A qualitative exploratory study of training requirements for general practitioners attending older people resident in care homes.

Abstract

Purpose: Older people who reside in care homes have varying access and quality of medical care; in the UK this is provided by general practitioners (GPs). We aimed to explore the experiences of trainee GPs in delivering integrated care and discuss, with senior GPs, opportunities to improve training.

Method: Two trainees and thirteen senior GPs were recruited through professional networks and participated in semi-structured interviews. Transcriptions were analysed using thematic analysis and the theory of negotiated order was used to interpret findings.

Findings: Trainees received no specific training on working with care homes. Exposure to the care home setting was variable, and could be negligible, depending on the GP practice placement. Senior GPs expressed concerns about patient safety, due to practical challenges of the consultation and a sense of lack of control. Considering the theory of negotiated order, where GPs had trusting relationships with care home staff, the input of the staff could mitigate the sense of risk. Care plans could communicate needs and preferences within the team and may be a way of extending the negotiated order, for example giving care homes authority to implement end-of-life care when GP is not present.

Discussion: We identified a need for trainees to engage with the organisational aspect of the care home to deliver integrated care. Trusted relationships with staff led to improved consultations, care plans, and better management of risk.

Originality: This is the first study of learning needs for GP trainees to provide integrated care for older care home residents.

Keywords

Care homes; Medical education; General practice; long term care facilities
Classifications: Research paper

Plain language summary

The general practitioner (GP) is the doctor responsible for medical care of older people who live in care homes, in the UK. Care homes include residential and nursing homes, known internationally as long-term care facilities or residential aged care facilities. Ideally the role of the doctor should be integrated with the team of care staff and other healthcare staff to provide comprehensive care. We aimed to explore how GPs learn to integrate their practice within the team and how training could be improved.

We talked with trainee GPs as well as senior GPs, who supervise trainees, in order to understand current training and need for improvements to address the challenges of providing integrated care.

We heard from GPs that there was no specific training on how to work with care homes. Trainees on placement had variable levels of attending care homes, and some GP practices may have no associated care homes. We heard from senior GPs that they felt a sense of challenge and risk in providing care within care home because these were independent organisations from the GP practice. We interpreted our findings using theory of negotiated order, which explains how the barriers of traditional hierarchies can be flattened to improve team-work. Thus we interpreted where trusting relationships were present between GP and

care home staff, the sense of risk that the GP may feel about providing treatment to the resident could be mitigated by input and reassurance from care staff. We noted that care plans could be a way of formalising these arrangements between different members of the care team. Care plans mentioned were either for long-term care or end-of-life care.

In conclusion, we found a need to provide training specific for delivery of care to older people living in care homes. This would include training about how GPs should engage with care homes as organisations, rather than attending to a list of patients. Training should encourage GPs to build trusting relationships with care home staff, to facilitate listening to the input from the care staff and team and contribute effectively to person-centred integrated care.

Introduction

Care homes are a setting providing social care to older people (residential care homes) and many also provide nursing care (nursing homes). One in seven people aged 85 years or older live in care homes in England (NHS England, 2016). 'Enhanced Health in Care Homes' (EHCH) is an English policy aiming to improve integration of healthcare (National Health Service (NHS)) within care homes. It includes residents having a named general practitioner (GP) and all residents of one care home being cared for by the same GP practice (known as alignment) (NHS England, 2016). Recent research showed that relationships between GPs and care homes were ill-defined and varied between the different care home companies, leading to varying priorities and inconsistency (Goodman et al., 2013), which implies that an individual resident's health needs may be unrecognised or their access to services may be constrained. An aspect of complexity was different funding arrangements, where GPs are funded by NHS and care homes are funded by local government (Goodman et al., 2013).

The role of the physician in care homes varies in different countries, with an American study highlighting that physicians could be an advocate for patient-centred care (Johnson, 2010). In contrast a German study found physicians spending substantial time reviewing patient records without face-to-face consultation (Theile et al., 2011), which does not enable the resident to have a say in their care. Similarly, in England cases were found where residents were not involved in care planning (Goodman et al., 2013), and a lack of involvement could disrupt continuity of care and autonomy.

For scheduling medical consultations within care homes, EHCH policy in England has recommended that GPs conduct weekly care home rounds (NHS England, 2016). However, in Germany, one study of medical care found the care home ward-round lacked intimacy and confidentiality (Theile et al., 2011), while another study identified four different formats of collaborations between GPs and care homes (on demand, periodical, decision based ad hoc and ward-round visits) (Fleischmann et al., 2016), however no differences in outcome were identified. Regardless of the format, a prepared and informed nurse was beneficial in supporting the medical consultation (Theile et al., 2011).

Personal care is provided by care assistants in the care home and healthcare is provided by nurses and allied healthcare professionals. To explore complex relationships within multidisciplinary teams we draw upon the theory of negotiated order. Originating in 1963 by Strauss and colleagues, the theory conceptualises how individuals negotiate their roles and responsibilities in order to complete tasks. Negotiations are within the context of social structures and hierarchies, and can lead to sustaining or transformation of these social structures (Allen, 1997, Copp, 2005, Watson, 2006). The theory has previously been applied to the interaction between nurse and doctors, where the doctor has traditionally held a high position within the hierarchy (Svensson, 1996, Allen, 1997). Roles are changing as the multi-disciplinary approach becomes more common (Neden; et al., 2019, Mulvale et al., 2016), and another influence is the greater emphasis that is given to patients' preferences (Svensson, 1996, Reeve et al., 2014). Another study of the doctor-nurse boundary in different departments of a hospital found that the negotiation context was important in shaping the negotiated boundary (Liberati, 2017), and this may be important for the care home setting which is quite a different context compared to the hospital. Considering the community

setting, a study of telehealth applied the theory of negotiated order to interpret how nurses implemented telehealth, describing how nurses reflect and adapt their practice with a new technology (Wessels et al., 2017). Interactions between different organisations are also shaped by negotiation, for example a study of the tensions within the relationship between public sector and private sector healthcare organisations found that negotiated order could explain resolution of such tensions (Bishop and Waring, 2016).

When it comes to training GPs, the only mention of care homes in the general practitioner curriculum is to gain experience in frailty and multi-morbidity (Royal College of General Practitioners, 2019). EHCH framework (NHS England, 2016) recommends training, but there is no specification of training for GPs. A study about training of health and social care staff for care of older people highlighted the importance of clinical exposure and training in multi-disciplinary teams (MDTs) (Burger et al., 2018).

Due to the above reported complexity of care in care homes and lack of consistency of training for GPs for this setting, the aim for this study is to explore the current training and working practice of GPs in care homes and produce recommendations for training of GPs.

Method

Senior and trainee GPs were recruited via professional networks within [two counties], England; the sample frame was approximately 30 junior and 15 senior GPs. The participant information sheet (PIS) was emailed and participants were encouraged to forward this to other GPs, creating a snowball convenience sample, which was appropriate for this exploratory study. Semi-structured interviews were used to capture in-depth perspectives. The interview schedule was designed by the authors based on scoping of literature (see

references in introduction). Interview schedule included: suitability of training, integration of care and interaction with care home staff (see appendix 1). Interviews were conducted either face-to-face or via telephone and were recorded, transcribed and anonymised. Transcripts were coded using thematic analysis guidance (Braun and Clarke, 2006) and reporting followed CoreQ guidelines (Tong et al., 2007).

The positionality of the authors is that the lead author is a medical student and the corresponding author is a non-clinical researcher in public health.

This study was approved by the [Faculty] Research Ethics Committee at the [University] [Ref number]. All participants gave informed written consent.

Results

A total of 15 GPs were recruited and given anonymous ID codes, as detailed in table 1. We had difficulties in recruiting trainee GPs and therefore we are limited in our analysis of the experience of trainees.

Table 1. Position (senior (S) or trainee (T)) and geographical location of participants

[Table 1 near here]

Our thematic analysis of the interview data revealed a lack of specific training and a lack of placements for trainees within care homes. Our analysis reported a need for trainees to understand concepts of inter-organisation working between GP practice and the care home organisation. We found many practical challenges of consultation in care homes and also how care home staff can support the consultation, to mitigate GPs perception of risk to patient safety.Our analysis also found that bringing together the wishes of the resident, as

well as coordination of the team, care plans may help to communicate and formalise arrangements.

Current training and placement

While GPs reported that they had not received specific training for care homes, two trainee participants reported that their postgraduate general practice training covered the broad competencies required for care of residents. All participants agreed that specific training for delivering medical care to care home residents would be beneficial, because the approach to clinical scenarios was different in the care home compared to the GP surgery. A trainee reported that trainees benefit from exposure to the complexities and variation within the residential and nursing homes.

> It could be quite difficult delivering training on that because there's so many differences between the hierarchy in nursing homes. (T2)

Trainees are required to have competencies in care of older people and some senior GP participants felt that, if combined with placements, this would be sufficient. However, some GP practices have no residents on their register, and one senior GP noted that trainees placed with their practice had never visited care homes.

Relationship between GP and care home

Participants reported variations in management of visits, while many conducted weekly visits with additional visits as required. Due to recent policy, most surgeries had been aligned to care homes, meaning that all residents within a care home were registered with the same GP practice (NHS England, 2016). However, this was not the case for one GP who stated that

their practice attended only a small number of residents within one care home. This reflects the variability of practice, despite implementation of EHCH policy. Alignment was thought to encourage relationships between GP and care home as an organisation, enabling collaborative care.

> If it's the same person going in, they can establish the relationship with the multidisciplinary team. (S1)

It was also highlighted that the approach the GPs took was very dependent on the care home staff:

> You feel quite in the hands of the care home, so it depends, to an extent, how supportive they are… every home works differently; it's not terribly consistent… (S6)

The relationship with care home staff is a key distinction from regular consultations, where GPs work within their own organisation. The phrasing within this quote 'in the hands of the care home'suggests two things, firstly that GPs may feel exposed to risk and secondly that they feel partly dependent on input from care home staff to manage/mitigate this risk. In situations of traditional hierarchy where the doctor is senior and instructs nursing and assistant staff, this acknowledgement of being 'in the hands of' may be unexpected, and this implies a non-traditional hierarchy.

Challenges and support for the GP consultation

Practical challenges involved in attending residents were identified by participants, for example lighting was unsatisfactory and this could mean that the physical examination, and hence clinical judgement, were not optimal.

> …the ideal setting to see a patient is in the surgery because we have access to equipment, better lighting. Say you're reviewing a rash or something… all those things can affect quality and it can actually affect judgement… (S7)

The daily routine also could add complications, as some GPs visited during lunch times, medication rounds or family visits.

There were challenges in accessing patient records at the care homes. GPs took paper copies of patients' summaries, as 'slow' internet access inhibited retrieval of notes. There was potential risk to patient safety if the doctor was asked to see additional patients without access to their notes.

> You're working without even the paper copies so there's a big clinical risk. You don't know what their medications are, they have to go and get the folder, you don't know their allergies, you don't know what the last person consulting that patient said, so on-the-spot situations you can do, but they're more dangerous. S4

Again the concept of risk or danger is related to providing care for residents, in this case due to lack of access to digital medical records or being requested to consult a patient without being prepared.

GPs developed work-arounds to address these problems, for example one senior GP reported using a laptop with software for accessing electronic medical records (SystmOne). However, underlying these technical issues may be the GPs' perception of risk to patient safety, because of the unfamiliar environment of the consultation within the care home.

GPs reported that the involvement of care home staff in consultations with residents was crucial and adds another dimension to the relationship between GP and resident. Frequent monitoring of health status of residents enabled care home staff to contact GP early. One GP said 'they're the ones that are going to actually pick up subtle changes in behaviour' (S5). Staff then provided important observations and relevant history. Many residents have dementia or cognitive impairment, which led to the staff members being an important source of information on recent temperament. Where GPs trusted the input from staff, they could gain a better history compared with a patient in the community. Care staff also acted as the patient's advocate and provided context, enabling care to be more patient-centred. The GPs valued this communication from a trusted member of the team; despite potential perceptions of staff being lower in the traditional hierarchy of professions.

> If you've got good nurses who know their patients and then if a patient isn't right, they'll be able to say "Mrs so and so isn't right"… and you trust your staff to have that judgement call… S5

However, if there was a lack of trust in the care staff, then this reliance led to frustration for some GPs. GPs suggested that there was a risk to resident safety if the staff member was new on shift or did not have the clinical skills expected: 'staff in a residential home; they are not medically trained…' (S11). Another GP reported 'I've taught the staff how to take

observations for me' (S5), thus the GP helping the staff develop skills would also break down hierarchical barriers and improve trusted communication.

There were also differences in organisational cultures between the GP practice and the care home as an organisation; these may result from the difference between health care and social care. '…their priority is to make sure that they are demonstrating safety and quality to their governing bodies, and we disagree with some of the things that are thought necessary' (S2). On occasion, GPs were called out to fulfil safeguarding protocols, despite the individual having no immediate medical needs. Thus, alongside professional relationships, differences in organisational priorities shape the context and hence may be perceived as barriers for communication about resident care.

Multidisciplinary team

GP practices had implemented various forms of multidisciplinary working for care homes; where advanced nurse practitioners or senior nurses would carry out routine visits for some practices. This arrangement was perceived as a financially sustainable way of enabling a healthcare practitioner to spend additional time with residents.

> We're developing a community housebound team, so this has a GP, whose job is purely to lead this team. They have ANP, district nurses, care co-ordinators, they have community matrons, their own phlebotomy team. So they have a team of people whose priority is to look after the patients within the care home. (S4)

This quote indicates good relationships within the team and potentially a flatter hierarchy including the care home staff, but it is notable that the GP assumes the leadership role within the team. This may be a challenging role for a trainee GP to learn, due to the complexity of

the team and again because of potential boundaries between the care home team and the GP team.

Other GPs assembled a specific multidisciplinary team to meet the individual needs of a resident and team meetings could include the family, to improve person-centredness. Even if full team meetings may be infrequent, the GP had well-established communication with the team.

> …whenever there is a discussion that will involve relevant services for the patient, so we arrange a MDT meeting with those services and family as well… S11

Difficulties arose when there was a lack of communication between the different care providers. One GP expressed frustration with the involvement of other care providers who appeared to upset the GP relationship with care home staff.

> Occasionally the nursing home staff say "We've had a visit from a nurse that tells us we've got to ask you to do all of this stuff". And I'm thinking who is this, and how can they tell me what to do? (S3)

This exemplifies the problems that can occur, and re-emergence of disciplinary boundaries, when team members are not communicating effectively.due to lack of negotiation of roles. and power-relations. This is neatly summarised in the following quote as 'making sure everyone's on the same page'.

> …the organisational challenge and challenge of communication with relatives and staff to make sure the message is clear, and a clear plan is developed for a particular

> patient and communicating that clearly. It's not so much setting up the plan, it's more now delivering it and making sure everyone's on the same page… (S3)

This quote highlights the importance for trainee GPs to learn that medical care is not just about the one-to-one consultation with the resident but is also about the team providing comprehensive care.

Proactive care planning and advance care planning

Key concerns of GPs were acute presentations of chronic conditions, because this could result in a firefighting mode of working, while the preferred mode was of proactive care:

> …it requires proactive planning, to be able to provide the care in care homes. Proactive care planning means you are required to know the people and you are required to visit them regularly. (S1)

Proactive care is individualised and often involves care planning. Interviewees referred to two types of care plans; a general term for proactive or preventative care and a more specific term, 'advance care plan' for recording preferences of an individual with deteriorating cognition or end-of-life care. Recent policy in the UK has encouraged documentation of advance care plans for all residents. Proactive care plans were described as clear instructions for the care home staff, thus allowing common presentations to be treated at the first signs, preventing deterioration and possibly avoiding hospital admissions.

> …a really robust sort of plan of 'if this happens, do this', this is when you contact the GP, out of hours, and this is when you call 999 [emergency ambulance]. So, as long

> as you have a really clear, defined plan for the carers to carry out, I think that's a really good thing as well. (S10)

Referring to advance care planning, many GPs expressed how it acted to mediate between the GP, the patient and their family.

> …the care home understanding that they don't have to dial 999 (emergency ambulance) for this patient, there has been a conversation, it is documented that it is not the right thing to admit this patient to hospital…I would have thought we've done a slightly better job of patient dying in a care home when they would prefer to do that. (S12)

This quote highlights that the advance care plan acts to reassure care home staff that they are continuing to act in the resident's interests in terms of end-of-life care, which may involve the decision to not call the ambulance and enable the individual to die in their place of preference; often the care home, rather than the hospital. If the GP is not present at this time, the advance care plan acts to convey the authority of the GP and enable the care home staff to make decisions that otherwise they may perceive to be risky.

Discussion

Our findings show a lack of specific training for GPs for care of residents of care homes, and potentially, a lack of trainee placements in care homes. Our participants describe care home practice as quite distinct from regular GP work within the surgery. In summary, this is because the care home is a separate organisation with a distinct non-medical culture, where care home staff (nurses and care assistants) can play an important mediating role in the consultation. Further, there is diversity in the relationship between GP practices and care

home organisations, thus it is not straightforward to convey to trainees a standard process or way of working with care homes; different arrangements for visiting and responding to urgent requests are in place in different locations. We have applied the theory of negotiated order to interpret these interactions. Whilst a conventional hierarchy between professions may shape interactions within the GP surgery, in the care home the GP may feel partly dependent on the care home staff, and this may disrupt the hierarchy. Where GPs develop trusting working relationships with care home staff, a negotiated order alleviates this tension and the GP trusts the staff members to mediate in the relationship between GP and patient; that is conveying information about the patient as well as individual preferences, or input from family members. Negotiated order enables a flatter hierarchy where the GP can integrate their medical input into the multidisciplinary team. Other quotes indicate that where there is a lack of trusting relationship between GP and care home staff, the GP does not integrate within the team, but instead, perceives that the care home staff are a barrier or problem for delivering safe medical care. Various participants used words such as 'judgement call', 'risk' or even 'dangerous'; these terms convey a sense that GPs feel exposed to risk in delivering care to residents, and our interpretation is that through a negotiated order and flattening of the hierarchy, decision-making becomes shared and responsibility distributed amongst the team.

GPs described their aim of delivering proactive care and, for this, care planning was instrumental. While participants described care plans as a way of documenting the needs and preferences of the individual resident, including input from family, it was also considered as a way of recording future actions of care team. Thus the care plan could be thought of as a material output of the negotiated order that has occurred within multidisciplinary interactions.

Thus we might anticipate that a care plan developed by a team shaped by negotiated order may be implemented more effectively, for example care home staff may implement actions such as end-of-life care in the absence of immediate medical input.

Aspects of medical care being delivered 'at a distance' from the GP surgery, and in collaboration with a team, may be novel or unusual for GP trainees and therefore these are key issues to enable trainees to understand the situations that they may meet. A recent literature review has described processes and relationships within the context of GPs visiting patients in their own home and found that the relationship between GP and other care professionals is important(Abrams et al., 2020), however there are important differences in the context, where the care home is an institution rather than a private home, and care staff are always present, rather than visiting. A recent review of the care home setting found there to be a lack of research about the interaction of GPs with care homes (Chadborn et al., 2021).

Previous research indicated that the relationship between the care home and the GP was ill-defined and complex (Goodman et al., 2013). Our findings did describe specific differences in the format of visits, however, there was variability in the approaches taken by different GPs. Different processes within care homes were also deemed to add complexity to the interaction between GP and care home.

Our findings on the interaction with care home staff were mixed. Previous studies found that GPs perceived a lack of coordination with care home staff, causing problems for the GP consultation (Goodman et al., 2013, Fleischmann et al., 2016). However German studies found well-coordinated staff and highlighted the benefit as an adjunct for the consultation (Fleischmann et al., 2016, Theile et al., 2011). We found differing priorities between care

home staff and GPs and this was consistent with previous research (Goodman et al., 2013). Participants reported a sense of frustration, however this highlights the need for training in multidisciplinary working, to recognise the strengths of different points of view. The mix of perspectives within social interactions is acknowledged within the theory of negotiated order, implying the need to learn ways of working that respect different positions (Watson, 2006).

These aspects could be incorporated in future training; there may be an opportunity to add these components to training to be developed for the implementation of Enhanced Healthcare in Care Homes policy. Also we note there is no requirement for trainees to gain experience in care homes (Royal College of General Practitioners, 2019), which could explain the inconsistency in experiences reported by our participants. One German study linked the professional challenges of care home work with the lack of training (Theile et al., 2011). Although our participants felt that additional training would be beneficial, none of the participants specifically linked challenges to a lack of training. The different contexts of Germany and the UK may explain these divergent findings. The importance of experience in care homes to support holistic care has been identified (Burger et al., 2018) and our findings about building relationships between GP and care homes are consistent.

The strength of this study were the varied roles and seniorities of the GP participants; covering a broad range of experiences, allowing different perspectives to be analysed. The weakness was the small sample size, especially of trainees, representing a limited geography. GPs who may struggle with care home work may not have been willing to participate, and therefore views may be absent from this study. The study focused on the GP side of the interaction and therefore was limited by not including staff and residents, who may have different views.

Conclusion

Our interview study aimed to explore the training needs of trainee GPs in delivering care to residents of care homes. Due to small sample size of trainees, we cannot make claims about experience of trainees, but with a larger sample of senior GPs we analysed the challenges of medical care in this setting, and this can inform future training. We found that care staff mediated the GPs visit to the care home and also mediated the consultation with residents, for example providing additional information on the resident's health status. We applied the theory of negotiated order to interpret a flattening of the hierarchy between professions and this helped our understanding of how GPs trusted and depended on the care team, and that their medical recommendations were shared within the team. On the other hand, where trusting relationships had not developed, GPs could perceive staff as problematic for the medical management of residents. Care planning can be seen as an output of multidisciplinary communication. Our analysis suggests that complex multidisciplinary relationships are an important part of good quality care of care home residents and that experience of these ways of working should be part of GP's training.

Recommendations for practice

Based on our findings and interpretation, we offer some recommendations for future training of postgraduate GPs (junior doctors). Due to the changing demographic, we recommend that every trainee GP should receive a placement in care homes for older people. We argue that this placement would enable trainees to learn three key aspects of care delivery that may not be common practice in other areas of general practice. When visiting residents, GP trainees should appreciate the organisational aspect of the care home, where staff are providing

various aspects of care and therefore have insights into the residents history and current health status, communication needs and behaviours. In delivering care, GP should acknowledge the care team and consider how their medical input contributes to multidisciplinary care. Clear communication within the team is important and care plans and advance care plans are important elements of communication. Further research should explore the best arrangement to manage placements and to organise clinical supervision, for example can a senior nurse within the care home team provide supervision, or are senior GPs with a special interest in care of older people available within the local network (primary care network). Alternatively a community geriatrician could provide clinical supervision.

Future research

Literature on clinical reasoning indicates a reliance on setting-specific knowledge (Linn et al., 2012, Higgs et al., 2008), therefore future research should explore clinical reasoning within the care home in more depth. Training opportunities should be audited to identify gaps.

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Declaration of interest statement

The authors have no competing interests.

Data availability

Data can be made available upon enquiry to corresponding author.

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Table 1 Summary of participants

Position of participant	Identity code	
	[county 1]	[county 2]
Trainee GP	T1	T2
Senior GP	S1-3, 5	S4,6,8,10-12
Community GP		S9,13
GP trainer		S7