: ccomplex health needs and the intrinsic nature of residents' illness trajectories; a mismatch between health care requirements and GP time; reactive or anticipatory health care?; a dissonance in health care knowledge and ethos; and tensions in the responsibility for the health care of residents.

Care home managers and staff were pivotal to health care delivery for residents despite their perceived role in social care provision. Formal health care for residents was primarily provided via one or more general practitioners (GPs), often organised to provide a reactive service that did not meet residents' complex needs. Deficiencies were identified in training required to meet residents' needs for both care home staff and GPs. Misunderstandings, ambiguities and boundaries around roles and responsibilities of health and social care staff limited the development of constructive relationships.

Conclusions: Health care of care home residents is difficult because their needs are complex and unpredictable. Neither GPs nor care home staff have enough time to do meet these needs and many lack the prerequisite skills and training. Anticipatory care is generally held to be preferable to reactive care. Attempts to structure care to make it more anticipatory are dependent upon effective relationships between GPs and care home staff and their ability to establish common goals. Roles and responsibilities for many aspects of health care are not made explicit and this risks poor outcomes for residents.

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ARTICLE SUMMARY

Article focus

- Care home residents suffer from long term co-morbid conditions, with acute deteriorations, rendering them disabled and vulnerable.
- There is a growing body of evidence that care home residents have unmet health needs and may be admitted to hospital unnecessarily.
- This study aimed to understand health care delivery to care home residents from both the care home and primary care perspectives, in order to explain why hospital admissions occur and to identify where the barriers and solutions to improving health care lie.

Key messages

- Both general practitioners and care home staff described that care for residents was affected by inadequate training, insufficient time and uncertainty about who from health and social care sectors held responsibility for key aspects of health care provision.
- Care home staff played an important, yet little recognised, role in delivering health care to residents. They did this through contributions to observation, shared decision making and by mediating access to both primary and secondary healthcare.
- Primary health care was not organised to deliver effective health care to meet the needs of care home residents. It was predominantly ad hoc and reactive and, as such, was poorly placed to anticipate either gradual or acute deterioration in a way that would facilitate proactive management.

Strengths and Limitations

- The study considered accounts from both health and social care staff. This allowed us to recognize the commonalities in the challenges described by health and social care staff and their shared understanding of the role that social care staff play in health care delivery.
- Patient and family carer perspectives were not explored and the study was therefore unable to comment on the patient-user perspective of health care for care homes.

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INTRODUCTION

Around 423,000 care home places are provided by the private and voluntary sector in England and Wales[1]. Ninety one percent of residents are over 70 years old, 78% have at least one form of mental impairment and 76% require assistance with mobility or are immobile[2]. There is growing evidence that care home residents have unmet health needs[3-7], may be admitted to hospital unnecessarily[8] and that their dignity may be affected by poor access to health care[9].

Primary health care provision in UK care homes is co-ordinated by general practitioners (GPs), supported by district nurses and a team of community-based allied health professionals. This provision should be identical to that for individuals living in their own homes, but is in contrast to the situation in the USA and The Netherlands where there is care home-specific health care provision[10]. Existing mechanisms for quality assurance of health care may fail to meet the needs of care home residents. The Quality Outcomes Framework (QoF), used by the National Health Service to ensure that primary care across the UK is systematic and evidence-based, does not address residents' needs[11]. Meanwhile, the regulator of care homes, the Care Quality Commission (CQC), has primarily focused on the quality of social care provision[12]. When the CQC did turn its attention to healthcare, with a recent national survey, it reported that residents were often not informed of the health care arrangements for the home, and that for nearly half (44%) there was no regular GP visit to the home[13].

This study set out to contribute to the debate on how to improve health care in care homes by understanding why health care provision is such a cause for concern when commissioners believe that they have put adequate services in place. In order to do this we needed to find out what actually happens when a care home resident needs health care and why the processes that take place occur. We needed to understand the underlying facilitators and barriers to achieving the best and most appropriate health care for patients. From such an understanding, recommendations could then be made for the design of future provision.

METHOD

Methodological approach

With the existing paucity of knowledge concerning how health care is delivered in care homes, a grounded theory approach [16] was adopted.

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A phenomenological interview study was used to understand how formal health care was delivered in care homes. The perspectives of care home staff and primary care services were sought using qualitative interviews which aimed to provide a description of context, different cultures of work, concepts and behaviours[16,17] and to give parity to accounts from different professional and organisational perspectives.

Semi-structured interviews were used, expecting respondents' time to be limited. In light of the media and regulatory scrutiny, it was anticipated care home staff might feel defensive and that their care was being judged. Therefore a hypothetical case vignette (box 1) was used to help elicit talk and to generate valid data.

Sampling strategy

The initial intention was for both residential and nursing homes, with and without dementia registration, to be sampled. The aim was to sample participants from the typical range of care staff who work in care homes and from primary care. Initial interviews were therefore planned with managers, nurses and care assistants employed in care homes and GPs, district nurses and allied health professionals providing services from primary care. The data-driven grounded theory approach required theoretical sampling whereby sampling decisions could change as the study progressed in order to test evolving theoretical constructs.

Ethics

Ethical approval was gained from the local NHS ethics committee (REC 09/H046/82).

Recruitment

As part of the NIHR-funded Medical Crises in Older People research programme (http://www.nottingham.ac.uk/mcop/index.aspx), the managers of all care homes within Nottinghamshire and a 10 mile radius of the University of Nottingham Medical School (n=131) were invited to a care home educational event. Of these, 18 care homes accepted an invitation to take part in a cohort study [18]. 11 care homes were selected from these for the cohort study using a purposive sampling matrix which reproduced the proportion of residents housed in residential/nursing and dementia registered homes nationally. All 11 homes from the cohort study were invited to take part in the interview study. Once the home was recruited, individual care home staff were invited to participate through a circular letter and posters placed in staff rooms and on notice-boards. Data saturation was reached after 6 homes were recruited.

GPs were approached after recruitment of the care home. One practice attached to each home was identified and the GP who most frequently provided care was approached.

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Allied health professionals and district nurses were recruited from contacts made during the conduct of research in GP practices and care homes, or sought-out by telephone and letter where their participation was considered to be important to the emerging theoretical framework.

Interviews

The interviews were completed at a time and place to suit the participants and lasted between 20 and 90 minutes. An interview guide (Appendix supplementary file) and case vignette (Box 1) guided the interview. Recordings were made using a digital recorder and transferred to compact discs, transcribed and anonymised. The recordings were erased as soon as the anonymised transcription was verified as a true record by the interviewer.

The interviews were undertaken by IJR, (female, a registered nurse and post-doctoral sociologist with qualitative expertise) and ALG (male, academic geriatrician undertaking doctoral studies). Neither had direct clinical responsibility for the residents in the care homes, but ALG worked as an NHS community geriatrician in the same region.

Box 1 The vignette

Imagine a resident who is short and stooped with a curved spine. She suffers from stiff, painful joints. She is thin. She becomes muddled and disorientated from time to time. She usually needs some help with personal care and wears a small pad for urinary incontinence – a little leakage. She keeps getting urinary tract infections. She has long spells when she is well, but when she gets an infections, staff notice changes in her. She starts to become more confused, so that she needs more help with her personal care than usual. She becomes a bit more unsteady on her feet. The last time that this happened, she had a brief emergency visit to hospital and it took a week or two for her to get back to normal. Can you think about your own experience and recount a similar case?

Analysis

To understand the complexity of health care delivery, an iterative process ran in parallel with data collection. After each interview IJR and AG discussed the interview content

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which they checked against interview schedules. The schedules were adapted, with emerging themes to be used in later interviews. Memos were written after interviews, recording ideas and initial analysis. Contradicting evidence was sought in the emerging theories. Recruitment was stopped when data saturation was felt to have been reached. Further analysis was performed using NVivo 8 to organise the interview data and memos. Coding of all the data was carried out by IJR and AG, independently initially, to develop subthemes. The final analysis was triangulated by all authors through team discussions, literature review, and the writing phase of this process.

Quotes from participants are identified using the following abbreviations: CHM - care home manager; CA - care assistant; GP - General Practitioner; TN - trained nurse; ANP – Advanced Nurse Practitioner; Res - residential care home; Nurs - care home with nursing; and Dual - Dual Registered home (residential and nursing)

RESULTS

Sample

The participating care homes are described in Table 1. All of these were dementia registered. Two had formal health care provided by a single GP practice, with whom all residents were registered. The remaining homes had relationships with multiple practices. None of the homes had private contractual arrangements with GPs.

Early in the course of the analysis, the relationship between care home managers and GPs emerged as pivotal in the delivery of all aspects of health care. In line with theoretical sampling we therefore sought out more participants from these two groups as the study progressed in an attempt to better understand these relationships. Likewise fewer participants from the wider primary care team were sought. Thirty two interviews were conducted: 7 care home managers (one home had a different manager for its residential and nursing and both were recruited); 2 care home staff nurses; 9 care assistant; 6 GPs (one for each home); 3 members of dementia outreach teams; 2 district nurses, 2 advanced nurse practitioners; and 1 occupational therapist.

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Table 1. Profile of participating care homes

	Type of care home	Type of ownership	Number of residents	Location
1	Residential with dementia care	Charity	38	Urban
2	Nursing and residential with dementia care	Private Small chain of homes	42	Suburban
3	Residential with dementia care	Owner/manager	25	Suburban
4	Nursing with dementia care	Owner/manager	40	Rural
5	Nursing with dementia care	Owner/manager	27	Rural
6	Residential and nursing with dementia care	Private	30	Suburban

Coding framework

The accounts offered by participants helped build a picture of health care that took place as a composite of the formal contributions of health professionals and the less formal work of care home staff. The provision of formal health care was, for the most part, driven by unanticipated deterioration in residents' health status, rather than being anticipatory or preventative. The care given by the care home staff, although often labelled as social care, was commonly targeted at health problems or at the maintenance or restoration of health. All participants expressed concern for residents and patients, acknowledging the considerable challenges of caring for frail older people at the end of their lives but attributing shortcomings to aspects of the system, rather than the residents or patients themselves.

The main themes of the analysis (Table 2) explain why there are such shortcomings and uncovered barriers to providing effective health care in care homes.

Table 2 Coding and analytic framework

Main themes	Subthemes
Healthcare issues	Acuity of residents, complex co-morbidities Best interests: dementia and capacity Deterioration or rehabilitation

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	Emergency care Access to medical care Anticipatory care Frailty Residential versus nursing status
Professional boundaries as barriers to delivering care	Not calling the GP Deference Expert vs. tacit knowledge Role and disempowerment Recognising change Best interests Relationships/family Social care
Risk	Distinguishing between minor and catastrophic symptoms Moral and legal tensions: who takes responsibility for health care decisions
Responsibility	Care homes as the last refuge when neither family or the NHS can/will take on care An ethic of care (moral ought) Care staff skill, disempowerment and responsibility
Home or hospital - where should the care be delivered?	Stranger at the bedside – hospital care that inevitably means people who do not know the residents caring for them. The absence of end of life planning and care “Give her a chance” Substandard care (hospital): the experience of care home residents sometimes returning to the care home more ill than when they went “We’re not short of work” (GPs) Support for care home staff in caring for ill residents
Expectations and tensions:	Normative assumptions of care homes as businesses/poor care (NHS staff) Care homes held at arm’s length Dealing with end of life “Oh God you know they've got septicaemia” (social care practitioners as health care practitioners)
Contradictions:	The economy of care: untrained staff in care homes and GP time Ethic of care vs. business ethic (both care home managers and GPs refer to

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	the economy of their work) Deontological ethics vs. consequentialist ethics: end of life (moral and legal tensions)
Consequences:	Care homes in isolation Formal health care at a distance Care homes as a last resort, "picking up the pieces" Residents waiting for health care Reactive health care Quality of life?

Analytic themes were finally expanded and organised under the following headings:

- **Complex health needs and the unpredictable nature of residents' illness trajectories**.
- **A mismatch between health care requirements and GP time**
- **Reactive or anticipatory health care?**
- **A dissonance in health care knowledge and ethos**
- **Tensions in the responsibility for the health care of residents**

Complex health needs and the unpredictable nature of residents' illness trajectories

Several participants suggested that that the health profile of care home residents has shifted over the recent past. *Nursing home* residents now resemble those previously cared for in long stay hospitals, and *residential home* occupants those previously cared for in nursing homes.

"Well I mean, I think the main changes people who have got, become more dependent, I mean hugely dependent, whereas, I mean when Kimpton Lodge opened most people could walk independently some would use zimmer frames. We didn't have anybody initially that needed hoisting. We bought our first hoist in '91 and that's sufficed for about 10 years I think it was. And now we've got hoists coming out of everywhere. I mean we just haven't got the space to store them basically". (Care home manager 5)

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Participants suggested that higher levels of support in the community were a key reason for the increasing dependency of the cohort as a whole.

"But I think the big change in the last ten years is that we are taking people into care homes much further on into their dementia than we ever used to. Because people are being cared for much longer at home with good care packages going in, lots of family support… So I think that's helpful but I think we are getting people coming in, you know, much more moderate to advanced than we ever used to, so care homes are filling up with quite dependent, quite challenging people". (Outreach dementia care team)

Care home residents were perceived to experience complex illnesses with high levels of health and social need. Although the vignette used in the interview referred to a minor illness in a presumed long-standing resident, participants often raised admission to the care home as a particularly difficult time.

"We've got a lady about to be admitted to us, she's obese, lymphodema, chronic obstructive airways disease, continuous oxygen, they've put in a caecostomy tube, she's catheterised, she's in bed, she's feeling nauseous all the time, she's hasn't been out of bed for 5 months, as far as I'm aware she hasn't got any pressure sores but she does tell me that her bottom's very sore". (CHM4Nurs)

On-going health care of residents, of the sort discussed in the interview vignette, was recognized as part of the core work of both care home staff and GPs. All participants, from both health professional and social care backgrounds, found it difficult and challenging at times to interpret the significance of changes in the symptoms of residents who usually had multiple and chronic health conditions.

"I had one of my residents admitted last week to hospital with, and we thought she'd had a stroke. It was a UTI". (CHM1Res)

Participants also frequently spoke of death and dying as being difficult to predict.

"Because one day, they can be fine, the next day, they stop eating, and then they could linger for months, or the next day, they could die." (GP3)

"She seemed alright, and all of a sudden she had a funny turn during tea, and so we put her in a wheelchair as quick as we could to get her out of sight from the others you know, because they can't understand what's happening and it upsets some people, and we put her in her bedroom, and we had to dial 999 and the lady actually died before she got to hospital." (CA5Res)

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Participants reported the negative effect of poor information transfer to care homes, particularly around admission and discharge from hospital. There was a mistaken expectation held by hospital staff that further management and additional health care such as speech and language therapy, occupational therapy, and physiotherapy would be easily accessible to care homes.

For newly admitted residents, transfer of patient notes from one GP to another could be delayed for weeks, delaying crucial information for safe care and management.

"... Complete disaster, when she moved into the home, took us ages to get hold of ... her old records. And the staff at the home thought she'd got diabetes. But in fact she had diabetes insipidus ..." (GP1)

A mismatch in health care requirements and GP time

GPs described visits to care home residents taking up a substantial amount of their workload.

"10% of our elderly patients are in care homes, and 10% of our population are over 75... we have at least two to three out of the average of 10 visits a day are to care homes" (GP3)

Two patterns of primary care organisation were evident in our data. The residents of the two rural care homes were served by single GPs, whereas the urban homes were served by several GPs from local general practices. Having a one-to-one relationship with a single GP in the rural care homes arose out of geographical necessity and was praised by all respondents for one home whilst being roundly criticised in the second example. For the former, a constructive working relationship was described, defined by frank and open discussion of differences around patient care and a history of joint initiatives between the GP and care home to improve healthcare for residents.

"Because we do it that way, we do get to know the patients.....one GP practice covering the whole nursing home, I think also works because the nurses know what to expect when they call the doctors. I mean, they know us and we know them." (GP4)

The relationship at the second home was defined by mistrust, conflict and reluctance on behalf of both care home staff and GP to engage with each other. The sense was that a one-to-one relationship would not have been chosen were it not for the geographical necessity.

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"Yes they [the care home] are hard work ... all the other GP's have said, 'No,' so we are lumbered with it. What we did propose was that we have half the patients in [the village] and let's have half the nursing home people, but no, all the practices have turned round and said, 'No, it's not in our area'. Of course it's in their area....."(GP5)

Multiple GPs assigned to each care home, and reports of the variable attitudes and skills of GPs, made communication and developing relationships problematic.

"We have seven GP surgeries looking after our residents.....well sometimes I'll pick up the phone and I'll speak to a GP, I don't recognise your name doctor, are you new there?"(CHM2Dual)

The suburban GPs in our sample could see some advantages to organising a one-to-one relationship in terms of facilitating a relationship with care home staff and getting to know their patients better. But they also perceived barriers to this approach in the form of patient choice and organisational issues with neighbouring practices.

"it's a relatively new home that….started about three or four years ago in the area, and what we're doing with them is we've actually said to them, we're prepared to take on ten of your patients but after that, it becomes too much of a sort of, too much of a burden really, because it's a, it's a specialist dementia home and they're very difficult management-wise" (GP1)

Reactive or anticipatory health care?

The rural care home in our sample with an effective one-to-one relationship with the GP had regular scheduled visits to the home. These were perceived to enable efficient, anticipatory care and reduce out-of-hours care. However, the remainder of the homes studied did not have regular scheduled visits from their GPs. Two of the urban GPs had previously attempted to establish these types of arrangements with local care homes but had abandoned the custom, concluding that it had no effect on calls from the home between scheduled visits.

"In the past, we used to try and do anticipatory things like a little ward round once a week. And I think we just found that it wasn't making a lot of difference to just letting the staff call us when they needed help. So we were putting more hours in without seeing very much for it."(GP1)

For some care home managers the concept of weekly visits was unhelpful because they considered that their residents sometimes fell ill without warning, and it was at these times they required support.

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"two weeks ago one of the doctors sent a letter…saying that the doctor gets called out on numerous days for minor issues, and they want to come just once a week, so I phoned up the practice manager and said, 'I cannot tell you when a resident is going to be ill, that's fine, I'll call an after hours' doctor out, you'll get charged.' So they know they have to visit, when I want a doctor, a doctor comes."(CHM6)

Given the reliance on a system where care homes called GPs reactively, care home staff were concerned when access to primary care was poor and slow.

"There is always a time limit sometimes you have to call before 10, but if something like that after 10 I have to do it myself because I have to use my charm again with the [receptionist] there, so that they can book it immediately. So I just have to say, 'I know I'm a bit late, but you see it's a bit of an emergency here'. " (CHM2Dual)

Efforts to protect GP time were made. For example, some homes accumulated individual issues for the GP to attend to in one visit and one care home manager took residents to the surgery if their condition allowed. Although well intentioned, these practices could have serious implications for resident wellbeing.

"Somebody was almost moribund when I went to see them, and you know, the visit had been put through to reception as just a routine sort of unwell sort of thing, the receptionist hadn't realised quite how unwell, just put it down for a routine visit." (GP2)

A dissonance in health care knowledge and ethos

Staff in care homes, which are social care institutions, are trained at least to meet the minimum standards of social care required by regulation. It was obvious to care home staff that this did not equip them to deal with the health care needs of their residents.

"Some of our residents do have some really complex healthcare needs and, and obviously, because we're not a registered nursing home and we're not healthcare professionals, we're really dependent on the service we get from GPs," (CHM1Res)

Some GPs highlighted a link between social care training and the inability to identify health care problems, with consequences upon resident wellbeing and GP time.

"The staff particularly in a residential home, are not trained medically so they, they might see there's a bit of a change in a resident but think, 'Oh well, they're just having a bad day today, we'll wait a little bit longer.' And that, you know, we kind of want them to do….It's difficult to get the balance right….very difficult....for them to try and anticipate when people are becoming ill and call us in to pick things up earlier". (GP1)

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Health care staff often attributed what they considered to be inadequate training of care home staff to the "profit motive" of care homes operating in the private sector.

"But they're privately employed and there's always, there's always these issues, isn't there, about, I suppose, well, as a, what you read in the papers, there's always the issue about owners wanting the maximum profit, and therefore the minimum staffing and all the rest of it". (GP2)

Despite this, GP training and skills were also felt to be inadequate, or as one GP candidly put it.

"The average General Practitioner isn't experienced enough.....and you need a, basically another specialism going in and I think that would deliver better care to the patient."(GP5)

Despite the concerns of GPs that care home staff lacked health care skills, care home staff revealed a body of experientially-derived health-related knowledge. Examples included nutrition, rehabilitation or the identification of new illnesses.

"So we've got him on the, we tried the hoist and he was okay and then, they had to stand him, and I said, 'Could he stand?' and they said 'Yes.' I said, 'Right, don't use the hoist, get the rotunda out, two of you, and do him on that.' So he's going to gain that little bit of strength, isn't he?"(CHM3Res)

Tensions in the responsibility for the health care of residents

A recurring issue in both the nursing and dual-registered homes was the ambiguous nature of what care should be provided by care home nurses and what should be provided by NHS district nursing services.

"As a district nurse is a bit of an issue, because there are times when we have to go into a residential home to administer insulin when there are nurses there, trained nurses, and they will not administer the insulin because they're saying we're not insured, so that piles even more pressure, even more visits onto the district nurses."(DN1)

Some care homes recognised that they could provide more health care and that it would be beneficial to residents if they did so, but expressed a strong fear of being blamed for mistakes.

"At the back of your mind you always know that if there's a deterioration in somebody's condition, if there's a medical change, we would be neglectful if we just sat there and

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recognised that, and thought oh we'll get the doctors to see it next Tuesday." (CHM2dual)

Legislation and regulation sets out standards for care home managers. There was an understanding by managers that, as part of their responsibility for residents' well-being, they would ultimately be held responsible for residents' health as well as their social welfare. They therefore saw mediating access to health care as part of their role.

"Obviously, being a registered manager, you're legally responsible for an awful lot for, under the care homes regulations act, care standards act". (CHM1)

This perceived responsibility for health care decisions extended to end of life issues, which were universally considered to be difficult. Some care home managers described tackling the issue of DNAR orders directly with residents and families and having to take important decisions about advance care planning without support from health care professionals.

"Social services don't want the family to make that [do not resuscitate] decision. So I'm in the middle here, because if you don't do it means you're neglecting it, you're not good a nurse, you're not a good home, but the GP does not want to take responsibility for that." (CHM2)

There was a mismatch between care home managers' expression of responsibilities bounded by duty of care and fear of regulation and NHS staff's frequent assertion that fear of litigation influenced how care homes undertook their work.

"Although they're writing 'today Bill', for example, 'refused a bath, was too ill to get in the bath and just wanted hands and face washed', documenting it but the care plan says Bill is able to make a, is able to have a bath or shower each day. So that would not stand up in a court of law if it had to". (ANP1)

GPs often reported not liking this work. One of their main concerns, attributed to poor staff skills and hence risk assessment, was that some patients were referred to them for what they considered to be trivial reasons.

"....the leg's a bit red, or something like that, and you know you can see from looking at the notes that your colleague's been that week, said it might be a mild cellulitis, not too bad, probably give some antibiotics, but you know let's not worry too much about it, leg's not better come back and visit again. Hang on a minute you haven't given it long enough"(GP4)

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GPs also expressed concern regarding the value of medical intervention in many of the residents.

*"A person who's in a home, it's the end of their life. They become ill, they get a chest infection, are we going to treat them? Are we going to bother? Do they want to go into hospital, be messed around, needles stuck in them, people messing them about? You know, isn't it better they just died? "(*GP1)

Despite their limited health care skills, care home staff are responsible for accessing health care and felt they have important contributions to make to health care decisions. However, inadequate working relationships with primary care staff prevented them from doing so. This was particularly evident in their role as advocate for the residents, most of whom they knew well and with whom they had close relationships - at times accepting a role comparable to kinship for those with no family. The particular contributions they described related to assessments of mental capacity for medical decisions and in establishing the best interests of residents.

"A lady...with advanced dementia, a succession of chest infections and asthmatic. GP wanted [this lady] to be admitted into hospital. The nurse didn't think it was in this lady's best interests....she was treated with IV antibiotics, she came out of hospital. She died eight days later". (TN2)

DISCUSSION

The study set out to describe facilitators and barriers to providing best quality health care for care home residents. The findings presented under the five main headings provide a summary of these but also contribute to an understanding what might be seen to comprise good healthcare in this setting.

The findings presented under complex health needs and the unpredictable nature of residents illness trajectories, suggest a patient cohort defined by dependency added to complexity and considerable clinical fluctuation, which it is difficult to predict. Respondents from all disciplines found this challenging. This recognition, that much of the difficulty in dealing with residents comes from the complexity of their conditions, represents an important starting point for constructive approaches to health care provision. The failure to provide timely and comprehensive medical information was a recurrent observation which seemed to compound these difficulties and is a legitimate target for quality improvement.

Under mismatch between health care requirements and GP's time there was a broad consensus that good care for such complex residents takes time, which many GPs were

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unable to make. Further discussions focussed on how care is, or ought to be, structured. The most positive descriptions of health care came from a home with a 1:1 relationship with a GP but so did the most negative. Such relationships would seem to be able to facilitate high quality care where the home and GP are suitably and mutually engaged and can establish common goals. They can clearly be destructive when these conditions are not met.

Considering reactive versus anticipatory care, the latter seemed to be an ambition for most respondents. For many, this was fostered out of frustration at the negative consequences of reactive care, rather than experience of anticipatory care models which had been seen to work. Some spoke positively of the role that regular scheduled GP visits could play but it was clear that this should not be proposed at the exclusion of rapid response between scheduled visits, given the unpredictable illness trajectories already discussed.

The dissonance between healthcare knowledge and ethos seemed to be located as much in perception as reality. Once again health and social care staff seemed to describe common, rather than separate, challenges. Both described deficiencies in their own and each other's training. It was clear that, with very few exceptions, staff from all sectors felt inadequately prepared and resourced to care for residents and that more expertise was desired.

Finally, under tensions in the responsibility for healthcare of residents, care home managers and staff described vividly how they often played a co-ordinating role in both delivering and mediating access to health care for residents. They also described uncertainty as to where this role sat within existing regulatory frameworks, being driven more by duty of care than specific guidance. This uncertainty could lead to deficiencies in care, where neither health care staff or general practitioners were clear on who should take primary responsibility for, as an example, anticipatory care planning.

Previously the care home population has not been well described, although this has been accomplished in the recent past [2,18]. This study goes beyond description and qualitatively explains how health and social care staff experience the high degree of dependency and illness manifest by care home residents. Wide variation in GP provision to care homes[5-8] and difficulties in delimiting the role of care home staff [19] have both been described in previous studies. It has hitherto been explained that care home staff feel that their priorities and expertise are not acknowledged [20-22]. Our study not only confirms this but also shows how it can affect the health care of residents – for example in the formulation of end of life care planning. By considering the question of health care delivery to residents from the perspective of both care home and health care

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staff we have added to this understanding by recognising the commonalities in many of the challenges described. These commonalities were not often recognised by interviewees themselves. Failure to recognise common ground contributes to the difficulty of relationships between care home managers, senior care home staff and GPs. This may be a consequence of inadequate partnerships and integration between the (publically-funded) health service and the (private) care home sector.

The main strength of this study is that it considered the perspectives of both health and social care staff and studied dyads of health and social care providers. This allowed a balanced account of the provision of health care to care homes to be established. There were a few limitations. The study was conducted in a single region and so cannot be taken as representative of the situation across all of England, or the UK as a whole. It also did not take account of the perspective of patients or family carers. Whilst this was rationalised on the basis that these groups would have a limited insight into the practicalities of health care as negotiated between health and social care providers, it does mean that a potentially useful perspective was omitted.

In conclusion, on the basis of these findings, a large part of the challenge of providing effective health care to care home residents comes from the complexity of the medical problems presented by the residents themselves. Their health care needs would be more effectively met by models of care which: provide health and social care staff with specific training in anticipating and managing fluctuations in health status; ensure effective transfer of adequately detailed information at the point of arrival to and departure from a care home; provide sufficient time for assessment and management of health problems as a routine; and provide explicit lines of responsibility for particular aspects of health care management.

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CONFLICT OF INTERESTS

All authors have completed the Unified Competing Interest form at **http://www.icmje.org/coi_disclosure.pdf** (available on request from the corresponding author) and declare: no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years [or describe if any], no other relationships or activities that could appear to have influenced the submitted work.

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Explaining the barriers to and tensions in delivering effective health care in UK care homes: a qualitative study

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ABSTRACT

Objective: To explain the current delivery of healthcare to residents living in UK care homes.

Design Qualitative interview study using a grounded theory approach.

Setting Six UK care homes, and primary care professionals serving the homes.

Participants 32: 7 care home managers, 2 care home nurses, 9 care home assistants, 6 GPs, 3 dementia outreach nurses, 2 district nurses, 2 advanced nurse practitioners, 1 occupational therapist.

Results Five themes were identified: ccomplex health needs and the intrinsic nature of residents' illness trajectories; a mismatch between health care requirements and GP time; reactive or anticipatory health care?; a dissonance in health care knowledge and ethos; and tensions in the responsibility for the health care of residents.

Care home managers and staff were pivotal to health care delivery for residents despite their perceived role in social care provision. Formal health care for residents was primarily provided via one or more general practitioners (GPs), often organised to provide a reactive service that did not meet residents' complex needs. Deficiencies were identified in training required to meet residents' needs for both care home staff and GPs. Misunderstandings, ambiguities and boundaries around roles and responsibilities of health and social care staff limited the development of constructive relationships.

Conclusions: Health care of care home residents is difficult because their needs are complex and unpredictable. Neither GPs nor care home staff have enough time to do meet these needs and many lack the prerequisite skills and training. Anticipatory care is generally held to be preferable to reactive care. Attempts to structure care to make it more anticipatory are dependent upon effective relationships between GPs and care home staff and their ability to establish common goals. Roles and responsibilities for many aspects of health care are not made explicit and this risks poor outcomes for residents.

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ARTICLE SUMMARY

Article focus

- Care home residents suffer from long term co-morbid conditions, with acute deteriorations, rendering them disabled and vulnerable.
- There is a growing body of evidence that care home residents have unmet health needs and may be admitted to hospital unnecessarily.
- This study aimed to understand health care delivery to care home residents from both the care home and primary care perspectives, in order to explain why hospital admissions occur and to identify where the barriers and solutions to improving health care lie.

Key messages

- Both general practitioners and care home staff described that care for residents was affected by inadequate training, insufficient time and uncertainty about who from health and social care sectors held responsibility for key aspects of health care provision.
- Care home staff played an important, yet little recognised, role in delivering health care to residents. They did this through contributions to observation, shared decision making and by mediating access to both primary and secondary healthcare.
- Primary health care was not organised to deliver effective health care to meet the needs of care home residents. It was predominantly ad hoc and reactive and, as such, was poorly placed to anticipate either gradual or acute deterioration in a way that would facilitate proactive management.

Strengths and Limitations

- The study considered accounts from both health and social care staff. This allowed us to recognize the commonalities in the challenges described by health and social care staff and their shared understanding of the role that social care staff play in health care delivery.
- Patient and family carer perspectives were not explored and the study was therefore unable to comment on the patient-user perspective of health care for care homes.

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INTRODUCTION

Around 423,000 care home places are provided by the private and voluntary sector in England and Wales[1]. Ninety one percent of residents are over 70 years old, 78% have at least one form of mental impairment and 76% require assistance with mobility or are immobile[2]. There is growing evidence that care home residents have unmet health needs[3-7], may be admitted to hospital unnecessarily[8] and that their dignity may be affected by poor access to health care[9].

Primary health care provision in UK care homes is co-ordinated by general practitioners (GPs), supported by district nurses and a team of community-based allied health professionals. This provision should be identical to that for individuals living in their own homes, but is in contrast to the situation in the USA and The Netherlands where there is care home-specific health care provision[10]. Existing mechanisms for quality assurance of health care may fail to meet the needs of care home residents. The Quality Outcomes Framework (QoF), used by the National Health Service to ensure that primary care across the UK is systematic and evidence-based, does not address residents' needs[11]. Meanwhile, the regulator of care homes, the Care Quality Commission (CQC), has primarily focused on the quality of social care provision[12]. When the CQC did turn its attention to healthcare, with a recent national survey, it reported that residents were often not informed of the health care arrangements for the home, and that for nearly half (44%) there was no regular GP visit to the home[13].

This study set out to contribute to the debate on how to improve health care in care homes by understanding why health care provision is such a cause for concern when commissioners believe that they have put adequate services in place. In order to do this we needed to find out what actually happens when a care home resident needs health care and why the processes that take place occur. We needed to understand the underlying facilitators and barriers to achieving the best and most appropriate health care for patients. From such an understanding, recommendations could then be made for the design of future provision.

METHOD

Methodological approach

With the existing paucity of knowledge concerning how health care is delivered in care homes, a grounded theory approach [16] was adopted.

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A phenomenological interview study was used to understand how formal health care was delivered in care homes. The perspectives of care home staff and primary care services were sought using qualitative interviews which aimed to provide a description of context, different cultures of work, concepts and behaviours[16,17] and to give parity to accounts from different professional and organisational perspectives.

Semi-structured interviews were used, expecting respondents' time to be limited. In light of the media and regulatory scrutiny, it was anticipated care home staff might feel defensive and that their care was being judged. Therefore a hypothetical case vignette (box 1) was used to help elicit talk and to generate valid data.

Sampling strategy

The initial intention was for both residential and nursing homes, with and without dementia registration, to be sampled. The aim was to sample participants from the typical range of care staff who work in care homes and from primary care. Initial interviews were therefore planned with managers, nurses and care assistants employed in care homes and GPs, district nurses and allied health professionals providing services from primary care. The data-driven grounded theory approach required theoretical sampling whereby sampling decisions could change as the study progressed in order to test evolving theoretical constructs.

Ethics

Ethical approval was gained from the local NHS ethics committee (REC 09/H046/82).

Recruitment

As part of the NIHR-funded Medical Crises in Older People research programme (http://www.nottingham.ac.uk/mcop/index.aspx), the managers of all care homes within Nottinghamshire and a 10 mile radius of the University of Nottingham Medical School (n=131) were invited to a care home educational event. Of these, 18 care homes accepted an invitation to take part in a cohort study [18]. 11 care homes were selected from these for the cohort study using a purposive sampling matrix which reproduced the proportion of residents housed in residential/nursing and dementia registered homes nationally. All 11 homes from the cohort study were invited to take part in the interview study. Once the home was recruited, individual care home staff were invited to participate through a circular letter and posters placed in staff rooms and on notice-boards. Data saturation was reached after 6 homes were recruited.

GPs were approached after recruitment of the care home. One practice attached to each home was identified and the GP who most frequently provided care was approached.

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Allied health professionals and district nurses were recruited from contacts made during the conduct of research in GP practices and care homes, or sought-out by telephone and letter where their participation was considered to be important to the emerging theoretical framework.

Interviews

The interviews were completed at a time and place to suit the participants and lasted between 20 and 90 minutes. An interview guide (Appendix supplementary file) and case vignette (Box 1) guided the interview. Recordings were made using a digital recorder and transferred to compact discs, transcribed and anonymised. The recordings were erased as soon as the anonymised transcription was verified as a true record by the interviewer.

The interviews were undertaken by IJR, (female, a registered nurse and post-doctoral sociologist with qualitative expertise) and ALG (male, academic geriatrician undertaking doctoral studies). Neither had direct clinical responsibility for the residents in the care homes, but ALG worked as an NHS community geriatrician in the same region.

Box 1 The vignette

Imagine a resident who is short and stooped with a curved spine. She suffers from stiff, painful joints. She is thin. She becomes muddled and disorientated from time to time. She usually needs some help with personal care and wears a small pad for urinary incontinence – a little leakage. She keeps getting urinary tract infections. She has long spells when she is well, but when she gets an infections, staff notice changes in her. She starts to become more confused, so that she needs more help with her personal care than usual. She becomes a bit more unsteady on her feet. The last time that this happened, she had a brief emergency visit to hospital and it took a week or two for her to get back to normal. Can you think about your own experience and recount a similar case?

Analysis

To understand the complexity of health care delivery, an iterative process ran in parallel with data collection. After each interview IJR and AG discussed the interview content

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which they checked against interview schedules. The schedules were adapted, with emerging themes to be used in later interviews. Memos were written after interviews, recording ideas and initial analysis. Contradicting evidence was sought in the emerging theories. Recruitment was stopped when data saturation was felt to have been reached. Further analysis was performed using NVivo 8 to organise the interview data and memos. Coding of all the data was carried out by IJR and AG, independently initially, to develop subthemes. The final analysis was triangulated by all authors through team discussions, literature review, and the writing phase of this process.

Quotes from participants are identified using the following abbreviations: CHM - care home manager; CA - care assistant; GP - General Practitioner; TN - trained nurse; ANP – Advanced Nurse Practitioner; Res - residential care home; Nurs - care home with nursing; and Dual - Dual Registered home (residential and nursing)

RESULTS

Sample

The participating care homes are described in Table 1. All of these were dementia registered. Two had formal health care provided by a single GP practice, with whom all residents were registered. The remaining homes had relationships with multiple practices. None of the homes had private contractual arrangements with GPs.

Early in the course of the analysis, the relationship between care home managers and GPs emerged as pivotal in the delivery of all aspects of health care. In line with theoretical sampling we therefore sought out more participants from these two groups as the study progressed in an attempt to better understand these relationships. Likewise fewer participants from the wider primary care team were sought. Thirty two interviews were conducted: 7 care home managers (one home had a different manager for its residential and nursing and both were recruited); 2 care home staff nurses; 9 care assistant; 6 GPs (one for each home); 3 members of dementia outreach teams; 2 district nurses, 2 advanced nurse practitioners; and 1 occupational therapist.

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Table 1. Profile of participating care homes

	Type of care home	Type of ownership	Number of residents	Location
1	Residential with dementia care	Charity	38	Urban
2	Nursing and residential with dementia care	Private Small chain of homes	42	Suburban
3	Residential with dementia care	Owner/manager	25	Suburban
4	Nursing with dementia care	Owner/manager	40	Rural
5	Nursing with dementia care	Owner/manager	27	Rural
6	Residential and nursing with dementia care	Private	30	Suburban

Coding framework

The accounts offered by participants helped build a picture of health care that took place as a composite of the formal contributions of health professionals and the less formal work of care home staff. The provision of formal health care was, for the most part, driven by unanticipated deterioration in residents' health status, rather than being anticipatory or preventative. The care given by the care home staff, although often labelled as social care, was commonly targeted at health problems or at the maintenance or restoration of health. All participants expressed concern for residents and patients, acknowledging the considerable challenges of caring for frail older people at the end of their lives but attributing shortcomings to aspects of the system, rather than the residents or patients themselves.

The main themes of the analysis (Table 2) explain why there are such shortcomings and uncovered barriers to providing effective health care in care homes.

Table 2 Coding and analytic framework

Main themes	Subthemes
Healthcare issues	Acuity of residents, complex co-morbidities Best interests: dementia and capacity Deterioration or rehabilitation

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	Emergency care Access to medical care Anticipatory care Frailty Residential versus nursing status
Professional boundaries as barriers to delivering care	Not calling the GP Deference Expert vs. tacit knowledge Role and disempowerment Recognising change Best interests Relationships/family Social care
Risk	Distinguishing between minor and catastrophic symptoms Moral and legal tensions: who takes responsibility for health care decisions
Responsibility	Care homes as the last refuge when neither family or the NHS can/will take on care An ethic of care (moral ought) Care staff skill, disempowerment and responsibility
Home or hospital - where should the care be delivered?	Stranger at the bedside – hospital care that inevitably means people who do not know the residents caring for them. The absence of end of life planning and care "Give her a chance" Substandard care (hospital): the experience of care home residents sometimes returning to the care home more ill than when they went "We're not short of work" (GPs) Support for care home staff in caring for ill residents
Expectations and tensions:	Normative assumptions of care homes as businesses/poor care (NHS staff) Care homes held at arm's length Dealing with end of life "Oh God you know they've got septicaemia" (social care practitioners as health care practitioners)
Contradictions:	The economy of care: untrained staff in care homes and GP time Ethic of care vs. business ethic (both care home managers and GPs refer to

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	the economy of their work) Deontological ethics vs. consequentialist ethics: end of life (moral and legal tensions)
Consequences:	Care homes in isolation Formal health care at a distance Care homes as a last resort, "picking up the pieces" Residents waiting for health care Reactive health care Quality of life?

Analytic themes were finally expanded and organised under the following headings:

- **Complex health needs and the unpredictable nature of residents' illness trajectories**.
- **A mismatch between health care requirements and GP time**
- **Reactive or anticipatory health care?**
- **A dissonance in health care knowledge and ethos**
- **Tensions in the responsibility for the health care of residents**

Complex health needs and the unpredictable nature of residents' illness trajectories

Several participants suggested that that the health profile of care home residents has shifted over the recent past. *Nursing home* residents now resemble those previously cared for in long stay hospitals, and *residential home* occupants those previously cared for in nursing homes.

"Well I mean, I think the main changes people who have got, become more dependent, I mean hugely dependent, whereas, I mean when Kimpton Lodge opened most people could walk independently some would use zimmer frames. We didn't have anybody initially that needed hoisting. We bought our first hoist in '91 and that's sufficed for about 10 years I think it was. And now we've got hoists coming out of everywhere. I mean we just haven't got the space to store them basically". (Care home manager 5)

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Participants suggested that higher levels of support in the community were a key reason for the increasing dependency of the cohort as a whole.

"But I think the big change in the last ten years is that we are taking people into care homes much further on into their dementia than we ever used to. Because people are being cared for much longer at home with good care packages going in, lots of family support… So I think that's helpful but I think we are getting people coming in, you know, much more moderate to advanced than we ever used to, so care homes are filling up with quite dependent, quite challenging people". (Outreach dementia care team)

Care home residents were perceived to experience complex illnesses with high levels of health and social need. Although the vignette used in the interview referred to a minor illness in a presumed long-standing resident, participants often raised admission to the care home as a particularly difficult time.

"We've got a lady about to be admitted to us, she's obese, lymphodema, chronic obstructive airways disease, continuous oxygen, they've put in a caecostomy tube, she's catheterised, she's in bed, she's feeling nauseous all the time, she's hasn't been out of bed for 5 months, as far as I'm aware she hasn't got any pressure sores but she does tell me that her bottom's very sore". (CHM4Nurs)

On-going health care of residents, of the sort discussed in the interview vignette, was recognized as part of the core work of both care home staff and GPs. All participants, from both health professional and social care backgrounds, found it difficult and challenging at times to interpret the significance of changes in the symptoms of residents who usually had multiple and chronic health conditions.

"I had one of my residents admitted last week to hospital with, and we thought she'd had a stroke. It was a UTI". (CHM1Res)

Participants also frequently spoke of death and dying as being difficult to predict.

"Because one day, they can be fine, the next day, they stop eating, and then they could linger for months, or the next day, they could die." (GP3)

"She seemed alright, and all of a sudden she had a funny turn during tea, and so we put her in a wheelchair as quick as we could to get her out of sight from the others you know, because they can't understand what's happening and it upsets some people, and we put her in her bedroom, and we had to dial 999 and the lady actually died before she got to hospital." (CA5Res)

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Participants reported the negative effect of poor information transfer to care homes, particularly around admission and discharge from hospital. There was a mistaken expectation held by hospital staff that further management and additional health care such as speech and language therapy, occupational therapy, and physiotherapy would be easily accessible to care homes.

For newly admitted residents, transfer of patient notes from one GP to another could be delayed for weeks, delaying crucial information for safe care and management.

"... Complete disaster, when she moved into the home, took us ages to get hold of ... her old records. And the staff at the home thought she'd got diabetes. But in fact she had diabetes insipidus ..." (GP1)

A mismatch in health care requirements and GP time

GPs described visits to care home residents taking up a substantial amount of their workload.

"10% of our elderly patients are in care homes, and 10% of our population are over 75... we have at least two to three out of the average of 10 visits a day are to care homes" (GP3)

Two patterns of primary care organisation were evident in our data. The residents of the two rural care homes were served by single GPs, whereas the urban homes were served by several GPs from local general practices. Having a one-to-one relationship with a single GP in the rural care homes arose out of geographical necessity and was praised by all respondents for one home whilst being roundly criticised in the second example. For the former, a constructive working relationship was described, defined by frank and open discussion of differences around patient care and a history of joint initiatives between the GP and care home to improve healthcare for residents.

"Because we do it that way, we do get to know the patients.....one GP practice covering the whole nursing home, I think also works because the nurses know what to expect when they call the doctors. I mean, they know us and we know them." (GP4)

The relationship at the second home was defined by mistrust, conflict and reluctance on behalf of both care home staff and GP to engage with each other. The sense was that a one-to-one relationship would not have been chosen were it not for the geographical necessity.

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"Yes they [the care home] are hard work ... all the other GP's have said, 'No,' so we are lumbered with it. What we did propose was that we have half the patients in [the village] and let's have half the nursing home people, but no, all the practices have turned round and said, 'No, it's not in our area'. Of course it's in their area....."(GP5)

Multiple GPs assigned to each care home, and reports of the variable attitudes and skills of GPs, made communication and developing relationships problematic.

"We have seven GP surgeries looking after our residents.....well sometimes I'll pick up the phone and I'll speak to a GP, I don't recognise your name doctor, are you new there?"(CHM2Dual)

The suburban GPs in our sample could see some advantages to organising a one-to-one relationship in terms of facilitating a relationship with care home staff and getting to know their patients better. But they also perceived barriers to this approach in the form of patient choice and organisational issues with neighbouring practices.

"it's a relatively new home that….started about three or four years ago in the area, and what we're doing with them is we've actually said to them, we're prepared to take on ten of your patients but after that, it becomes too much of a sort of, too much of a burden really, because it's a, it's a specialist dementia home and they're very difficult management-wise" (GP1)

Reactive or anticipatory health care?

The rural care home in our sample with an effective one-to-one relationship with the GP had regular scheduled visits to the home. These were perceived to enable efficient, anticipatory care and reduce out-of-hours care. However, the remainder of the homes studied did not have regular scheduled visits from their GPs. Two of the urban GPs had previously attempted to establish these types of arrangements with local care homes but had abandoned the custom, concluding that it had no effect on calls from the home between scheduled visits.

"In the past, we used to try and do anticipatory things like a little ward round once a week. And I think we just found that it wasn't making a lot of difference to just letting the staff call us when they needed help. So we were putting more hours in without seeing very much for it."(GP1)

For some care home managers the concept of weekly visits was unhelpful because they considered that their residents sometimes fell ill without warning, and it was at these times they required support.

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"two weeks ago one of the doctors sent a letter…saying that the doctor gets called out on numerous days for minor issues, and they want to come just once a week, so I phoned up the practice manager and said, 'I cannot tell you when a resident is going to be ill, that's fine, I'll call an after hours' doctor out, you'll get charged.' So they know they have to visit, when I want a doctor, a doctor comes."(CHM6)

Given the reliance on a system where care homes called GPs reactively, care home staff were concerned when access to primary care was poor and slow.

"There is always a time limit sometimes you have to call before 10, but if something like that after 10 I have to do it myself because I have to use my charm again with the [receptionist] there, so that they can book it immediately. So I just have to say, 'I know I'm a bit late, but you see it's a bit of an emergency here'. " (CHM2Dual)

Efforts to protect GP time were made. For example, some homes accumulated individual issues for the GP to attend to in one visit and one care home manager took residents to the surgery if their condition allowed. Although well intentioned, these practices could have serious implications for resident wellbeing.

"Somebody was almost moribund when I went to see them, and you know, the visit had been put through to reception as just a routine sort of unwell sort of thing, the receptionist hadn't realised quite how unwell, just put it down for a routine visit." (GP2)

A dissonance in health care knowledge and ethos

Staff in care homes, which are social care institutions, are trained at least to meet the minimum standards of social care required by regulation. It was obvious to care home staff that this did not equip them to deal with the health care needs of their residents.

"Some of our residents do have some really complex healthcare needs and, and obviously, because we're not a registered nursing home and we're not healthcare professionals, we're really dependent on the service we get from GPs," (CHM1Res)

Some GPs highlighted a link between social care training and the inability to identify health care problems, with consequences upon resident wellbeing and GP time.

"The staff particularly in a residential home, are not trained medically so they, they might see there's a bit of a change in a resident but think, 'Oh well, they're just having a bad day today, we'll wait a little bit longer.' And that, you know, we kind of want them to do….It's difficult to get the balance right….very difficult....for them to try and anticipate when people are becoming ill and call us in to pick things up earlier". (GP1)

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Health care staff often attributed what they considered to be inadequate training of care home staff to the "profit motive" of care homes operating in the private sector.

"But they're privately employed and there's always, there's always these issues, isn't there, about, I suppose, well, as a, what you read in the papers, there's always the issue about owners wanting the maximum profit, and therefore the minimum staffing and all the rest of it". (GP2)

Despite this, GP training and skills were also felt to be inadequate, or as one GP candidly put it.

"The average General Practitioner isn't experienced enough.....and you need a, basically another specialism going in and I think that would deliver better care to the patient."(GP5)

Despite the concerns of GPs that care home staff lacked health care skills, care home staff revealed a body of experientially-derived health-related knowledge. Examples included nutrition, rehabilitation or the identification of new illnesses.

"So we've got him on the, we tried the hoist and he was okay and then, they had to stand him, and I said, 'Could he stand?' and they said 'Yes.' I said, 'Right, don't use the hoist, get the rotunda out, two of you, and do him on that.' So he's going to gain that little bit of strength, isn't he?"(CHM3Res)

Tensions in the responsibility for the health care of residents

A recurring issue in both the nursing and dual-registered homes was the ambiguous nature of what care should be provided by care home nurses and what should be provided by NHS district nursing services.

"As a district nurse is a bit of an issue, because there are times when we have to go into a residential home to administer insulin when there are nurses there, trained nurses, and they will not administer the insulin because they're saying we're not insured, so that piles even more pressure, even more visits onto the district nurses."(DN1)

Some care homes recognised that they could provide more health care and that it would be beneficial to residents if they did so, but expressed a strong fear of being blamed for mistakes.

"At the back of your mind you always know that if there's a deterioration in somebody's condition, if there's a medical change, we would be neglectful if we just sat there and

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recognised that, and thought oh we'll get the doctors to see it next Tuesday." (CHM2dual)

Legislation and regulation sets out standards for care home managers. There was an understanding by managers that, as part of their responsibility for residents' well-being, they would ultimately be held responsible for residents' health as well as their social welfare. They therefore saw mediating access to health care as part of their role.

"Obviously, being a registered manager, you're legally responsible for an awful lot for, under the care homes regulations act, care standards act". (CHM1)

This perceived responsibility for health care decisions extended to end of life issues, which were universally considered to be difficult. Some care home managers described tackling the issue of DNAR orders directly with residents and families and having to take important decisions about advance care planning without support from health care professionals.

"Social services don't want the family to make that [do not resuscitate] decision. So I'm in the middle here, because if you don't do it means you're neglecting it, you're not good a nurse, you're not a good home, but the GP does not want to take responsibility for that." (CHM2)

There was a mismatch between care home managers' expression of responsibilities bounded by duty of care and fear of regulation and NHS staff's frequent assertion that fear of litigation influenced how care homes undertook their work.

"Although they're writing 'today Bill', for example, 'refused a bath, was too ill to get in the bath and just wanted hands and face washed', documenting it but the care plan says Bill is able to make a, is able to have a bath or shower each day. So that would not stand up in a court of law if it had to". (ANP1)

GPs often reported not liking this work. One of their main concerns, attributed to poor staff skills and hence risk assessment, was that some patients were referred to them for what they considered to be trivial reasons.

"....the leg's a bit red, or something like that, and you know you can see from looking at the notes that your colleague's been that week, said it might be a mild cellulitis, not too bad, probably give some antibiotics, but you know let's not worry too much about it, leg's not better come back and visit again. Hang on a minute you haven't given it long enough"(GP4)

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GPs also expressed concern regarding the value of medical intervention in many of the residents.

*"A person who's in a home, it's the end of their life. They become ill, they get a chest infection, are we going to treat them? Are we going to bother? Do they want to go into hospital, be messed around, needles stuck in them, people messing them about? You know, isn't it better they just died? "(*GP1)

Despite their limited health care skills, care home staff are responsible for accessing health care and felt they have important contributions to make to health care decisions. However, inadequate working relationships with primary care staff prevented them from doing so. This was particularly evident in their role as advocate for the residents, most of whom they knew well and with whom they had close relationships - at times accepting a role comparable to kinship for those with no family. The particular contributions they described related to assessments of mental capacity for medical decisions and in establishing the best interests of residents.

"A lady...with advanced dementia, a succession of chest infections and asthmatic. GP wanted [this lady] to be admitted into hospital. The nurse didn't think it was in this lady's best interests....she was treated with IV antibiotics, she came out of hospital. She died eight days later". (TN2)

DISCUSSION

The study set out to describe facilitators and barriers to providing best quality health care for care home residents. The findings presented under the five main headings provide a summary of these but also contribute to an understanding what might be seen to comprise good healthcare in this setting.

The findings presented under complex health needs and the unpredictable nature of residents illness trajectories, suggest a patient cohort defined by dependency added to complexity and considerable clinical fluctuation, which it is difficult to predict. Respondents from all disciplines found this challenging. This recognition, that much of the difficulty in dealing with residents comes from the complexity of their conditions, represents an important starting point for constructive approaches to health care provision. The failure to provide timely and comprehensive medical information was a recurrent observation which seemed to compound these difficulties and is a legitimate target for quality improvement.

Under mismatch between health care requirements and GP's time there was a broad consensus that good care for such complex residents takes time, which many GPs were

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unable to make. Further discussions focussed on how care is, or ought to be, structured. The most positive descriptions of health care came from a home with a 1:1 relationship with a GP but so did the most negative. Such relationships would seem to be able to facilitate high quality care where the home and GP are suitably and mutually engaged and can establish common goals. They can clearly be destructive when these conditions are not met.

Considering reactive versus anticipatory care, the latter seemed to be an ambition for most respondents. For many, this was fostered out of frustration at the negative consequences of reactive care, rather than experience of anticipatory care models which had been seen to work. Some spoke positively of the role that regular scheduled GP visits could play but it was clear that this should not be proposed at the exclusion of rapid response between scheduled visits, given the unpredictable illness trajectories already discussed.

The dissonance between healthcare knowledge and ethos seemed to be located as much in perception as reality. Once again health and social care staff seemed to describe common, rather than separate, challenges. Both described deficiencies in their own and each other's training. It was clear that, with very few exceptions, staff from all sectors felt inadequately prepared and resourced to care for residents and that more expertise was desired.

Finally, under tensions in the responsibility for healthcare of residents, care home managers and staff described vividly how they often played a co-ordinating role in both delivering and mediating access to health care for residents. They also described uncertainty as to where this role sat within existing regulatory frameworks, being driven more by duty of care than specific guidance. This uncertainty could lead to deficiencies in care, where neither health care staff or general practitioners were clear on who should take primary responsibility for, as an example, anticipatory care planning.

Previously the care home population has not been well described, although this has been accomplished in the recent past [2,18]. This study goes beyond description and qualitatively explains how health and social care staff experience the high degree of dependency and illness manifest by care home residents. Wide variation in GP provision to care homes[5-8] and difficulties in delimiting the role of care home staff [19] have both been described in previous studies. It has hitherto been explained that care home staff feel that their priorities and expertise are not acknowledged [20-22]. Our study not only confirms this but also shows how it can affect the health care of residents – for example in the formulation of end of life care planning. By considering the question of health care delivery to residents from the perspective of both care home and health care

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staff we have added to this understanding by recognising the commonalities in many of the challenges described. These commonalities were not often recognised by interviewees themselves. Failure to recognise common ground contributes to the difficulty of relationships between care home managers, senior care home staff and GPs. This may be a consequence of inadequate partnerships and integration between the (publically-funded) health service and the (private) care home sector.

The main strength of this study is that it considered the perspectives of both health and social care staff and studied dyads of health and social care providers. This allowed a balanced account of the provision of health care to care homes to be established. There were a few limitations. The study was conducted in a single region and so cannot be taken as representative of the situation across all of England, or the UK as a whole. It also did not take account of the perspective of patients or family carers. Whilst this was rationalised on the basis that these groups would have a limited insight into the practicalities of health care as negotiated between health and social care providers, it does mean that a potentially useful perspective was omitted.

In conclusion, on the basis of these findings, a large part of the challenge of providing effective health care to care home residents comes from the complexity of the medical problems presented by the residents themselves. Their health care needs would be more effectively met by models of care which: provide health and social care staff with specific training in anticipating and managing fluctuations in health status; ensure effective transfer of adequately detailed information at the point of arrival to and departure from a care home; provide sufficient time for assessment and management of health problems as a routine; and provide explicit lines of responsibility for particular aspects of health care management.

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CONFLICT OF INTERESTS

All authors have completed the Unified Competing Interest form at **http://www.icmje.org/coi_disclosure.pdf** (available on request from the corresponding author) and declare: no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years [or describe if any], no other relationships or activities that could appear to have influenced the submitted work.

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Appendix: Interview guide - Explaining the barriers to and tensions in delivering effective health care in UK care homes: a qualitative study:

Themes	Example question	Prompts
Consent and confidentiality issues		Thank you Confidentiality/anonymity Recording Explain interview structure, some questions first and then the vignette Any questions
Adapt questions to work/role/place of work		
General questions about role	How long have you been a care home manager? How long have you worked here? Can you tell me what you think are the most important parts of your job? Tell me about the kind of jobs you do on a typical shift? What sort of training did you have to do in order to get to where you are now?	What proportion of your time do you spend doing that? Is that something you regard as important? Why/why not? Do you feel that you training has prepared you adequate for your role? Do you have ongoing training? Who takes responsibility for that? How do you identify your training needs?
Vignette	The purpose is so that everyone we are interviewing has the same story to help us explore some of the important things we need to	Does this make sense to you?

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	know about residents and their help. After we have given you time to read it we shall discuss it with you. It is not going to be a test or anything like that!	
	Can you think about your own experience of caring for residents and recount a similar case?	Does this kind of situation sound familiar to you? Tell me more about that. How did you feel about that? What did you do next? Who did you tell about it? Was the nurse/manager/GP/district nurse involved? What are the issues that this case raises for you? Were you happy with how this went?
Day to day life in home	Are there jobs that you do that are not directly involved with the care of the residents? How well would you say you know the residents? Do you look after the same residents every day? If so, does this ever change? Could you tell me what a typical day for a resident is like? Tell me about how much time you spend with each resident on a shift? When the residents are sitting in the dayroom, how do you decide who accompanies them to the toilet?	

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Changes in health status	Can you tell me about the overall health of the residents? When a resident isn't well, how do you manage that? How would you tell if one of the residents seemed unwell? What is the role of the resident/their family in identifying changes? Do you do any regular checks on the health of residents?	Tell me more about that. How would you spot that? Is there any other way that you could tell they were unwell? How do you respond if approached by the family? How do you know when/what to check.
Communication of health status	If you notice change in a residents' wellbeing, who might you tell? How do you decide who to tell within the home/outside the home? Would you contact NHS staff/GPs/district nurse? How would you document changes in health status?	Why that person? How would you communicate your concern? Who would you contact? If not, who would? How would they make contact? Is that an easy decision to make? How could it be made easier? Written in notes? Verbal/written handover? Computer records?
Role in health management	What do you see the HCA/nurse/manager/GP/hospitals role in managing changes in	Why is that their/your responsibility? Is there any other way that

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	health? How are lines of responsibility defined?	could work? Is that written down anywhere? Policy vs practice
Strength/weaknesses of the system	Does anything get in the way of indentifying changes in residents' health/wellbeing? How do you get around these problems? Can you think of a way to change things for the better?	Can you explain that for me? Who does that? Could that be easier?
Structured assessment	If we were to introduce a more structured way of assessing and managing residents to improve their health, what do you think that we would need to do? If we were to ask for changes to the way care were documented, what sort of things should we be suggesting? If we were to change the type of medical support provided to care homes, what do you think we would need to do in order to address the issues you raise?	…..and how would we go about that? What might get in the way of that? Whose support would we need for that? Thinking about your previous experience, why do you say that? Can you give me an example from your own experience of why you think that would be useful? What might get in the way of that? How could we make that work from your perspective?
Wrap up	*Are there any questions you would like to ask me?* *Thank the participant for their time and help.* *Reiterate confidentiality and anonymity issues.*	

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