Managing Deterioration

Preventing, Recognising and Responding to Deterioration in your Care Setting

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With thanks to Coventry and Warwickshire ICS from which this resource was inspired.

Managing Deterioration Pack

Keeping Residents Well

Frailty

Frailty is defined as ***"older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care"*** (NHS England).

There are interventions that can slow the progression and prevent frailty crises. The information in this section will help you to identify signs of frailty and support management of frailty with the people whom you care for.

Read more about the Frailty and the Clinical Frailty Scale and how to use this using the training resource **here**:

Frailty

The **Clinical Frailty Scale** is a useful tool to help understand the level of frailty of residents. Older residents in care homes are likely to be at least moderately or severely frail.

	Category	Description
1	**VERY FIT**	People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age
2	**FIT**	People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally. e.g. seasonally
3	**MANAGING WELL**	People whose medical problems are well controlled, but are not regularly active beyond routine walking
4	**LIVING WITH VERY MILD FRAILTY**	Previously 'vulnerable' this category marks early transition from complete independence. While not dependant on others for daily help, often symptoms limit activities. A common complaint is being "slowed up" and/or being tired during the day
5	**LIVING WITH MILD FRAILTY**	These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework
6	**LIVING WITH MODERATE FRAILTY**	People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance with dressing
7	**LIVING WITH SEVERE FRAILTY**	Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within 6 months)
8	**LIVING WITH VERY SEVERE FRAILTY**	Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness
9	**TERMINALLY ILL**	Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in **mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

Keeping Active

Why is Keeping Active So Important?

Keeping active helps with keeping joints and muscles working, the brain active, helping with sleep, avoids legs becoming swollen, blood clots, pressure sores and helps maintain a healthy weight.

Small Changes Can Make Big Differences

Whenever possible, people should be encouraged to do as many daily activities as they can independently rather than things being done for them.

- **Moving** – standing up from their chair several times a day, moving in bed, brushing their teeth and washing their face at the sink
- **Meaningful activities** – walking about for any reason - including for people with dementia - can be meaningful and beneficial even if the purpose isn't always obvious

For more information on supporting a person with dementia who likes to walk, please visit **here**:

Each time a resident stands up you are helping them to maintain independence, social connections, reduce the risk of complications from immobility, maintain strength and balance and reduce the risk of falls.

Planning Activities Within the Home

Activities are important to keep physically and mentally well.

People's daily activities should be meaningful and support people to have optimal health and wellbeing. People should be asked ***'what's important to you*?'** For example, a retired chef may wish to be supported to complete some form of meal prep if they wish, a hairdresser may wish to have a role in a care home salon. Thinking how you can adapt the task most so a person can be supported to have an active role in their daily activities and things that are important and enjoyable to them.

For an A-Z of activity ideas and more information on how to support different activities including top tips for running groups in care homes see **here**:

Falls Prevention

The World Health Organisation defines a fall as:
"an unexpected event in which the participant comes to rest on the ground, floor, or lower level".

Falls and the consequences of falls can significantly impact a person's wellbeing, mobility and confidence. Older people living in care homes are three times more likely to fall than older people living in their own homes, with the results of these falls often being more serious.

The risk of falling can never be completely removed, but by being able to identify risk factors action can be taken to remove or reduce risk where possible.

The Most Common Falls Risks:

- Loose fitting footwear and clothing
- Weak muscles
- Being physically inactive
- Long term conditions
- Some medications or a combination of many
- Excessive alcohol
- Unsteadiness and / or difficulty walking
- Foot problems
- Numbness in the ankles and feet
- Vision and hearing problems
- Dizziness or blackouts
- Continence problems
- Fear of falling
- Pain
- Cognitive problems and / or confusion
- Low temperature
- Poor lighting, especially on the stairs
- Wet, slippery or uneven floor surfaces
- Clutter
- Chairs, toilets or beds being too high, too low or unstable
- Inappropriate or unsafe walking aids including worn ferrules
- Inadequately maintained wheelchairs, e.g. brakes not locking
- Improper use of wheelchairs, e.g. failing to use foot plates
- Unsafe or absent equipment such as handrails.

Are these factors affecting any of your residents' falls risk?

What steps are your home taking to reduce these risks for residents?

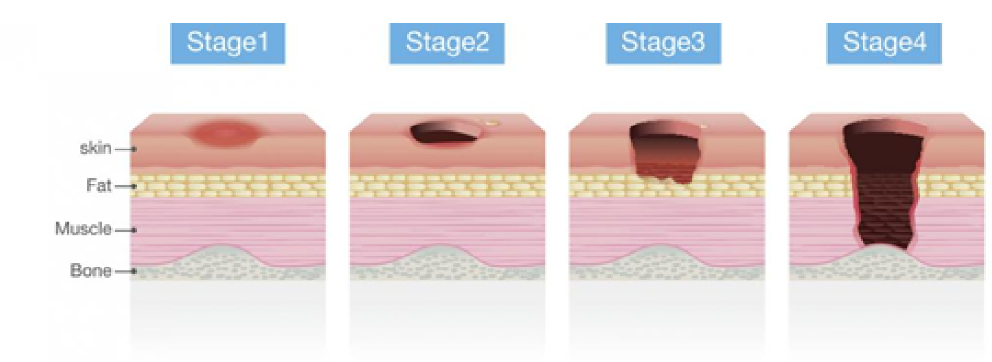
It is important to seek support from the multidisciplinary team via the weekly home rounds for residents presenting with any of these risks.

REACT TO FALLS
For further training and support please access the free evidence based online training tool REACT TO FALLS via the link **here**:

Tissue Viability

What is a Pressure Ulcer?

"A pressure ulcer is damage to the skin and the deeper layer of tissue under the skin. This happens when pressure is applied to the same area of skin for a period of time and cuts off its blood supply. It is more likely if a person has to stay in a bed or chair for a long time. Pressure ulcers are sometimes called 'bedsores' or 'pressure sores'. Without care, pressure ulcers can become very serious. They may cause pain, or mean a longer stay in hospital. Severe pressure ulcers can badly damage the muscle or bone underneath the skin, and can take a very long time to heal."
NICE, 2014



How Does a Pressure Ulcer Occur?

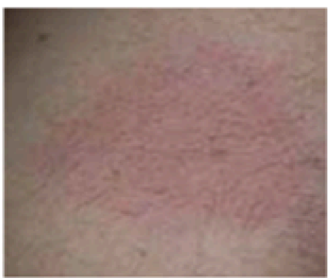
When skin and tissue are directly compressed between two hard surfaces such as a bony prominence (bottom or spine) and your bed, or chair, the blood supply is disrupted, and the area is starved of oxygen and nutrients and tissue damage begins. Pressure ulcers can occur over a short period of time if a large amount of pressure is applied, but they can also occur over a longer period of time when less pressure is applied.

The first sign of tissue damage may be pain, skin may feel warm, cool, numb, swollen, hard, boggy, and skin may be red depending on skin tone. Redness is not always seen in darkly pigmented skin; skin may present as purplish/ bluish in people with toned skin.

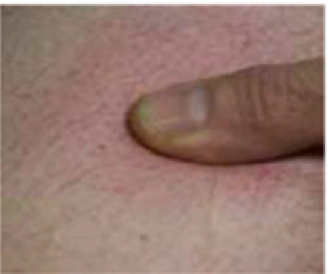
Tissue Viability

How to Check for Signs of Skin Damage

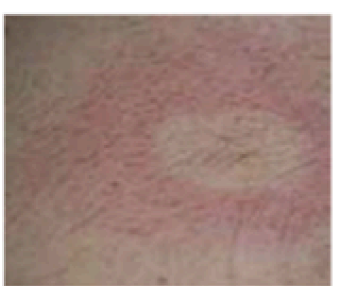
The Blanche / Skin Tolerance Test



Normal skin response to pressure



Press finger over reddened area for 5 seconds, then lift up finger

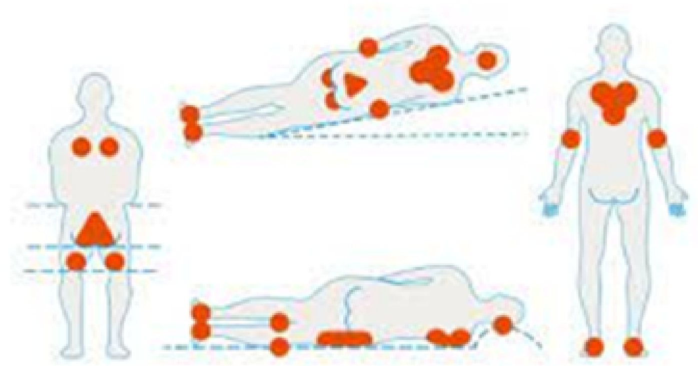


If the area blanches, it is NOT pressure damage. If it stays red then it IS the start of pressure damage

*****Please note this wont be effective on darkly pigmented skin***

Red, blanching areas should not be ignored.
Think of these blanching **red** areas as warning signs and act.
Early detection means early prevention.

Buttocks
Ears and elbows
Sacram
Trochanter (hips)
Spine / shoulders
Heels
Occipital area
Toes



Also, be mindful of other areas such as:

Nose
Fingers
Knees
Ankles

Tissue Viability

It is difficult to ascertain pressure damage when blanching darker skin tones, so please check for these other signs:

- Skin may feel warm or cool to touch
- Skin may feel boggy/soft or hard/thickened
- Skin may have localised heat (inflammation)
- Pain/discomfort or numbness
- Previously damaged skin may be lighter in colour and will be more fragile
- Swelling may occur and the skin maybe appear tight or shiny
- Blisters
- Purple/bluish skin tones – this is similar with redness in people with light toned skin.

Moisture Skin Damage

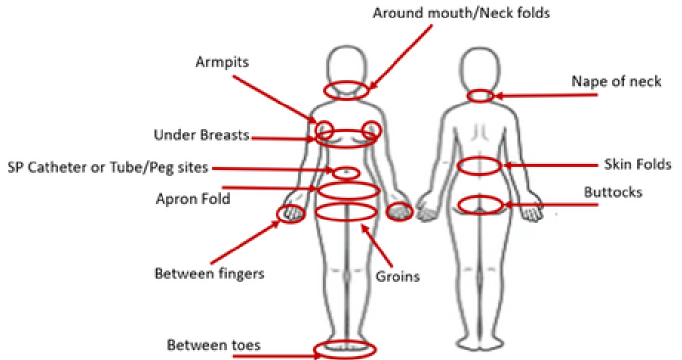
Moisture damage occurs by moisture being in prolonged contact with the skin, altering the pH balance of the skin, irritating the skin, making it more vulnerable and thus at risk of damage from pressure, friction and shear.

Causes of Moisture Damage

- Heat / sweat
- Urine
- Faeces
- Wound leakage
- Drool
- Being immobile
- Cognitive impairment
- Improper use of equipment
- Medication
- Illnesses / comorbidities
- UTI's
- No access to facilities

To Help Prevent Moisture Damage:

- Wash the area with pH friendly products
- Pat dry, DO NOT RUB, as this can be painful and damage already fragile skin
- Apply a prescribed barrier cream/film (Cavilon or Medi Derma-S) as directed
- We advocate that oil-based products are not used as they can clog up continence pads
- Continence assessments should be undertaken for those who are incontinent and reviewed regularly so they are wearing the pad that meets their needs
- Offer the toilet regularly and provide regular personal hygiene assistance.



Please refer here for more information, videos, and resources.

If you have any concerns about a resident with moisture/pressure damage or need general advice, please speak to your local District Nursing Team or Care Home Team who will be able to help and advise.

SSKIN Resource

Nottinghamshire Healthcare NHS
NHS Foundation Trust

S Surface

Check all SURFACES the patient is in contact with- *the list below is not exhaustive and may include other items*

Mattresses	Wheelchairs	Positional Aids
Pressure Cushions	Footstools	Chairs
Heel Boots	Clothing	Medical Devices

IMPORTANT- Check the weight on the air flow mattress reflects the patient's current weight.

Check all SURFACES are fit for use, working correctly and not causing pressure damage.

S Skin Inspection

Check BESTSHOT areas when able. Document this has been done, ensuring that if any skin changes are noted that this is accurately documented and reported.
BESTSHOT areas are bony prominences located across the body.
Please refer to the BESTSHOT guide within the resource folder for more details.
IMPORTANT-Blanch any red areas to determine if the red area is the result of pressure damage.

K Keep Moving

Support and encourage those at risk to reposition, at least 2 hourly in the daytime.
Document refusals clearly and inform individual of the risks, try a short time later or ask another carer to try. Document whatever steps you take to encourage the resident to reposition. Discuss capacity of individual if refuses.
Use slide sheets and other equipment such as hoists/stand aids if needed. Check this equipment is fit for use.
IMPORTANT-Documentation is vital! It should be TIMELY, ACCURATE and APPROPRIATE.

Incontinent individuals should be assessed for their continence wear and reassessments carried out should a resident's needs change. Nets should be worn to ensure pads are kept close to the skin to prevent leakage.
Offer and support your residents to use the toilet regularly.
Give good personal care using pH friendly products.
Report any concerns.
IMPORTANT-Apply a small amount of barrier cream, applying a thin layer, to prevent moisture damage.

Think about the individual- "can't eat or won't eat". Do they have a poor appetite or have trouble chewing/swallowing? Is it painful to eat? Do they require assistance or adapted cutlery?
Monitor and document diet and fluid intake if concerned, weighing regularly. Encourage healthy diets. Fortifying diets can help to support an individual's calorie/nutrients intake, be mindful not every resident need's fortification.
IMPORTANT-Report any concerns and refer to GP/Dietician/SALT/discuss on MDT if concerns arise.

If you have any concerns or issues in relating to any of the topics above, report to a senior, your manager, the GP and/or the Community Nursing Team.
Always voice your concerns, early detection means early prevention!

Effective Nutrition and Hydration to Keep Residents Well

Adequate nutrition and hydration is important to keep people well. Good food and hydration are essential for general wellbeing. So, as a care worker, ensuring that your residents receive adequate amounts of nutrition and hydration is a fundamental aspect of holistic care.

Below is a list of resources to support you in managing the risk of malnutrition and dehydration of your residents:

- **Malnutrition**: Malnutrition means poor nutrition. Most commonly this is caused by not eating enough (undernutrition) or not eating enough of the right food to give your body the nutrients it needs.
https://reactto.co.uk/react-to-malnutrition-and-dehydration

- **Malnutrition Universal Screening Tool (MUST):** MUST is a commonly used, validated tool to screen your residents for risk of malnutrition. Considering BMI and weight loss, it gives a more comprehensive picture of risk than looking at weight alone.
https://www.bapen.org.uk/must-and-self-screening/must-calculator/

- **Dysphagia:** Dysphagia is a term used to describe difficulties swallowing food and / or fluids which can lead to 'aspiration', where food and fluid enter the lungs.
Dysphagia checklist (see pg 69 onwards)
https://www.e-lfh.org.uk/programmes/dysphagiaguide/

- **Hydration**: Good hydration is achieved by drinking enough fluid to replace normal day to day needs and unexpected fluid losses (such as diarrhoea or vomiting). Each individual resident will have different fluid needs depending on their size, age and environment (such as needing more in hot weather). All fluids (except alcohol) count towards hydration including water, squash, fruit juice, milk, tea, and coffee.
https://reactto.co.uk/react-to-malnutrition-and-dehydration

- **International Dysphagia Diet Standardisation Initiative (IDDSI):** The IDDSI Framework provides a common terminology to describe food textures and drink thickness. It is vital all staff are familiar with each IDDSI level to ensure residents with dysphagia are offered appropriate food and fluids; both at, and in between, meals.
https://www.e-lfh.org.uk/programmes/dysphagiaguide/

- **The Eatwell Guide:** The Eatwell Guide shows how much of what we eat overall should come from each food group to achieve a healthy, balanced diet.
https://www.nhs.uk/live-well/eat-well/food-guidelines-and-food-labels/the-eatwell-guide/

The Role of the Home Round (Care Homes Only)

What is a Home Round?

The Home Round (also known as a Board Round or Weekly Check In) is a structured meeting in which the care home, General Practice and community healthcare come together to jointly agree care solutions for residents who live in a care home.

The meeting includes consistent medical input from a GP or Clinical Lead and has input from key members of the wider healthcare team – e.g., Pharmacist, Proactive Care Homes Nurse, Practice Administrator.

A representative from the care home must attend each Home Round. Care home residents and their families may also be informed and involved in the Home Round. The meeting might be face to face, virtual (i.e., via Microsoft Teams), over the phone or a combination of these. The meeting should be arranged at the same time, each week, at a time to suit all members.

Before the Home Round takes place:

You may be contacted by your local practice to identify which residents you would like to discuss that week. A standard checklist is included in this guidance (page 68) to support you to identify appropriate residents.

You might be asked to undertake further tasks to support the Home Round, this could be undertaking basic observations or completing a Dysphagia Checklist (see page 69 onwards).

The Role of the Home Round (Care Homes Only)

What Should be Discussed at the Home Round?

- New residents (residents admitted to the home within the last 7 working days)
- Residents who have had a recent stay in hospital and have returned to the care home (within the last 7 working days)
- Elective admissions
- Any urgent or emergency activity that has not resulted in admission since the last home round, i.e., UCR, Out of Hours, ED attendance
- Residents due their annual birthday review
- Residents who have had a fall since the last home round (all falls – injury / non injury)
- Residents whose mobility and transfer ability have declined, or a resident who hasn't fallen but has nearly done so
- ReSPECT plan review – those who require a ReSPECT form or update, or those newly admitted to the home
- End of life management - initiate EPaCCs if identified as EOL
- Residents who have had an ambulance called for them but no admission
- Speech and language changes – concerns around dysphagia / aspiration
- Changes to mental health / behaviours
- Unplanned weight loss or weight gain
- General resident deterioration – this may have been noted through application of a managing deterioration tool such as RESTORE
- A resident whose status has changed from being there for respite or temporary to permanent

The Home Round isn't just for Deteriorating Care Home Residents

Your aligned Practice must ensure that there are processes in place to enable all residents who require reviews within your care home to be completed in a proactive manner – meaning not only those residents who have a deteriorating or changing issue are reviewed by the team.

Reviews could be:

- Structured medication reviews
- Annual holistic assessment in line with Community Geriatric Assessment (CGA)
- Falls assessment
- Annual 'birth month' reviews to proactively assess resident deterioration and carry out long term condition reviews
- Regular review of End of Life planning, including review of ReSPECT forms annually or if the residents' health changes.

Managing Deterioration Pack

Managing Deterioration

Recognising and Responding to Deterioration with the Person You're Caring For

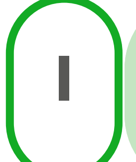
An essential part of supporting any person is ensuring they are safe and well and that any changes in their presentation are recognised early and responded to in a timely way. Within Nottingham and Nottinghamshire we want to offer care staff the right tools and training to recognise any changes but more importantly the help and support that may be required as a result of these changes through health and social care services.

The approach that underpins managing deterioration is the **PIER (Prevention, Identification, Escalation and Response) framework.** This is a standardised approach that all health and social care sectors should be adopting:

P

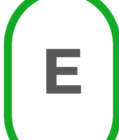
Prevention: interventions reducing the risk of deterioration.

What do you do to prevent deterioration?



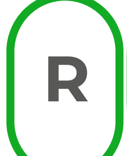
Identification: the early recognition of physical deterioration through the reliable monitoring, identification and assessment of all patients' – RESTORE2 is the tool of choice in Nottinghamshire.

Do you use a managing deterioration tool? Do you assess soft signs with your residents? Do you use NEWS2?



Escalation: using standardised protocols and the reliable escalation and communication of deterioration using a 'common language' recognised across the NHS and Social Care.

Do you find the escalation table within RESTORE useful? Do you feel empowered by this information? What about SBARD?



Response: the timely response and review by appropriately senior clinicians and reliable activation of clinical interventions including acute or end-of-life treatment appropriate to the patient and setting.

How do you communicate the 'decision' about what the response should be? What does this look like practically? Digital record, paper records...

There are a number of deterioration tools that can be used but locally we champion RESTORE2.

For people with learning disabilities or with dementia it is particularly important that carers can identify soft signs of deterioration that the person may not be able to communicate verbally. They are designed for any carer, including families, to use and help recognise deterioration early.

Step One: You've Noticed a Change in a Person You're Caring For

What are 'Soft Signs' of Deterioration?

- Soft signs are early indicators that the person you support might be becoming unwell. This could be anything such as a change in physical presentation or behaviour or changes in mental state.
- Sometimes it can be obvious that someone is unwell, but at other times it might be much harder to spot.
- Often families and friends will pick up on the subtle changes in a resident's behaviour, manner or appearance. These concerns should always be taken seriously, even if you think the person is fine.

It is important to understand what is normal for the person.

Examples of 'Soft Signs'

Soft Signs can be related to many things including:

Changes in physical presentations

- Increased breathlessness or chestiness
- Not passing much urine / change in urine appearance / smell
- Being hot, cold or clammy to touch
- Being unsteady while walking
- Diarrhoea, vomiting, dehydration

Changes in behaviour or ability

- Changes to usual level of alertness / sleeping more or less
- New or increased confusion / agitation / anxiety / pain
- Change in usual drinking / diet habits and / or a deterioration in swallow function
- Reduced mobility – 'off legs'
- Being very restless or hyperactive

Changes in mental state

- Having new or worse confusion
- Feeling more anxious or agitated
- Being more withdrawn than normal

OR just your own gut feeling that something is wrong or the person has concerns.

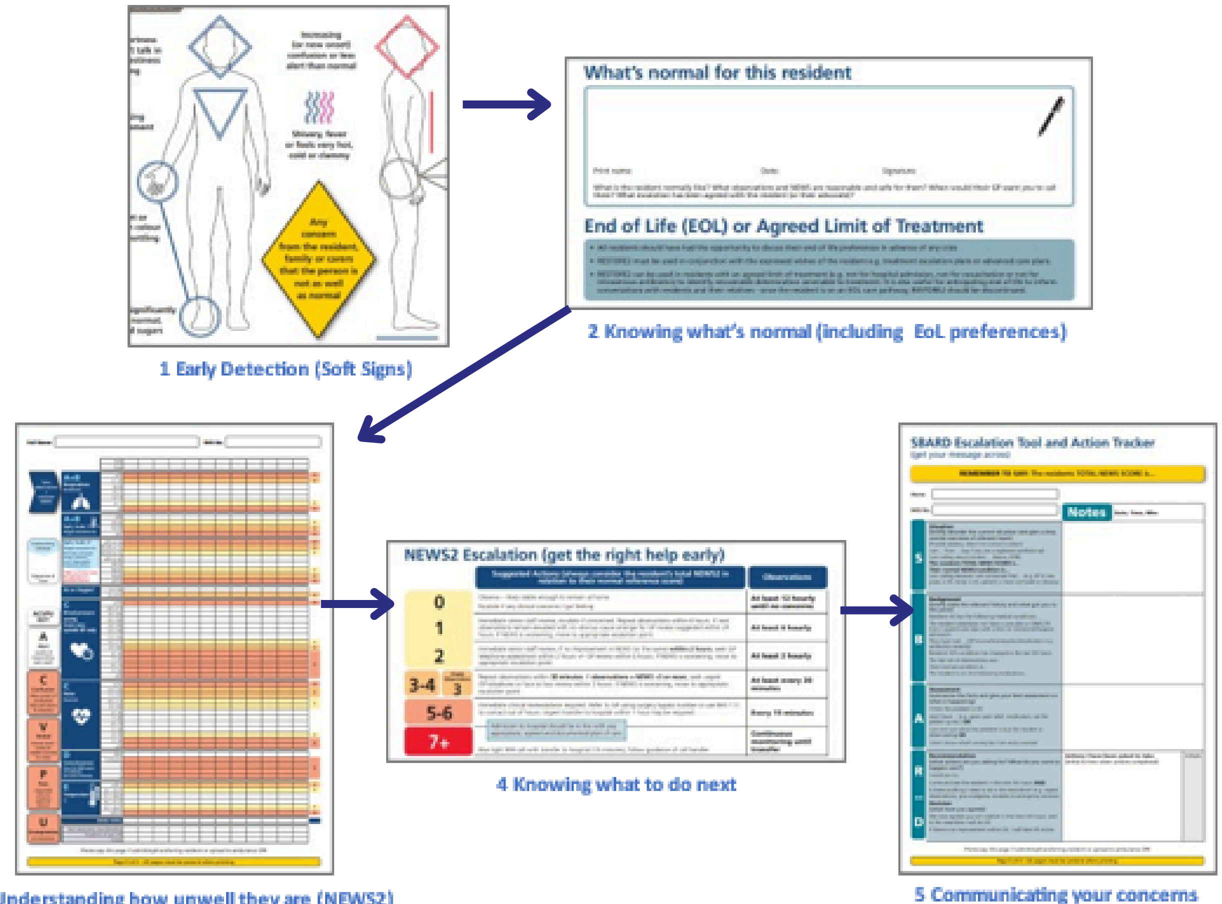
Step Two: Using NEWS2 to Collect and Record Observations

NEWS2 Escalation (get the right help early)

NEWS2 is a guide to aid early recognition of deterioration. You need to be trained to take observations to calculate a NEWS2 score.

Please note this does **NOT** replace clinical decision making and if the person's presentation indicates the need for escalation this must still be undertaken even if not identified by the NEWS2 tool.

Five Key Elements of Managing Deterioration



Step Three: Understanding Who to Contact and When

Once you've completed your observations, calculated the score and reviewed the RESPECT form, use the escalation tool below to refer appropriately:

Score	Suggested Actions (always consider the resident's total NEWS2 in relation to their normal reference score)	Observations
0	Observe – likely stable enough to remain at home Escalate if any clinical concerns / gut feeling	**At least 12 hourly until no concerns**
1	Immediate senior staff review, escalate if concerned. Repeat observations within 6 hours. If next observations remain elevated with no obvious cause arrange for GP review suggested within 24 hours. If NEWS is worsening, move to appropriate escalation point.	**At least 6 hourly**
2	Immediate senior staff review, if no improvement in NEWS (or the same) **within 2 hours**, seek GP telephone assessment within 2 hours +/- GP review within 6 hours. If NEWS is worsening, move to appropriate escalation point.	**At least 2 hourly**
3-4 / Single Observation 3	Repeat observations within **30 minutes**. If **observations = NEWS +3 or more**, seek urgent GP telephone or face to face review within 2 hours. If NEWS is worsening, move to appropriate escalation point.	**At least every 30 minutes**
5-6	Immediate clinical review/advice required. Refer to GP using surgery bypass number or use NHS 111 to contact out of hours. Urgent transfer to hospital within 1 hour may be required.	**Every 15 minutes**
7+	Admission to hospital should be in line with any appropriate, agreed and documented plan of care. Blue light 999 call with transfer to hospital (15 minutes), follow guidance of call handler	**Continuous monitoring until transfer**

Urgent and Emergency Care (UEC) Services - What Service is Needed When?

UCR

When is it UCR?

Urgent clinical assessment and 2-hour response not requiring 999 to prevent an admission, referrals are accepted from 8am up to 8pm 7days a week e.g, falls, sudden deterioration. This service does currently not include prescribing. Support can be given for around 48 hours post referral.

Care staff and patients can refer here:

0300 373 0600

Virtual Ward

When is it Virtual Ward?

When there's an escalating medical need where a 'hospital at home' approach may prevent admission and /or further deterioration.

This pathway can support medical oversight and intervention similar to what can be given in hospital, including prescribing.

111

When is it 111?

When there's a non-emergency change in health need that needs a rapid response from a healthcare team to keep the patient at home and prevent further deterioration.

999

When it's an emergency?

There are some occasions when the early signs of deterioration may be a medical emergency. Such situations include:

- Chest pain or a suspected heart attack
- Where the individual is displaying signs consistent with having a stroke
- Prolonged seizure where the patient does not have a care plan in place to manage it or their breathing is compromised
- Where the resident has sustained a significant injury - e.g. a fracture, head injury

When It's An Emergency

Medical Emergencies

There are some occasions when the early signs of deterioration may be a medical emergency. In these cases, it is not appropriate to delay contacting the emergency services in order to record a NEWS. It may be appropriate to monitor the person's vital signs once you have contacted the emergency services.

Such situations include:

- Chest pain or a suspected heart attack (not all six signs need to be present for a resident to be having a heart attack)

Pain or discomfort in chest

Lightheadedness nausea, or vomitting

Jaw, neck or back pain

Discomfort or pain in arms or shoulder

Shortness of breath

Sweating and clamminess, grey colour

- Where the individual is displaying signs consistent with having a Stroke

Facial weakness

Arm weakness

Speech problems

Time to call 999

- Prolonged seizure where the patient does not have a care plan in place to manage it or their breathing is compromised
- Where the resident has sustained a significant injury – e.g. a fracture, head injury.

Urgent Community Response (UCR)

Urgent Community Response (UCR) is a pathway to reduce preventable hospital admissions through a multi-skilled team approach to people in their usual place of residence.

Operating Hours	Contact
8am – 8pm 7 days a week	0300 373 0600

In case of emergency:

New onset central chest pain/heart attack/cardiac arrest/stroke (face/arm weakness, speech problems), or sudden onset severe pain, collapse.

Call 999

See appendix A (page 67) for further details on UCR.

UCR Referral Criteria

UCR is an urgent two-hour response service that supports people; over the age of 18 years, who live in the Nottingham and Nottinghamshire area and are presenting with acute health needs, within their home environment to ensure timely assessment and intervention to prevent avoidable hospital admissions.

Referrers

If you are staff from a care home in Nottinghamshire County (not City) you are able to refer directly to UCR.

All other people that do not fall into the above category can be referred to UCR via the below pathways. These pathways are also open to care home residents as well as direct referral:

- General Practitioners (GPs)
- Attending Paramedics (EMAS)
- 999 Clinical Triage
- 111 Clinical Triage
- Health Care Professionals (e.g. district nurses, mental health professionals, allied health professionals, etc)

Exclusion Criteria

- Acute medical emergencies such a suspicion of Stroke/ Heart Attack/SEPSIS etc.
- Fall – with obvious bone injury
- Palliative/End of Life residents without an acute medical need
- Head injury – with loss of consciousness/ resident on anticoagulation medication (such as Warfarin)
- Seizures
- Mental health needs including acute crisis

Referral Criteria

- Acute infection (such as cellulitis, a urinary tract or chest infection etc.)
- Confusion / delirium
- Fall with no obvious bone injury but unknown cause of fall
- Reduction in mobility/functional ability
- Acute/Trauma wound care (including suspected wound infection/acute skin-tear)
- Blocked/expelled catheters
- Urgent diabetes care
- Acute frailty management (e.g. sudden change in mobility/transfer status)
- Palliative care support

What Makes a Good Referral

Information Needed for a Good Referral into UCR:

- Care home resident demographics – date of birth, next of kin, contact details, age, etc...
- When they were last seen by their GP?
- What is their past medical history?
- Do they have a Respect document or Advance Care Plan?
- What medication are they taking?
- Do they have any end of life medication in the home?
- What is wrong with them today?
- What are they normally like?
- Are there any soft signs of deterioration? Refer to your deterioration tool
- What are their vital signs – blood pressure, pulse, temperature, respirations? For nursing homes please include a full set of observations (RR Sats HR BP Temp and conscious level or the ACVPU score, and blood sugar if diabetic). Having completed the observation calculate a NEWS2 score and include a baseline NEWS2 score if available
- What are their usual care needs?
- SBARD (Situation Background Assessment and Recommendation Decision) is the tool staff should be using to escalate concerns and is part of each deterioration tool.

Please note that not all the information above is necessary for a referral into UCR. Please continue to refer even if you only have some of the information available.

Virtual Wards

Virtual wards (also known as hospital at home) allow patients to get the care they need at home safely and conveniently, rather than being in hospital.

Virtual wards support people at the place they call home, including care homes.

The virtual ward is a multi disciplinary team which provides medical oversight for up to 14 days. The team includes doctors, nurses, physios, occupational therapists and support staff.

What is the Potential Harm to your Resident from an Unnecessary Hospital Admission?

- Residents with a diagnosis of Dementia or Alzheimer's can become more confused and their function may not return to previous.
- Residents with a diagnosis of a Learning Disability or Autism may find hospital environments anxiety-provoking and it may increase their levels of agitation or challenging behaviours which could affect the decision on treatment options and it's success.
- Residents are at risk of catching other hospital acquired infections, such as norovirus/c-diff, whilst in the hospital environment.

- As a carer you know your residents well and are more likely to be able to support them and their usual routines e.g. eating and drinking. As the resident is not in their usual routine and environment they may be more at risk of malnutrition and dehydration.

There is some evidence that 10 days in hospital is the equivalent of 10 years of ageing of the muscles for an over 80 person (*NHS England, 2017*).

Ultimately, evidence indicates that your residents are best looked after in their own home, with people they know around them, unless they are so acutely unwell that hospital admission is the only option.

Managing Deterioration Pack

Common Conditions

Chest Infections

Possible Causes Can Include:

- Bacteria or viral infections
- Coughing and sneezing which can spread the virus or bacteria
- Potential aspiration(inhalation) of food or fluid due to; dysphagia (problems associated with swallowing); environmental factors; behaviour and cognition
- Poor posture especially when sitting in bed/chair
- Smoking or vaping, or history of these
- Some long-term health conditions make people more at risk such as those with asthma, heart disease, diabetes, kidney disease, chronic obstructive pulmonary disease (COPD)
- Obesity
- Bed bound residents or those who have very poor mobility
- Consolidation (sputum becoming congested in the lungs)
- Residents with a weakened immune system such as those on chemotherapy
- Over 65 years old
- Individuals with profound and multiple learning disability (PMLD)
- Residents who have a history of working in dust creating industry.

P = Prevention

- Ensure visitors who aren't well do not visit until well to prevent introducing illness into the home
- Encourage residents who are eligible to have their seasonal flu vaccination
- Maintain strict hand washing practice by residents/staff/ relatives
- Provide clean tissues and receiver for disposal. Encourage the use of alcohol hand gel after using tissues
- Early recognition of residents with any swallowing problems can help e.g. coughing or throat clearing when eating and drinking. Adhere to and/or seek advice from the Speech and Language Therapy (SALT) Team and complete the dysphagia checklist to identify potential risk
- Offer support to quit smoking through your local GP practice

Chest Infections

I = Identification

- Breathing faster than normal
- Persistent cough
- Bringing up thick yellow/green sputum
- Noisy breathing
- Fast heartbeat
- Any notable changes of colour to skin/lips/nails (cyanosis)
- Poor appetite
- High temperature with residents feeling hot
- Uncontrollable shivering
- Nausea (feeling sick)
- Vomiting
- Chest pains
- Any change in mental state including an increase in confusion /disorientation or drowsiness

E = Escalation

If you notice any of the above soft signs in your resident please complete a NEWS2 observation and refer to the NEWS2 escalation tool (see page 18).

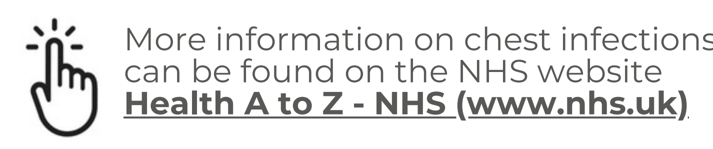
R = Response

Refer to the outcome of the NEWS2 observation and the resident's RESPECT plan, to inform next steps.

If the resident is able to remain within the home consider the following:

- Give medication as prescribed (may be given antibiotics). Follow the instructions on the prescription closely as it often affects how they work
- Assist good posture as sitting upright can help the resident to bring up secretions, especially when eating and drinking. This can happen particularly at night when residents slump in bed and need repositioning regularly
- Encourage deep breathing – your visiting health care professional can help you with breathing techniques
- Observe any sputum production for any changes in colour and consistency – get a sample if it changes colour and becomes darker
- Encourage fluids
- Infection control management use of tissues to '**Catch it, Bin it, Kill it'** and good hand washing for residents/staff/visitors
- Plenty of rest

Continue to monitor NEWS2 observations until your resident is back to their baseline.



More information on chest infections can be found on the NHS website
Health A to Z - NHS (www.nhs.uk)

Flu

What is Flu?

Flu is a highly contagious disease that is transmitted through the air in millions of tiny droplets from an infected person's nose or mouth. These droplets can survive for up to 24 hours and infect people of all ages who breathe in the droplets or touch a surface that the droplets have landed on and then a recipient touches that surface (indirect contact) and then infects themselves on touching their eyes/ mouth. It can lead to serious illnesses, such as pneumonia, particularly in the vulnerable and young. Tiredness symptoms can last for up to several weeks.

Flu symptoms can develop rapidly and will stop residents from completing their normal daily activities whilst a cold usually develops gradually and mainly affects the nose and throat and is usually fairly mild.

P = Prevention

- Annual flu vaccine
- Pneumococcal vaccine
- Covid vaccine

All residents are entitled to receive an annual flu vaccine from their local GP surgery. Although not 100% effective as there are different strains of flu, it does offers some worthwhile protection to your residents.

I = Identification

- A high temperature of 38°C or above
- Tiredness and weakness and feeling so exhausted and unwell that a resident has to stay in bed
- A persistent headache
- Limb or joint pain
- Aching muscles
- A sore throat
- A dry chesty cough
- Cold like symptoms
- Diarrhoea or abdominal pains
- Reduced appetite
- Nausea and vomiting (gastric flu i.e. norovirus) – liaise with local IPC team for advice.

E = Escalation

If you notice any of the above soft signs in your resident please complete a NEWS2 observation and refer to the NEWS2 escalation tool (see page 18)

Flu

Ⓡ = Response

Refer to the outcome of the NEWS2 observation and the resident's RESPECT plan, to inform next steps.

If the resident is able to remain within the home consider the following:

- Allow residents to rest
- Keep them warm (be wary of high temperatures)
- Push fluids to avoid dehydration, light diet as tolerated
- Offer regular paracetamol as prescribed, depending on the residents' allergies/intolerances.

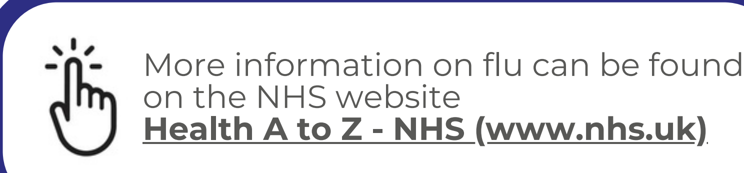
Continue to monitor NEWS2 observations until your resident is back to their baseline.

How to Manage a Flu Outbreak in your Care Home:

- Attempt to isolate residents if possible to prevent the spread of the outbreak
- Wash hands regularly with soap and water
- Use universal precautions including gloves/aprons/masks when caring for an infected resident
- Increase the cleaning protocol of the home by regularly cleaning surfaces and door handles
- Encourage residents to cover their mouths with a tissues when sneezing or coughing, binning the tissue and using alcohol gel on their hands
- Infection control management use of tissues to 'Catch it, Bin it, Kill it' and good hand washing for residents/staff/visitors
- Report an outbreak as per the Local IPC guidance/Health Protection Agency/your own Care Home Policies.

Complications of Flu:

- Chest infection
- Pneumonia
- Sepsis
- Dehydration
- Worsening of existing conditions such as Diabetes (raised blood sugars), COPD, Heart Failure, Chronic Kidney Disease



(P) = Prevention

COVID-19 spreads easily through contact with people who have the virus through respiratory droplets. Correct hand hygiene remains the best way to prevent the spread of any infection. With any respiratory illness use tissues when coughing or sneezing, dispose of the tissues as soon as possible and wash your hands as soon as you can.

Booster vaccinations are offered as the virus can change and protection can fade over time. It is important to top up your protection.

If you're at increased risk of serious illness from COVID-19, getting a COVID-19 vaccine can:

- Help to reduce your risk of getting severe symptoms
- Help you to recover more quickly if you catch COVID-19
- Help to reduce your risk of having to go to hospital or dying from COVID-19
- Protect against different strains of COVID-19.

How to avoid spreading COVID-19 in social care settings:

- Symptomatic staff should stay off work whilst they have symptoms, or for if they have taken a positive lateral flow test for a period of 5 days
- Isolate symptomatic residents for 5 days from onset of symptoms/date of positive test. Complete a risk assessment if isolation may be difficult (for example if someone is at risk of falls, if a resident wanders with purpose or if residents need to be cohorted)
- Ensure hand hygiene facilities are freely available for residents, staff and visitors
- Regularly clean surfaces you touch often (such as door handles and remote controls) and in shared spaces, such as lounges or bathrooms
- Risk assess to facilitate and support safe visiting during an outbreak
- Ensure staff have access to gloves, aprons and Type IIR face masks
- Ventilate rooms by opening windows regularly
- Ensure laundry and waste of affected residents is treated as infectious
- Ideally any admissions/discharges or transfers should be delayed until after the outbreak. If there are any urgent admission/discharges or transfer, they will need to be individually risk assessed
- In exceptional circumstances it may be decided the home needs to close to visiting and admissions/discharges.

Covid-19

I = Identification

COVID-19 symptoms can include:

- A high temperature or shivering (chills) NB: Older people may not always present with a high temperature
- A new, continuous cough
- A loss or change to your sense of smell or taste
- Shortness of breath
- Feeling tired or exhausted
- An aching body
- A headache
- A sore throat
- A blocked or runny nose
- Loss of appetite
- Diarrhoea
- Feeling sick or being sick

If you are eligible for treatments for COVID-19, you should take a rapid lateral flow test as soon as you get symptoms.

The symptoms for COVID-19 are very similar to symptoms of other illnesses, such as colds and flu. If there are 2 or more residents in the home with respiratory symptoms contact your community IPC team for further guidance.

E = Escalation

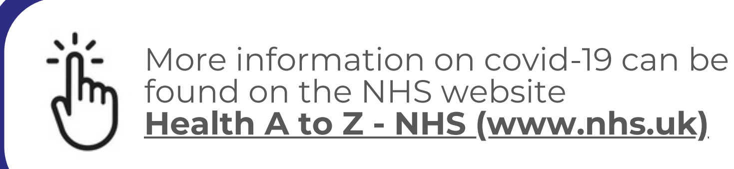
Older people and those with long term medical conditions such as diabetes, heart disease and COPD or those with an impaired immune system are at a higher risk of serious COVID-19 disease and/or death. It is important to recognise when a resident is at risk of deterioration. Using the RESTORE2 deterioration tool can help staff to be able to recognise deterioration and escalate appropriately.

Soft signs of deterioration are pre-diagnostic indicators of concern. Obtaining and regularly monitoring physical observations can help to identify physiological changes and deterioration. These processes can help to escalate any concerns, preventing further deterioration and hospital admission.

R = Response

Use the SBAR (Situation, Background, Assessment, Recommendation) tool to structure conversations. Providing a concise and structured history to health professionals will support their professional decision making.

Refer to the residents GP promptly if there are signs of deterioration, 111 if out of ours. If there is an acute deterioration contact 999 if it is appropriate for the individual resident. Ensure advanced care planning is discussed with residents so their priorities and preferences for their future care is discussed and documented.



Urinary Tract Infection (UTI's)

Possible Causes of UTI's Can Include:

- Reduced fluid intake (dehydration)
- Urinary and or faecal incontinence / poor hygiene
- Obstruction or blockage of the urinary tract such as kidney stones or in men enlarged prostrate
- Weakened immunity such as residents who are receiving chemotherapy or taking certain rheumatology medication
- Any condition which prevents your resident from emptying their bladder regularly, such as constipation, as the bladder is an excellent environment for bacteria to multiply if urine remains in the bladder too long.

P = Prevention

- Encourage residents to drink plenty of water to avoid dehydration and help clear bacteria from the urinary tract
- Residents need to go to the toilet as soon as they need to urinate rather than holding in
- Wipe front to back after using the toilet
- Encourage good personal hygiene every day assisting residents when necessary.

I = Identification

- Agitation or restlessness
- Difficulty concentrating
- Hallucinations or delusions
- Becoming unusually sleepy or withdrawn
- Reduced mobility and increase in falls.

Do not dipstick the urine as this is not an effective way to diagnose a UTI. Follow local policy / guidance.

E = Escalation

Escalate patients with recurrent UTI's to their GP for further investigation and management.

UTIs can have more serious complications in certain residents including:

- Kidney disease
- Type 1 diabetes or type 2 diabetes
- Residents with reduced immunity such as those on chemotherapy
- Care home residents with kidney stones or a catheter
- Residents over 65 years old

R = Response

- Encourage increased fluid intake
- Ensure medication, including antibiotics, is administered correctly and that the course is completed
- Encourage increased fluid intake
- Ensure documentation is contemporaneous and clearly communicate any ongoing issues to the ward round.

More information on UTI's can be found on the NHS website **Health A to Z - NHS (www.nhs.uk)**

Catheters and UTI's

Residents with catheters can be more at risk of developing UTI's.

P = Prevention

- Empty bags regularly and record amount if necessary
- Always check position of catheter avoiding kinks, pulling on the tube or crushing by bed rails
- Keep catheter tubing clean
- Maintain drainage system with regular visual checks
- Change leg bags weekly and use disposable night bags

I = Identification

- Changes in behaviours, such as confusion or agitation
- Catheter blocking or bypassing
- Severe discharge in the catheter tube
- Offensive smelling urine when emptying the leg bag
- Dark coloured urine in the leg bag

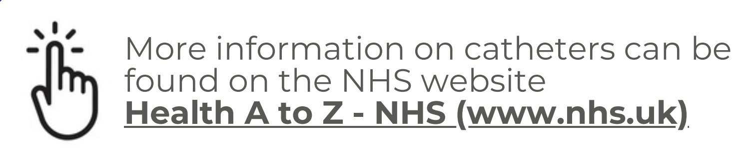
E = Escalation

If a UTI is suspected in a resident with a catheter you should contact a healthcare professional to review the catheter as antibiotics may be required and the catheter may need to be changed.

Do not dipstick the urine as this is not an effective way to diagnose a UTI. Follow local policy / guidance.

R = Response

Encourage the resident to drink plenty of water / fluids unless it is clear that the catheter is blocked and the resident is showing signs of discomfort from a full bladder. Record accurate amounts of fluid intake as per the cups used in your home. Monitor the resident and escalate to the appropriate health care professional.



What's In A Cup?

200ml
Spouted Beaker Cup

150ml
Plastic Cup

1000ml
Water Jug

180ml
Plastic Cup

150ml
Tea Cup

200ml
Mug

150ml
Glass

160ml
Dysphagia Cup

200ml
Dysphagia Mug

Constipation

Constipation is common and can affect people of all ages. Long-term constipation can lead to faecal impaction. This is where faeces has built up in the last part of the large intestine (rectum) and has become difficult to pass.

P = Prevention

- Eating enough fibre, which is found in fruits, vegetables and cereals
- Drinking enough fluids
- Moving enough and not spending long periods sitting or lying down
- Being more active and exercising
- Not ignoring the urge to go to the toilet
- Not changing your diet or daily routine
- Avoiding stress, anxiety or depression.

I = Identification

It's likely to be constipation if:

- They have not had a poo at least 3 times during the last week
- The poo is often large and dry, hard or lumpy
- They are straining or in pain when they have a poo often requesting to go to the toilet but unable to pass anything
- They may also have a stomach ache and feel bloated or sick
- If you're caring for someone with dementia or a learning disability, constipation may be easily missed. Look out for any behaviour changes, as it might mean they are in pain or discomfort
- Constipation can often be recognised by a change in an resident's usual bowel habits.

E = Escalation

Escalate ongoing issues to the ward round ensuring that you can provide a diary using the Bristol Stool Chart (see page 38).

R = Response

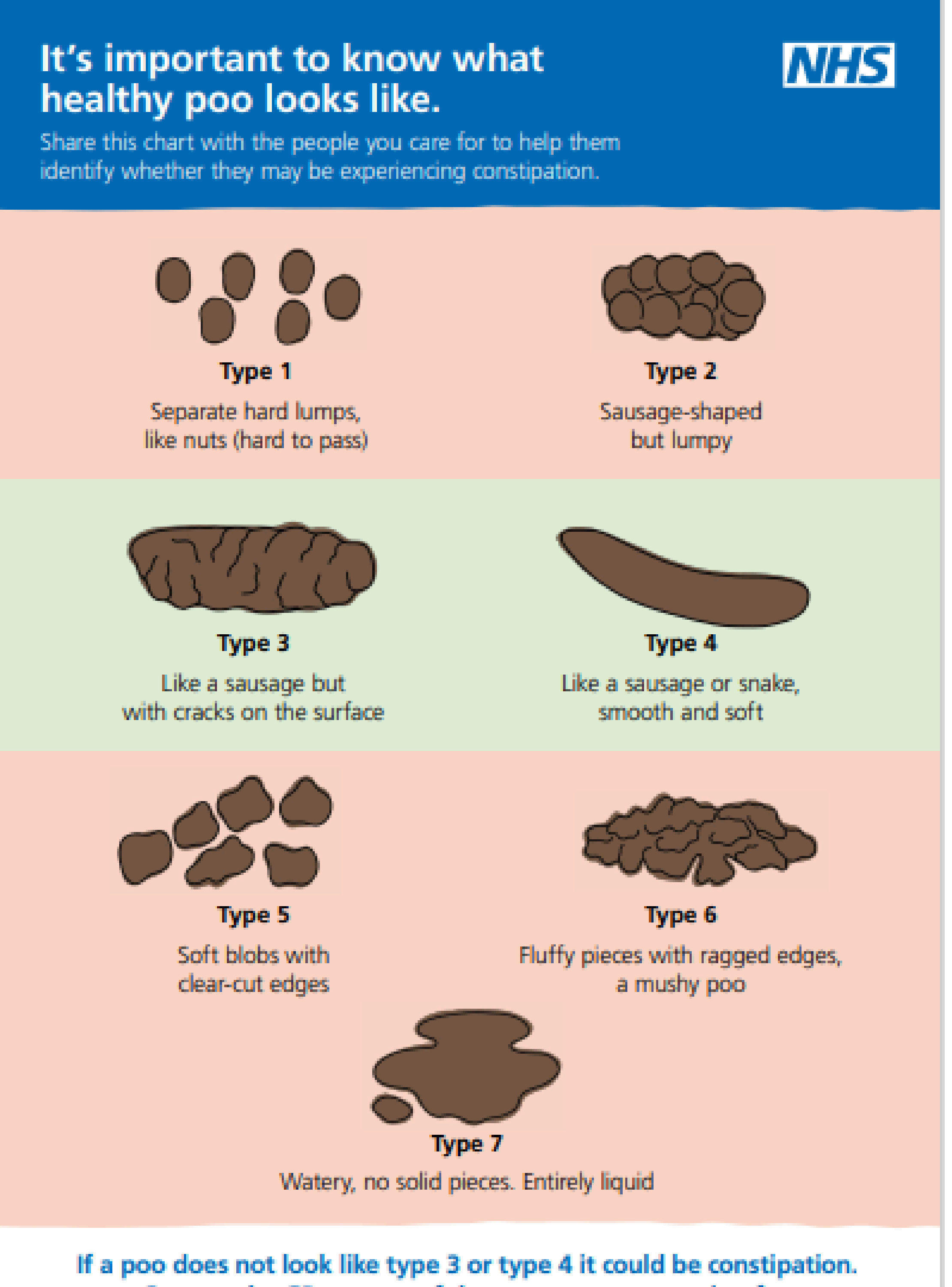
- Monitor bowel movements accurately for all residents to identify signs of difficulties at an earlier stage
- Use of pain tools for residents who are non-verbal to understand expressions and gestures that may indicate a person is in discomfort or in pain e.g. DisDat
- Offer plenty of fluids and avoid alcohol
- Increase fibre in their diet
- Improve toilet routines. Keep to a regular time and place and give plenty of time to use the toilet. Do not delay if they feel the urge to poo
- To make it easier to poo, suggest resting their feet on a low stool while going to the toilet. If possible they should raise their knees above their hips
- Consider increasing activity. A daily walk can help you go to the toilet more regularly.

More information on DisDat can be found at: stoswaldsuk.org

More information on constipation can be found on the NHS website **Health A to Z - NHS (www.nhs.uk)**

Constipation

The Bristol Stool Chart:



Gastroenteritis

Gastroenteritis is a very common condition that causes diarrhoea and vomiting. It's usually caused by a bacterial or viral tummy bug. It affects people of all ages, but is particularly common in young children. Most cases in children are caused by a virus called rotavirus. Cases in adults are usually caused by norovirus (the "winter vomiting bug") or bacterial food poisoning.

IF YOU HAVE 2 OR MORE RESIDENTS WITH GASTROENTERITIS, PLEASE CONTACT YOUR IPC NURSE AND REPORT AS AN OUTBREAK.

Possible Causes of Gastroenteritis:

- Norovirus (commonly described as the "Winter Vomiting Bug")
- Food Poisoning
- Travel infections which may be passed onto residents
- Overuse of antibiotics (C-Difficile infection)

P = Prevention

- Good hand washing techniques
- Storing and cooking foods as per care home policy
- Informing visitors/relatives not to visit if they have gastroenteritis symptoms
- Isolating residents who develop gastroenteritis from other residents
- Offering regular fluids and increasing resident fluid intake in warm weather

I = Identification

- Repeated watery diarrhoea
- Vomiting
- Feeling sick
- Loss of appetite
- Cramp like stomach pains
- Aching limbs
- Headache
- Possibly a high temperature (feeling warm and sweaty)

Gastroenteritis

E = Escalation

Residents require urgent referral to urgent community response if they are unable to keep down any fluids or who are passing blood or mucus in their stool or who are unable to stand up and are becoming increasingly drowsy or agitated. Monitor their observations and liaise with health care professional for advice.

R = Response

- Good infection control
- Isolate the resident from other residents to prevent spread
- Effective hand washing technique (7 steps hand washing technique)
- Ensure carers wear gloves and aprons when attending to affected resident (barrier nursing)
- Do not share commodes/toilets
- Ensure laundry is washed separately as per your internal Care Home protocols
- Offer regular cool fluids water preferably, but diluted juice and soup can be offered
- Ensure fluid intake is documented on resident records
- Residents may need oral rehydration solutions to replace salt, glucose and other important minerals via prescription from a health care professional
- If tolerated try a light diet. Small meals often. Avoid fatty or spicy foods
- Please obtain stool sample to isolate type of infection
- If there is an infective cause of the diarrhoea it is not good practice to use an anti-diarrhoeal medication such as Loperamide.

Gastroenteritis & Dehydration

Gastroenteritis can have more serious complications in certain residents including:

- Older persons
- Those residents with underlying health conditions including kidney problems, diabetes, heart failure (as they will most probably be taking watery tablets)
- Those residents who suffer from Crohns's disease or Ulcerative Colitis
- Those residents who have a weakened immune system such as those on chemotherapy and older residents.

Residents can easily become dehydrated when they have diarrhoea and vomiting.

Causes of Dehydration:

- Diarrhoea and vomiting
- Not drinking enough fluid
- Excessive passing of urine
- Excessive sweating
- Hot weather and hot environments
- Increased risk of dehydration in diabetic residents due to high levels of glucose in the blood stream.

P = Prevention

- Good hand washing techniques
- Storing and cooking foods as per care home policy
- Informing visitors/relatives not to visit if they have gastroenteritis symptoms
- Isolating residents who develop gastroenteritis from other residents
- Offering regular fluids and increasing resident fluid intake in warm weather.

I = Identification of Mild Dehydration:

- Thirst or a dry mouth
- Dark-coloured urine
- Dizziness and light headedness, particularly after standing up, which does not go away after a few seconds
- Feeling sick
- Lack of energy (lethargy)
- Headaches.

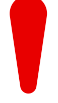
I = Identification of More Severe Dehydration:

- Weakness and apathy (a lack of emotion or enthusiasm)
- Muscle cramps
- Pinched face
- Sunken eyes
- Passing little or no urine in the previous eight hours
- Confusion or worsening confusion
- Rapid heartbeat/pulse
- Weak pulse
- A low level of consciousness.

Gastroenteritis & Dehydration

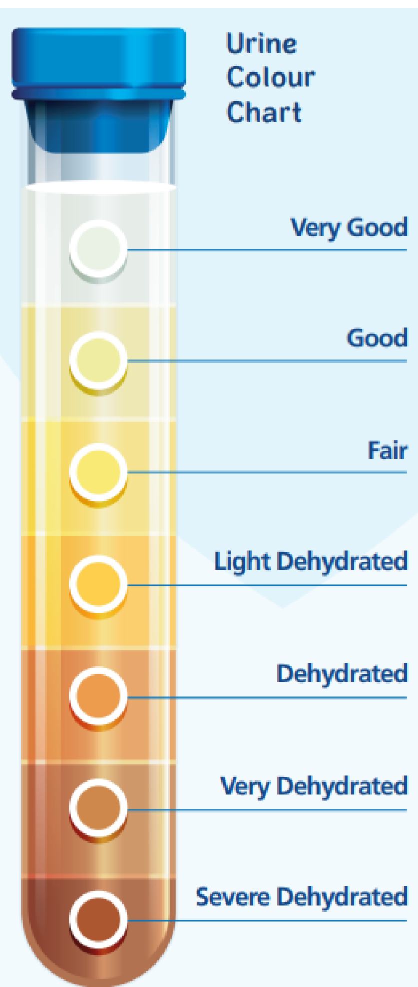
= Escalation

- Monitor for symptoms and signs of dehydration
- Make sure you know what is expected fluid intake for your resident
- Make sure you know what is expected urine output for your resident



IF THE URINE OUTPUT HAS BEEN LESS THAN 0.5ML/KG/H IN THE LAST 6 HOURS, ASK FOR AN URGENT MEDICAL REVIEW.

- If residents have signs and symptoms of severe dehydration which are complicated by not being able to keep fluids down and other illnesses such as crohn's disease they may need hospital admission for intravenous fluids.



= Response

- Offer regular clear fluids or diluted juice hourly. Regular sips are better than full glasses if residents are nauseous
- Oral rehydration solutions as previously stated can be used to replenish salts and fluid
- Maintain a fluid input and output chart. If the resident uses pads describe the weight of filled pad ie: is pad as wet/heavy as normal?
- Observe colour of urine if the resident has not passed urine in the last eight hours notify a clinician for advice
- Offer a light diet
- If residents have signs and symptoms of severe dehydration which are complicated by not being able to keep fluids down and other illnesses such as Crohn's disease they may need hospital admission for intravenous fluids.

More information on gastroenteritis can be found on the NHS website **Health A to Z - NHS (www.nhs.uk)**

Cellulitis (Red skin)

Cellulitis is a common, potentially serious bacterial skin infection. The affected skin is swollen and inflamed and is typically painful and warm to the touch. Cellulitis usually affects the lower legs, but it can occur on the face, arms and other areas. The infection happens when a break in the skin allows bacteria to enter and cause damage to skin cells.

Possible Causes:

- Bacterial infection of the deeper layers of the skin and the underlying tissue
- Can be caused more rarely by a fungal infection
- Infection enters through damaged or broken skin such as a cut, burn or bite
- Leg ulceration
- Eczema
- Athlete's foot
- Weak immune system from chemotherapy or underlying health issues
- Obesity
- Poorly controlled diabetes
- Having chickenpox or shingles
- Lymphoedema (fluid in limb)
- Previous cellulitis
- Circulatory problems.

P = Prevention

- Strict hand washing by residents/staff/relatives
- Well controlled blood glucose in diabetic residents
- Environment to prevent any trauma to skin
- Clothing not causing any restriction of movement
- Good skin care keeping skin well hydrated with use of moisturisers and fluid intake
- Treating any breaks in the skin appropriately
- Keeping nails short and clean (use of cotton gloves may be useful it residents are scratching area)
- Good compliance with any existing wound care treatment.

I = Identification

- Temperature above 38C (100.4F) or above/ feels hot and shivery
- Nausea (feeling sick)
- Vomiting
- Painful swelling and hot to touch area
- Area is wet or leaking fluid, this might look clear or like yellow puss and may smell offensive
- Wound dressing has become very wet or stained with yellow or blood stained discharge
- Any increase confusion/disorientated or drowsy
- Fast heartbeat
- Poor appetite
- Rapid breathing
- Blistering to the red area
- Dizziness
- Reduce urine output
- Looking pale
- Feeling cold, and clamminess to skin
- Altered consciousness.

Cellulitis (Red skin)

E = Escalation

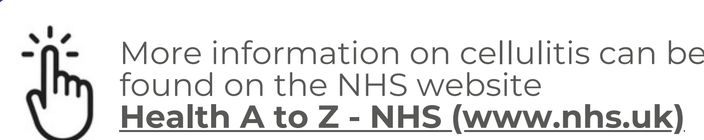
- Any changes or redness to the skin needs to be escalated by the ward round or to the GP directly if the resident is unwell
- Measure the affected area and take photographs with the resident's permission to document size
- Use RESTORE to check observations and SBARD to relay information as appropriate.

R = Response

- Give medication as prescribed (cellulitis usually responds well to antibiotics these may be given orally or in some cases intravenously, severe cases may need hospital admission)
- Pain relief
- Encourage fluids
- Rest and elevation of limb with gentle movement of any affected joints.

Complications:

- Transfer across to signs and symptoms.
- Facial cellulitis
- Abscess formation
- Increase redness/swelling/pain
- Stomach upset or diarrhoea from antibiotics
- Septicaemia.



More information on cellulitis can be found on the NHS website
Health A to Z - NHS (www.nhs.uk)

Sepsis

What is Sepsis?

Sepsis (also known as blood poisoning) is the immune system's overreaction to an infection or injury. Normally our immune system fights infection – but sometimes, for reasons we don't yet understand, it attacks our body's own organs and tissues. If not treated immediately, sepsis can result in organ failure and death. Yet with early diagnosis, it can be treated with antibiotics.

P = Prevention

- Prevent infections
- Take good care of chronic conditions
- Encourage recommended vaccine uptake in residents, such as flu and covid
- Practice good hygiene and encourage residents to practice good hand hygiene along with care home staff
- Keep any cuts clean and monitor any wounds carefully until they have healed
- Know the symptoms - ensure all staff know the symptoms of sepsis.

I = Identification

Sepsis can initially look like flu, gastroenteritis or a chest infection. There is no one sign, and sepsis symptoms present differently between adults and children.

- Slurred speech or confusion
- Extreme shivering or muscle pain
- Passing no urine (in a day)
- Severe breathlessness
- It feels like you are going to die
- Skin mottled or discoloured
- Scoring on a NEWS 2 through Restore can indicate Sepsis. Early detection and treatment is vital.

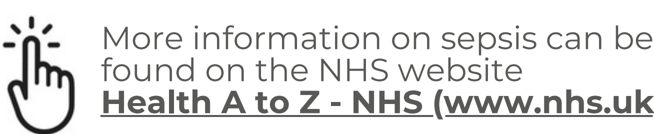
Don't forget to look for soft signs of deterioration as well as changing in observations.

E = Escalation

Call 999 if someone has any of the above sepsis symptoms.

R = Response

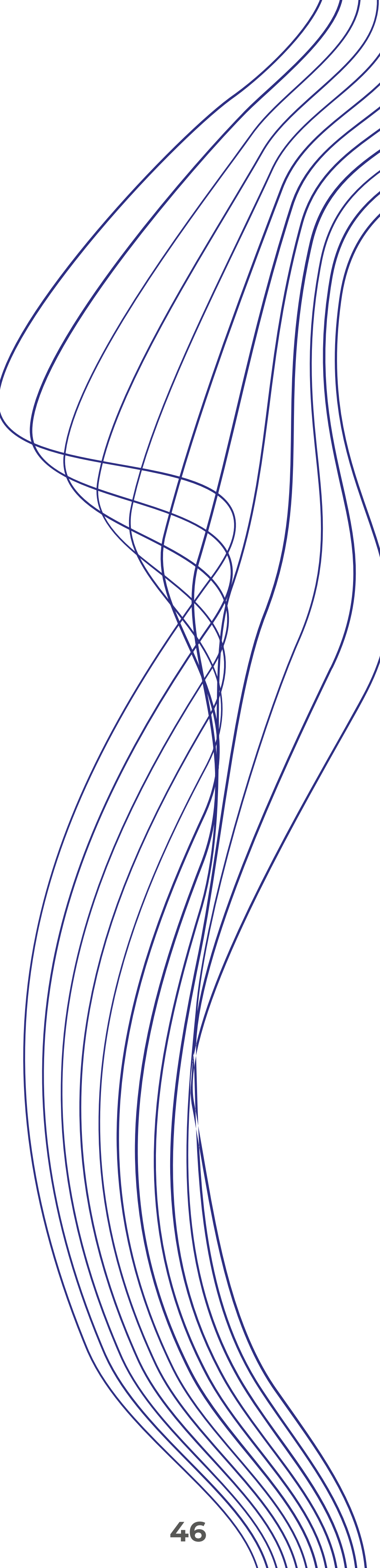
- Clearly communicate the outcome of escalation to the resident and their loved ones
- Ensure that clinicians involved have access to ReSPECT documentation and that it is reviewed appropriately at this time.



More information on sepsis can be found on the NHS website **Health A to Z - NHS (www.nhs.uk)**

Managing Deterioration Pack

Mental Health



Mental Health Information for Care Homes

Mental health problems can affect anyone at any time. An individual living with a learning disability, autism, or any other condition affecting cognition can still have a mental health need.

Signs of mental health deterioration may be more difficult to identify in these residents, and carers will need to be alert to changes that are out of character for the individual.

Delirium

Delirium is a state of heightened mental confusion that commonly affects older people admitted to hospital. 96% of cases are experienced by older people. When older people with dementia experience severe illness or trauma such as a hip fracture they are more at risk of delirium. They can suffer for from delirium for months and may be returned to the home with signs and symptoms which you may recognise.

Risk Factors for Developing Delirium:

- Age
- Pre-existing cognitive impairment
- Previous episode of delirium
- Current severe physical illness e.g. infection
- Sensory impairment: hearing or visual.

P = Prevention

Prevent delirium by improving sensory environment:

- Spectacles – available and clean
- Hearing aids – available and working
- Cognitive stimulation, appropriate reminiscence and activities (know your resident)
- Regular but sensitive reorientation
- Routine and structure to the day
- Use any communication aids for the person
- Clear and simple questions
- Tell patients clearly what is happening and why before you touch them, speak slowly
- Use eye contact
- Encourage sleep – as quiet environment as possible
- Mobilise during the day
- Encourage family to bring in familiar objects and visit
- Low stimulus environment, limit noise and inappropriate television programmes and
- Music

I = Identification

- A disturbance of consciousness and a change in cognition
- Signs of infection e.g. coughing, strong smelling urine, fever
- A reduced ability to focus or concentrate
- Starts over a short period of time – acute
- A tendency to fluctuate, can be worse in the evenings
- Hypoactive form – withdrawn, sleepy, not interacting
- Hyperactive – restless, agitated
- Sleep disturbance
- Emotional disturbance.

E = Escalation

- Escalate concerns and observations to the ward round or directly to the GP for review if behaviour changes are significant and rapid.

R = Response

- Liaise with health care professionals and GP
- Going into hospital tends to make delirium much worse
- Monitor observations as indicated on NEWS.

More information on delirium can be found on the NHS website
Health A to Z - NHS (www.nhs.uk)

Dementia

The word 'dementia' describes a set of symptoms that may include problems with memory, thinking or reasoning, these three elements are known as cognition. Changes to cognition are often small to start with but for someone with dementia they have become severe enough to affect daily life, a person with dementia may also experience changes in their mood or behaviour.

Alzheimer's Disease:

Alzheimer's disease is the most common cause of dementia.

For most people with Alzheimer's the earliest symptoms are memory lapses and difficulty recalling recent events and learning new information. Someone with the disease will go on to develop problems with other aspects of thinking, reasoning, perception or communication.

Vascular Dementia:

Vascular dementia is the second most common type of dementia. There are several different types of vascular dementia; they differ in the cause of the damage and the part of the brain that is affected and will have some symptoms in common and some symptoms that differ.

General Symptoms of Dementia:

- Language – struggling to follow a conversation or repeating themselves
- Visuospatial skills – problems judging distance or seeing objects in three dimensions
- Concentrating, planning or organising – difficulties making decisions, solving problems or carrying out a sequence of tasks (such as getting dressed)
- Orientation – becoming confused or losing track of the day or date.

Behavioural and Psychological Symptoms of Dementia (BPSD)

When a person with dementia behaves differently, this is often mistakenly seen as simply another symptom of the condition; however, this is often not the case. The behaviour may have many causes such as mental and physical health, habits, personality, interactions with others and the environment. The possible causes of someone behaving out of character may be divided into biological (e.g. being in pain), psychological (e.g. perceiving a threat) or social (e.g. being bored).

When supporting a person with dementia who is behaving out of character it's important to see beyond the behaviour itself and think about what may be causing it. People with dementia have the same basic needs as everyone else, however, they may be less able to recognise their needs, know how to meet them, or communicate them. Good quality ABC analysis (Antecedent, Behaviour, Consequence) can help identify patterns, trends and triggers for BPSD.

BPSD Can Include:

- Behavioural changes – aggression, pacing, restlessness, disinhibition
- Mood disturbance – fluctuating moods, depression
- Psychotic symptoms – delusions or hallucinations
- Can occur in 50-80% of people with dementia.

Out-of-Character Behaviour

Consider Reasons for Out-of-Character Behaviour

- Frustration – not understanding how others around the person are behaving, a sense of being out of control, or a feeling of not being listened to or understood
- An attempt to meet a need (e.g. removing clothing because they are too hot or walking around because they are bored or feel they need to be somewhere)
- Communicating a need (e.g. shouting out because they need the toilet, are hungry, thirsty or uncomfortable)
- Pain or discomfort, e.g. arthritic or dental pain
- A medical reason, e.g. constipation or the side effects of medication
- Anxiety
- The environment - it may be too hot or too cold, over-stimulating or under-stimulating.

Reducing and Managing Out-of-Character Behaviour

- Ensure continued social relationships
- Encourage the person to engage in meaningful activities - for it to be meaningful you should know the person's likes and dislikes
- Spend quality time with the person - perhaps chatting or sharing a task together
- Develop a structured daily routine (other than the routine dictated by the care setting e.g. medication rounds and mealtimes)
- Hand massage
- Reduce unnecessary or inappropriate noise and clutter
- Provide people with familiar personal items
- Support the person to walk around the environment safely
- Maintain a comfortable sleeping environment
- Divert the person away from potential conflict with others, if this is not possible without increasing distress consider diverting the other person instead
- Distract the person with appropriate resources - familiar and soothing objects such as cuddly toys/ dolls/photos or offer food and drink
- Reminiscence - for it to be meaningful you should know the person's background and avoid recalling any distressing memories.

Antipsychotic drugs can be prescribed to people with out-of-character behaviour. While these may be appropriate and helpful in some situations, they can suppress behaviour without addressing the cause and may add to the person's confusion and increase their risks of falls and subsequent injuries. They should only be prescribed by a doctor or specialist nurse prescriber when absolutely necessary. Medical guidelines state they should only be used in the first instance if there is evidence of delusions or hallucinations and the person is severely distressed, or if there is a risk of harm to them or those around them.

If antipsychotics are used, they should be regularly reviewed and monitored.

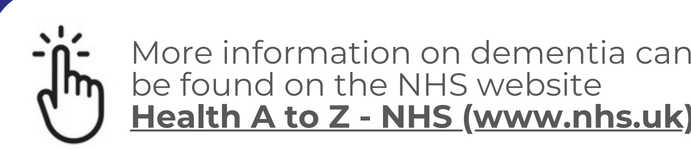
Sundowning and Sleep

Sometimes a person with dementia will exhibit an increase in certain behaviours in the late afternoon or early evening. For example, people may become more agitated, aggressive or confused. This is often referred to as ‘Sundowning’. This pattern may continue for several months and often occurs in those in the moderate to severe stages of dementia.

Sundowning May be Caused By:

- Disturbance to the 24-hour ‘body clock’ that tells our bodies when to sleep, caused by the physical changes to the brain
- Loss of routine at a previously busy time of day
- Too little or disturbed sleep
- Too little or too much light
- Prescribed medication (e.g. for pain or discomfort) wearing off
- Medications that worsen confusion and agitation
- Excessive or disturbing noise.

Dementia can affect people’s sleep patterns. This is separate and different from normal age-related sleep difficulties. It can cause problems with the sleep-wake cycle and also interfere with the person’s ‘body clock’. Disturbed sleep can have a negative impact on a person’s wellbeing (as well as that of their sleeping partner), so strategies to improve sleep will be beneficial.


More information on dementia can be found on the NHS website
Health A to Z - NHS (www.nhs.uk)

Depression

Most people feel low or down from time to time, but this is not the same as being depressed. Depression is a condition that lasts for longer periods. A number of feelings, such as sadness and hopelessness dominate a person's life and make it difficult for them to cope. People with depression may also experience physical symptoms, such as loss of energy and appetite changes.

Physical symptoms of depression are more common in older people with the condition. Depression is more common among people with dementia particularly those who have vascular dementia or Parkinson's disease dementia. Depression is often diagnosed in the early stages of dementia but it may come and go and may be present at any stage. Depression may also make behavioural changes worse in people with dementia, causing aggression, problems sleeping or refusal to eat.

Possible Causes of Depression and Anxiety Include:

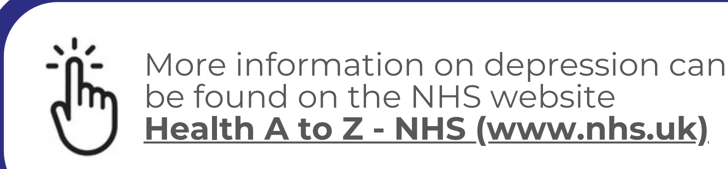
- Traumatic or upsetting events – these can trigger high levels of anxiety that continue long after the event is over
- The effects of certain illnesses or the side-effects of medication
- Lack of social support or social isolation – perhaps due to a change in environment or family not visiting
- Loss and bereavement – of family, or staff or residents that they were close to
- Lack of meaningful things to do, with feelings of boredom and aimlessness
- Feeling stressed or worried over issues such as money, relationships or the future
- Having a genetic predisposition to depression or anxiety.

Possible Signs:

- Not wanting to do usual activities
- Tearful
- Isolating self
- Not eating and drinking as well as usual
- Voicing passive ideas of not wanting to be here anymore or active thoughts of wanting to kill themselves.

Management:

- Refer to own GP or Community Mental Health
- **www.alzheimers.org.uk**



More information on depression can be found on the NHS website **Health A to Z - NHS (www.nhs.uk)**

Managing Deterioration Pack

Palliative Care and End of Life Care

Palliative Care and End of Life Care

For more detailed information on any of the below content please refer to the Nottinghamshire End of Life Toolkit at **https://nottinghamshire.eolcare.uk/**

Advance Care Planning

All residents should be offered help with advance care planning. Advance care planning is a voluntary process of person-centred discussion between an individual and their care providers about their preferences and priorities for their future care. This includes discussing what the resident would like those that care for them to do in the event that their health declines or in an emergency.

The evidence is clear that care is better and patient priorities significantly more likely to be acknowledged and acted upon where such plans exist and are shared.

Locally we use the RESPECT plan process as detailed on page 55.

Universal Principles for Advance Care Planning

1. The person is central to developing and agreeing their advance care plan including deciding who else should be involved in the process.

2. The person has personalised conversations about their future care focused on what matters to them and their needs.

3. The person agrees the outcomes of their advance care planning conversation through a shared decision making process in partnership with relevant professionals.

4. The person has a shareable advance care plan which records what matters to them, and their preferences and decisions about future care and treatment.

5. The person has the opportunity, and is encouraged, to review and revise their advance care plan.

6. Anyone involved in advance care planning is able to speak up if they feel that these universal principles are not being followed.

NICE Guidance

https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/advance-care-planning

Palliative Care Resources

Palliative Care Knowledge Zone:

Palliative Care Knowledge Zone (mariecurie.org.uk)

ReSPECT Plan

For more detailed information on any of the below content please refer to the Nottinghamshire End of Life Toolkit at: **https://nottinghamshire.eolcare.uk/**

ReSPECT stands for:
Recommended **S**ummary **P**lan for **E**mergency **C**are and **T**reatment.

- ReSPECT records overall emergency treatment plans, including whether CPR is recommended or not
- It is a process that creates personalised recommendations for a person's clinical care in a future emergency, in which they are unable to make or express choices
- It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment
- ReSPECT can be complementary to a wider process of advance/anticipatory care planning
- Care home staff are encouraged to contribute to and start off the Respect documentation. Ultimate sign off lies with the GP or appropriate healthcare professional who has been part of the process

The ReSPECT process can be for anyone but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.

ReSPECT National Resources

Resuscitation Council

www.resus.org.uk/respect/respect-healthcare-professionals

Education Resource

End-of-life Care For All (e-ELCA) - elearning for healthcare (e-lfh.org.uk)

ReSPECT Plan

ReSPECT Recommended Summary Plan for Emergency Care and Treatment

1. This plan belongs to:

Preferred name	Full name
Date completed	Date of birth
	Address
	NHS/CHI/Health and care number

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 ☐ **Yes** ☐ **No**

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me — **Quality of life and comfort matters most to me**

What I most value:	What I most fear / wish to avoid:

4. Clinical recommendations for emergency care and treatment

Prioritise extending life	or	Balance extending life with comfort and valued outcomes	or	Prioritise comfort
clinician signature		clinician signature		clinician signature

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

CPR attempts recommended Adult or child	For modified CPR **Child only, as detailed above**	CPR attempts **NOT** recommended Adult or child
clinician signature	clinician signature	clinician signature

www.respectprocess.org.uk

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5. Capacity for involvement in making this plan

Does the person have capacity to participate in making recommendations on this plan? ☐ **Yes** ☐ **No**
Document the full capacity assessment in the clinical record.

→ If no, in what way does this person lack capacity?

If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A, B or C, OR complete section D below):

☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.

☐ **B** This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

☐ **C** This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):

☐ **1** They have sufficient maturity and understanding to participate in making this plan

☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.

☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.

D If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Senior responsible clinician:				

8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: ☐			optional
☐			optional
☐			optional
☐			optional
☐			optional

9. Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

If this page is on a separate sheet from the first page: **Name:** **DoB:** **ID number:**

www.respectprocess.org.uk

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ReSPECT Mental Capacity Assessment (MCA)

Date assessment completed: -

Integrated Care System

Full Name		
NHS / Health and Care number		**Date of Birth:-**
Address		

Does the patient have capacity to participate in the process of making recommendations about their future care and treatment?

The following practicable steps have been taken to enable and support the person to participate in the decision-making process.

☐ Simple Verbal Language ☐ Picture Information ☐ Leaflet ☐ Other (please detail below)

3 Stage Test: -

Stage 1

Does the person have an impairment of or disturbance in the functioning of their brain or mind? ☐ **YES** ☐ **NO**

If YES, please indicate the nature of disturbance below and complete stage 2. If NO, sign below and file.

☐ Dementia ☐ Learning Disability
☐ Mental Illness ☐ Delirium/ unconsciousness
☐ Head Injury ☐ Symptoms of Alcohol/Drug Abuse
☐ Stroke ☐ Long Term Brain Damage/ Neurological Disorder
☐ Physical medical condition that cause confusion/ drowsiness or loss of consciousness.
☐ Other (please state):

Stage 2

The named person is unable to make a decision for themselves if they are unable to do any one of the following:
☐ Understand the relevant Information ☐ Use or weigh up the relevant information.
☐ Retain the relevant Information ☐ Communicate their decision.

Stage 3

Are you satisfied that the named person's inability to make the relevant decision is ***because*** of the identified impairment or disturbance. ☐ **YES** ☐ **NO**

Is the impairment a lifelong condition that will not improve? ☐ **YES** ☐ **NO**

Outcome of the capacity assessment: -
The named person **has** capacity to make the relevant decision at this time: - ☐ **YES** ☐ **NO**

Name of person completing MCA assessment:		Signature:
Job Title:		Date /Time:

If the patient lacks capacity - Does the patient have:

1. An advance decision to refuse treatment (ADRT) ☐ **YES** ☐ **NO** ☐ **Not Known**
2. *Registered lasting power of attorney for health and welfare ☐ **YES** ☐ **NO** ☐ **Not Known**

If the answer is Yes to question 1 or 2 above, then the original document **MUST** be seen.

The MCA applies to people aged 16 years of age and over. Consent to treatment for children and young people should be determined by Gillick Competence. Where treatment is going ahead on the basis of parental consent, records should show the person(s) holding parental responsibility has been identified and that they are legally capable of consenting on behalf of the child.

Name: ____________ **Date of Birth:** __/__/__ **NHS Number:** ____________

Details of conversations with patient / relatives / carers:

COPY TO GP

Gold Standard Framework

The GSF centres guidance to support early identification of care home residents nearing the end of life leading to improved proactive resident centred care.

The National Gold Standards Framework (GSF) Centre in End of Life Care is the national training and coordinating centre for all GSF programmes, enabling generalist frontline staff to provide a gold standard of care for people nearing the end of life. GSF improves the quality, coordination and organisation of care leading to better resident outcomes in line with their needs and preferences and greater cost efficiency through reducing hospitalisation.

GSF is a practical systematic, evidence-based end of life care service improvement programme, identifying the right people, promoting the right care, in the right place, at the right time, every time.

www.goldstandardsframework.org.uk

Needs Based Coding

A - Blue	B- Green	C- Yellow	D - Red
'**A**ll' from diagnosis	'**B**enefits' - DS1500	'**C**ontinuing Care	'**D**ays
Stable	**Unstable / Advanced disease**	**Deteriorating**	**Terminal phase / Final days**
Year plus prognosis	Months prognosis	Weeks prognosis	Days prognosis

The GSF framework uses a coloured prognostic indicator to suggest what the resident may need in the coming months:

- **Blue** - from diagnosis where disease is stable and there is a prognosis of a year or more
- **Green** - where disease is unstable or advanced and where there is a prognosis of months
- **Yellow** - where the resident is deteriorating and the prognosis may only be a matter of weeks
- **Red** - where a resident is in the final days of life, receiving all care and support, with a prognosis of only days.

Deterioration at End of Life & Recognising the Dying Resident

The last days or hours of a person's life are sometimes called the terminal phase. This is when someone is "actively dying".

Everyone's experience of dying is different, and some people will die suddenly or unexpectedly. But there are often signs that can help you to recognise when someone is entering the terminal phase.

These include:

- Getting worse day by day or hour by hour
- Becoming bed-bound for most of the day
- Extreme tiredness and weakness
- Needing help with all personal care
- Little interest in food or drink
- Difficulty swallowing oral medication
- Being less responsive and less able to communicate
- Sleepiness and drowsiness
- Reduced urine output
- New urinary or faecal incontinence
- Delirium, with increased restlessness, confusion and agitation
- Changes in their normal breathing pattern
- Noisy chest secretions
- Mottled skin and feeling cold to the touch
- The person telling you they feel like they're dying.

What Does Good Palliative Care Look Like?

Good palliative care is about supporting someone in their last period of life as well as enhancing the quality of life for residents and those close to them at every stage.

Palliative care focuses on the person and not the disease to meet the physical, practical, functional, social, emotional and spiritual needs of care home residents.

Deterioration and the ReSPECT Form

Box 4 on the ReSPECT plan details the clinical guidance on specific, realistic interventions that may or may not be wanted or be clinically appropriate.

Further information can be found at:

Palliative Care Knowledge Zone (mariecurie.org.uk)

Deterioration at End of Life & Recognising the Dying Resident

Anticipatory Prescribing

Anticipatory prescribing enables prompt symptom relief at whatever time the care home resident develops distressing symptoms. Anticipatory medications require the appropriate prescription from clinicians to enable their administration in the care home.

All gold standard framework amber should have anticipatory medications prescribed.

Consider:

- Are their medications no longer of benefit to the resident and can be stopped?
- Are essential medications available in liquid or soluble form?
- Has the care home got the equipment needed to administer the medication? This includes having a syringe driver that has been serviced in the last year prior to use and the correct consumables that are in date.
- Nurses in Nursing Homes will be able to provide this care. For those in residential care the community nursing teams will offer support and expertise.

Support and Deterioration

As well as symptom control and anticipatory medication a resident may require additional assessment and intervention for other deteriorating presentations. Consider what are the residents soft signs? What is their NEWS2? Use RESTORE2 a managing deterioration tool to help (see the Managing Deterioration section from page 15 onwards for further information).

Resources to Support the Identification of Palliative Care Emergencies:

Recognising Emergencies

https://www.mariecurie.org.uk

Deterioration at End of Life & Recognising the Dying Resident

End of Life in Residents with a Learning Disability or Dementia

Recognising when a person with a learning disability or dementia is in the end of life stage of the disease may not always be easy as they may have many general signs and symptoms of dying. Using pictures or prompts can help the person identify when they may be deteriorating and can help them communicate any anxieties.

For example, some common signs and symptoms seen in people dying are:
- Loss of their fine motor skills in mouth, eyes, fingers, and feet
- A reduced intake of food and fluids
- Needing an increased assistance with all care
- Drowsy or reduced awareness
- Gaunt appearance or weight loss
- Problems swallowing
- Spending more time being cared for in bed
- Not aware of the world around them (most of the time)
- Agitated or restless, or hardly moved
- Hard to get connected.

People with a learning disability or dementia may show some of these signs and symptoms for months or even years – making it hard to tell if the person is approaching death. However, if these symptoms become much worse over a period of two to three weeks, or even days or hours, it is important that a doctor or nurse sees the person. If the doctor or nurse thinks that the person is deteriorating or nearing the end of life and it would be in the person's best interest to be cared for in their own home, a care home or hospice then discuss this information with the person's family.

They should also be given an explanation of why the deterioration is happening and the care that is going to be given. When death is expected it is usually not of benefit for the person with communication difficulties to be sent to hospital: the death is more likely to be traumatic, unsupported and complicated by other medical events (such as an infection).

Care After Death

The person who provides the care after death takes part in a significant process which has sometimes been surrounded in ritual. Although based on comparatively straightforward procedures, it requires sensitive and skilled communication, addressing the needs of loved ones and respecting the integrity of the person who has died.

- Ensure that staff are correctly trained in the verification of expected death to avoid waiting for clinicians to visit from outside the home
- Honouring the spiritual or cultural wishes of the deceased person and their loved ones
- Preparing the body for transfer to the mortuary or the funeral director's premises
- Offering loved ones present the opportunity to participate in the process and supporting them to do so
- Ensuring that the privacy and dignity of the deceased person is maintained
- Ensuring that the health and safety of everyone who comes into contact with the body is protected
- Honouring people's wishes for organ and tissue donation
- Returning deceased person's personal possessions to their loved ones or encouraging the relatives to be involved in the collection of belongings
- Staff supporting each other following the death of a resident, who has been cared for by the care home team

Marie Curie Knowledge Zone Resources

www.bit.ly/MarieCurie-CareAfterDeath

Managing Deterioration Pack

Meds Optimisation

Guidance for the Management of Medicines in Social Care Establishments

This local guideline (written by the Nottingham and Nottinghamshire ICB Medicines Optimisation Team alongside Nottingham City Council and Nottinghamshire County Council) covers good practice for managing medicines in care homes.

It aims to promote the safe and effective use of medicines in care homes by advising on processes for prescribing, handling and administering medicines. It provides professional as well as practical guidance for service providers on how to manage medicines and is intended to be used in conjunction with relevant statutory legislation. It also provides templates and references for further information.

https://www.nottinghamshiremedicinesmanagement.nhs.uk/policies-and-documents/social-care/

Managing Deterioration Pack

Infection Prevention and Control

Infection Prevention and Control

Risk Assessment

Care Homes need to ensure risk assessment processes are in place to prepare for and manage any infectious outbreak.

An outbreak is two or more linked cases of the same illness in the same setting over a specified time period. Outbreaks should be reported to the IPC team or UK HSA out of hours so that early support and advice can be given to prevent the spread of infection to others in the setting.

- During an infectious outbreak, visiting should be allowed to continue in and out of the home
- In line with the guidance, whenever possible any admissions, discharges or transfers should be delayed until after any outbreak
- If there are any urgent admissions, discharges or transfers, a resident will need to be individually risk assessed
- Residents and their family members need to be fully aware of the situation. Discuss on a case-by-case basis with IPCT.

Standard Precautions

- Use of standard precautions to prevent infection and ensure safety of those being cared for, staff and visitors
- Know what PPE (personal protective equipment) to use and when.
- Keep updated through infection prevention and control (IPC) training, and be aware of any new local and/or national guidance
- Seek advice if unsure, by contacting your local IPC team or UKHSA if out of hours

Useful Resources

- Visiting in care homes during outbreaks:

Supporting safer visiting in care homes during infectious illness outbreaks - GOV.UK (www.gov.uk)

- Acute respiratory outbreaks in care homes:

Infection prevention and control (IPC) in adult social care: acute respiratory infection (ARI) - GOV.UK (www.gov.uk)

- IPC in social care settings:

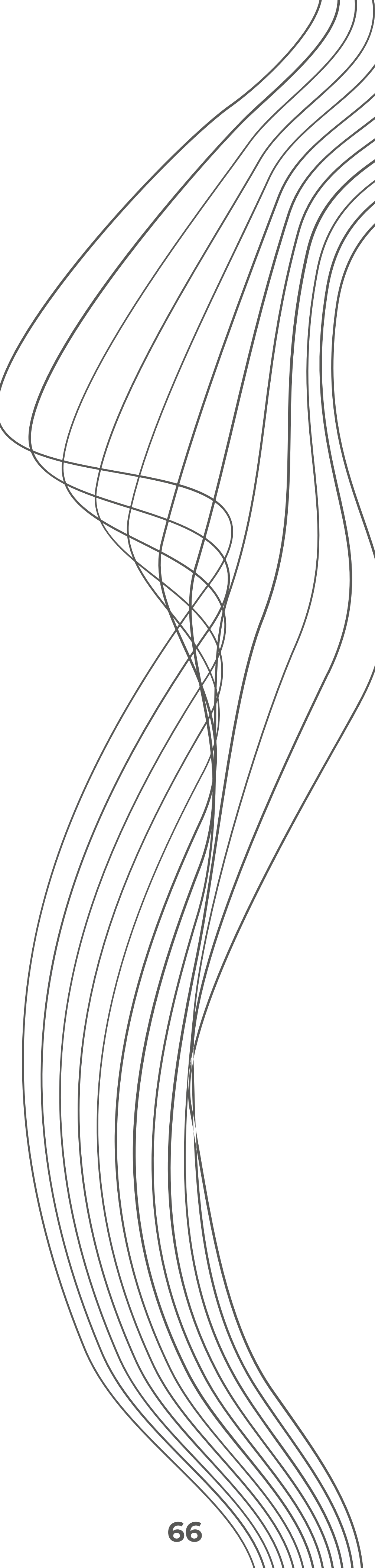
Infection prevention and control in adult social care settings - GOV.UK (www.gov.uk)

- National infection prevention and control manual for England

https://www.england.nhs.uk/wp-content/uploads/2022/04/national-infection-prevention-control-manual-England-version-2.10.pdf

The IPC team can be contacted on:

- County inc. Bassetlaw: 01623 673081 or nnicb-nn.ipc@nhs.net
- City: 0115 8834902 or ncp.ipct@net.net
- Out of Hours: UKHSA on 0344 225 4524



Managing Deterioration Pack

Supporting Information

Appendix A: UCR

URGENT COMMUNITY RESPONSE (UCR) FOR CARE HOMES NOTTINGHAMSHIRE COUNTY

Is the resident at risk of admission / likely to attend the hospital within the next 2-24 hours? Considering calling 999 OR 111?

THINK UCR
CARE HOME DIRECT REFERRAL
CALL: 0300 373 0600
7 days a week, 8am – 8pm

In case of emergency

New onset central chest pain/heart attack/cardiac arrest/stroke (face/arm weakness, speech problems), or sudden onset severe pain, collapse.

Call 999

All referrals are directly triaged by a clinician at the point of referral
Patients are seen within 2 hours, same day or next day depending on need

UCR can support care home residents with:

- Falls – including possible injury falls
- Acute infection/acute exacerbation of a long-term condition
- Reduction in mobility/functional ability
- In crisis and needing assessment or intervention within two hours – must also be safe to wait for two hours
- Medically safe to be treated or cared for in a community setting

Routine/Repeat prescriptions should continue to be directed to Primary Care

UCR: delivering clinical assessment and intervention to prevent further deterioration and where possible keep patients at home

Appendix B: Home Rounds Agenda: Who Can I Discuss at the Home Round?

Who Can I Discuss at the Home Round?

This document gives some examples of which residents to bring to the home round. If you have identified a need that requires direct referral to another service and does not require home round clinician advice, this should be actioned prior to the home round taking place.

Concern/Topic	Why?
New resident	To assess the new residents needs and get the right plan of care in place.
A resident that has been feeling unwell	We can discuss a resident who has been gradually declining. However, if they have suddenly become unwell, call the GP. Do not wait for the next round. Have a set of observations been undertaken, or have you implemented a managing deterioration tool i.e., RESTORE2
Any concerns around health	This includes issues or concerns that have already been escalated to a healthcare professional.
Hospital discharges	We aim to review those residents within 7 working days to try and prevent any further admissions.
Concerns around physical health	For example, pain on movement, gradual swelling, and advice regarding aids
Recent Falls	There may be issues contributing to why someone is falling.
Weight concerns	To monitor resident's weight and offer advice/signposting.
Poor oral intake	The Home Round can support with what might be causing the concern and discuss further actions.
Cognitive deterioration or changes to behaviour	The Home Round can offer advice around cognitive deterioration or changes to behaviour.
End of life/palliative	Knowing if a resident is in the end stages of life allows us to assess them and make sure everything is in place to ensure they are comfortable and pain free. We also work with the home and families to ensure a ReSPECT form meets the resident's health needs and wishes, alongside the homes EOL care plan
Issues with skin	We can assess and support issues relating to skin, refer to community nursing and contact Red Cross if required.
Bladder/bowel concerns	We can advise and signpost to other services.
Involvement with other services	To offer support and aid communication between external services.

Appendix C: ICS Dysphagia Management Checklist - NHT Bassetlaw

Page 1 of 9:

Dysphagia Management Checklist: 'How to' Guide

1. WHAT IS IT FOR?

- This checklist is to support care home staff to identify swallowing difficulties (Dysphagia) and other difficulties with eating and drinking.
- Provide suggestions which may resolve the difficulties observed
- Provides advice on how to refer and which professionals to refer to if the difficulties are not resolved.

2. WHEN SHOULD IT BE USED?

- With any new care home residents
- Anyone with new signs of difficulty
- Anyone with worsening or changing difficulties

3. HOW DO YOU USE IT?

1. Observe the resident having a meal and taking a drink
2. Use the checklist to record any difficulties they are having by ticking in the 'seen' column. (Make notes in the boxes provided)
3. Try the suggested strategies in the Action column to see if the difficulty can be resolved
4. If the difficulty is not resolved, or the aim is unachievable e.g., the patient is unable to achieve upright position due to contractures, please seek advice from a relevant healthcare professional or make a referral to the appropriate service

3. HOW TO REFER?

For Bassetlaw Care Homes:
Email bassetlawspa@nottshc.nhs.uk using the Bassetlaw referral form. Include a copy of this checklist within the referral form.

Appendix C: ICS Dysphagia Management Checklist - NHT Bassetlaw

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SPEECH AND LANGUAGE THERAPY DEPARTMENT – BASSETLAW

DYSPHAGIA MANAGEMENT CHECKLIST

- Please use this checklist as you **watch the person have their usual meal.**
- Identify the areas of need by placing a tick in the 'Seen' column, if noted during the meal.
- Please use the 'Care Home notes' section to note your observations.
- 'Local Healthcare Professional' could be a GP, Care Home team, Advanced Nurse Practitioner, etc.
- For support completing the checklist, please refer to the guidance leaflet provided.
- **This checklist can be used as often as required but should never be used to overrule the advice of a healthcare professional.**

If any of the problems observed persist after the actions have been completed, refer to your SLT team and enclose a copy of the completed checklist.

Alternatively, if all the observations have been resolved through the recommended actions, a referral to SLT is not required.

Glossary of terms:

Dysphagia - The term we use to describe difficulty with swallowing

Aspiration - Aspiration is when something enters the airway or lungs by accident.

Choking – when someone cannot breathe because something is blocking the airway. If someone is choking, they require immediate help to clear the obstruction.

For referral to SLT department:
Email bassetlawspa@nottshc.nhs.uk using the Bassetlaw referral form. Include a copy of this checklist within the referral.

Appendix C: ICS Dysphagia Management Checklist - NHT Bassetlaw

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Nottinghamshire Healthcare NHS
NHS Foundation Trust

SPEECH AND LANGUAGE THERAPY DEPARTMENT – BASSETLAW

Checklist for Management of Eating, Drinking and Swallowing Difficulties

Name of patient:................................ **DOB:**............................... **Date:**............................

Person completing observation: .... **IDDSI consistencies observed:**..........................

Watch the person have a meal: where you notice something, look on the checklist for recommended action

Observation – time:	Seen	Aim	Action - time: date (if different):	Resolved?	Notes
Pain on swallowing			Pain on swallowing must not be ignored. Please refer urgently via your weekly Home Round or GP.	Y/N	
Too drowsy to eat		Person is awake enough to eat/drink	• If levels of alertness are variable, allow them to rest when tired, and encourage food and drink when alert. • Do ordinary strategies work (calling their name, shaking gently, orientating them, giving them something to take an interest in, little and often approach)? • Think as a team about why this person might be drowsy (medical factors/ill health, social issues - insufficient interest to maintain alertness, end-of-life issues, medication). • Consider a referral for a health review from your local healthcare professional or SALT Department	Y/N	
Poor positioning: - head dropped down, making eating difficult - asymmetrical position (twisted or leaning to one side) - leaning back a long way,		Person can maintain the best possible sitting/head position to eat/drink	• Consider altering their position by attention to seating/cushions. • Consider trialling Nose Cut Out cups • Nose Cut Out Cup - Blue - NRS Healthcare Pro • Nose Cut Out Cup (mobilitysmart.co.uk)	Y/N	

Appendix C: ICS Dysphagia Management Checklist - NHT Bassetlaw

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Nottinghamshire Healthcare
NHS Foundation Trust

SPEECH AND LANGUAGE THERAPY DEPARTMENT – BASSETLAW

neck extended			• Does the positioning need specialist help? Please speak to your local healthcare professional		
Observation – time:	**Seen**	**Aim**	**Action - time:** **date (if different):**	**Resolved?**	**Notes**
Difficulty holding cutlery and cups		Increase independence, client able to grasp utensils	• Think with the team about why the person is having difficulty and what could be done? • Consider the need for adaptive cutlery, refer via your Local Healthcare Professional.	**Y/N**	
Putting food into the mouth too quickly – then having difficulties because of an over-full mouth		Person slows feeding rate to maximise swallow safety and reduce risk of choking	• Discuss with colleagues about managing this with verbal or physical prompts/reminders. • Giving a smaller spoon • Giving smaller mouthfuls of food/smaller sips of drinks • Cutting food into smaller pieces • Please refer to the Cramming leaflet.	**Y/N**	
Food/Drink pockets inside cheek		To ensure mouth is cleared between mouthfuls and after meal	• Remind the person to check their cheeks during the meal and clear any residue. • If assisting, watch to see that a swallow has happened before giving the next mouthful e.g.: movement of Adam's apple.	**Y/N**	
Difficulty/and or pain chewing		To make sure food is well chewed and moistened.	• Look in the mouth for swellings, lumps, bleeding gums, ulcers, broken teeth, loose dentures and signs of infection e.g., oral thrush. • Ask the person (if able) if they are having any pain or discomfort chewing. • If any of the above are observed, wait until the resident finishes their meal and complete an oral health checklist.	**Y/N**	

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Nottinghamshire Healthcare NHS
NHS Foundation Trust

SPEECH AND LANGUAGE THERAPY DEPARTMENT – BASSETLAW

			• Give food that is easier to chew remembering to check nutritional adequacy		
Observation – time:	**Seen**	**Aim**	**Action - time:** **date (if different):**	**Resolved?**	**Notes**
Food/drink stays in the mouth for a long time		To make sure food does not build up in the mouth and to prevent aspiration/choking.	• Give verbal reminders to swallow. • Enhance the flavour of the food and drink to stimulate and increase interest. • See Oral Holding leaflet.	**Y/N**	
Difficulty chewing usual diet texture		To make sure person can clear food from the mouth effectively	• Give reminders to chew and if these are not successful give food that is easier to chew. • Any consideration for textures lower than Level 6 soft and bite-sized diet, **must** be referred to Speech and Language Therapy. • Discuss via the next weekly Home Round or with your Local Healthcare Professional • Refer to the leaflets provided in this checklist	**Y/N**	
Food falls from the lips		To stop food/fluid loss from mouth	• Consider motivation for meals, food preferences and positioning.	**Y/N**	
Coughing when eating		Avoid aspiration	• Suggest the person tries tucking chin towards the chest when swallowing. • Consider pacing and whether slowing the pace of eating reduces coughing	**Y/N**	

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Nottinghamshire Healthcare
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SPEECH AND LANGUAGE THERAPY DEPARTMENT – BASSETLAW

Observation – time:	Seen	Aim	Action - time: date (if different):	Resolved?	Notes
Coughing when drinking		Avoid aspiration	• Reduce distractions and conversation. • Ensure positioning as upright and mid-line as comfortable. • Encourage small, single sips. • If using a spouted beaker or straw, try an open cup (with assistance if needed) • Try naturally thicker drinks (smoothies, tomato juice, hot chocolate made with full-fat milk) or discuss the use of thickener to slightly thick level 1 with your healthcare professional (1 scoop in 200mls)	Y/N	
Voice sounds gurgly after swallowing		Clear residue from throat	• Remind the person to cough or clear their throat between mouthfuls.	Y/N	
Mouth is very dry – little or no saliva being made		Moisten mouth adequately to enable safe eating	• Ensure that the person is well hydrated. • If the person is well hydrated and still producing little/no saliva please discuss this at your weekly Home Round.	Y/N	
Mouth is full of saliva that can't be managed		To reduce saliva production to a manageable level	• Try prompting to swallow more frequently. Discuss at your weekly Home Round for consideration of cause.	Y/N	
Refusing food		Maintain adequate nutrition	• If this persists for longer than expected for this individual, please escalate this urgently with your GP or at your weekly home round	Y/N	

Appendix C: ICS Dysphagia Management Checklist - NHT Bassetlaw

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Nottinghamshire Healthcare
NHS Foundation Trust

SPEECH AND LANGUAGE THERAPY DEPARTMENT – BASSETLAW

Difficulty swallowing medication		To take medication safely	• Contact your Pharmacist as soon as possible.	**Y/N**	

General advice:

- Thickeners are a prescription item and must be on a named patient basis only and reviewed if general health changes.
- Please ensure all fluids given with medication is given at the right consistency.
- GUM based thickener i.e., Nutilis clear, should not be used to thicken Nutritional supplements.
- Please refer to pharmacist or dietitian to ensure nutritional supplements are prescribed at the correct IDDSI level.
- Please be aware that medication can have an impact on eating, drinking and swallowing difficulties as well as increase the risk of aspiration pneumonia. Please discuss any concerns with your local healthcare professional.
- An open cup is preferable to a beaker with a lid unless otherwise directed. It increases dignity and allows for a more natural pattern of drinking. Lids are generally only advised for people with movement/mobility disorders, or who are being given drinks in a compromised position. Please contact your SLT for further advice if required.

Appendix C: ICS Dysphagia Management Checklist - NHT Bassetlaw

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Nottinghamshire Healthcare NHS
NHS Foundation Trust

SPEECH AND LANGUAGE THERAPY DEPARTMENT – BASSETLAW

Integrated Care System

Care Home observation notes:

Appendix C: ICS Dysphagia Management Checklist - NHT Bassetlaw

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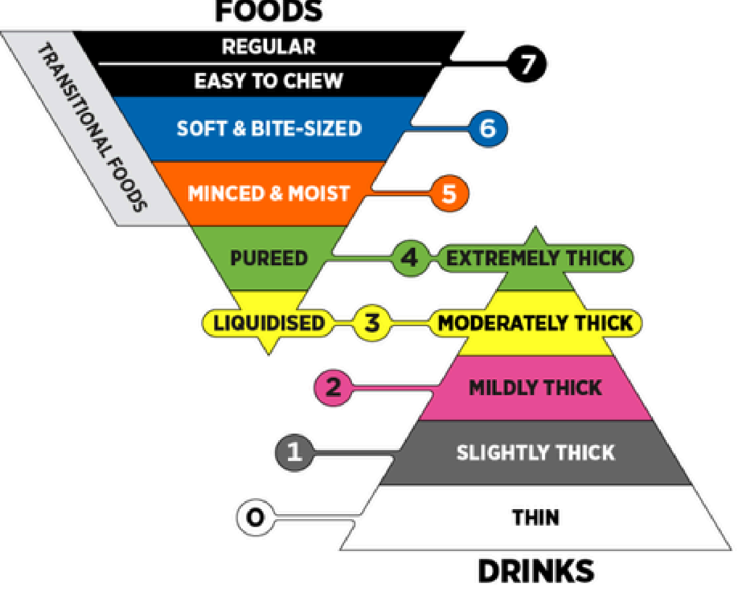
SPEECH AND LANGUAGE THERAPY DEPARTMENT – BASSETLAW

The IDDSI Framework

Providing a common terminology for describing food textures and drink thicknesses to improve safety for individuals with swallowing difficulties.



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Derivative works extending beyond language translation are NOT PERMITTED.

Appendix D: ICS Dysphagia Management Checklist - City

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SPEECH AND LANGUAGE THERAPY DEPARTMENT – CITYCARE

Dysphagia Management Checklist: 'How to' Guide

1. WHAT IS IT FOR?

- This checklist is to support care home staff to identify swallowing difficulties (Dysphagia) and other difficulties with eating and drinking.
- Provide suggestions which may resolve the difficulties observed.
- Provides advice on how to refer and which professionals to refer to if the difficulties are not resolved.

2. WHEN SHOULD IT BE USED?

- With any new care home residents.
- Anyone with new signs of difficulty.
- Anyone with worsening or changing difficulties.

3. HOW DO YOU USE IT?

1. Observe the resident having a meal and taking a drink.
2. Use the checklist to record any difficulties they are having by ticking in the 'seen' column. (Make notes in the boxes provided)
3. Try the suggested strategies in the Action column to see if the difficulty can be resolved.
4. If the difficulty is not resolved, or the aim is unachievable e.g., the patient is unable to achieve upright position due to contractures, please seek advice from a relevant healthcare professional or make a referral to the appropriate service.

4. HOW TO REFER?

The checklist is not designed to replace the current referral process to Speech and Language Therapy (SLT). It is designed to help with problem-solving around difficulties with eating, drinking, and swallowing, and to get appropriate support for residents as quickly as possible.
As always, please call the Adult SLT Team on **0115 883 4707** for advice on possible referrals and for any support with using the checklist.
If you have completed a checklist, and a referral to the SLT service is needed, please continue to refer by calling the SPA on **0300 131 0300, option 1 and then option 4.**

Appendix D: ICS Dysphagia Management Checklist - City

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SPEECH AND LANGUAGE THERAPY DEPARTMENT – CITYCARE

DYSPHAGIA MANAGEMENT CHECKLIST

- Please use this checklist as you **watch the person have their usual meal.**
- Identify the areas of need by placing a tick in the 'Seen' column, if noted during the meal.
- Please use the 'Care Home notes' section to note your observations.
- This checklist can be used as often as required but should never be used to overrule the advice of a healthcare professional.
- 'Local Healthcare Professional' could be a GP, Care Home team, Advanced Nurse Practitioner, etc.
- For support completing the checklist, please refer to the guidance leaflet provided.

If you've tried the actions but still have concerns about swallowing, please refer to your SLT team.

If the issues are resolved, a referral to SLT is not required.

Glossary of terms:

Dysphagia - The term we use to describe difficulty with swallowing

Aspiration - when something enters the airway or lungs by accident.

Choking – when someone cannot breathe because something is blocking the airway. If someone is choking, they require immediate help to clear the obstruction.

To speak to the SLT team please contact: **0115 8834707**

To make a referral to SLT: Call Nottingham Health and Care Point on 0300 131 0300, option 1 then option 4, or via: accesstoservices.citycare.org.uk.

Appendix D: ICS Dysphagia Management Checklist - City

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SPEECH AND LANGUAGE THERAPY DEPARTMENT – CITYCARE

Checklist for Management of Eating, Drinking and Swallowing Difficulties

Name of patient: .... **DOB:** .... **Date:** ....

Person completing observation: .... **IDDSI consistencies observed:** ....

Watch the person have a meal. Where you notice something, look on the checklist for recommended action:

Observation – time:	Seen?	Aim	Action - time: date if different:	Resolved?	Notes
Pain on swallowing.			Pain on swallowing must not be ignored. Please refer urgently via your weekly Home Round or GP.	Y/N	
Too drowsy to eat.		Person is awake enough to eat/drink.	• If levels of alertness are variable, allow them to rest when tired, and encourage food and drink when alert. • Do ordinary strategies work (calling their name, shaking gently, orientating them, giving them something to take an interest in, little and often approach)? • Think as a team about why this person might be drowsy (medical factors/ill health, social issues - insufficient interest to maintain alertness, end-of-life issues, medication). • Consider referral for a health review from a healthcare professional.	Y/N	
Poor positioning: - head dropped down, making eating difficult.		Person can maintain the best possible sitting/head	• Consider altering their position by attention to seating/cushions. • Consider trialling Nose Cut Out cups. • Nose Cut Out Cup - Blue - NRS Healthcare Pro	Y/N	

Appendix D: ICS Dysphagia Management Checklist - City

SPEECH AND LANGUAGE THERAPY DEPARTMENT – CITYCARE

Observation – time:	Seen?	Aim	Action - time: date if different:	Resolved?	Notes
- asymmetrical position (twisted or leaning to one side). - leaning back a long way, neck extended.		position to eat/drink.	• Nose Cut Out Cup (mobilitysmart.co.uk) • Does the positioning need specialist help? Please speak to your local healthcare professional.		
Needs assistance.		Promote independence without jeopardising swallow safety	• Assist only as much as is needed – encourage and maintain independence and involvement as much as possible e.g., hand over-hand feeding. • Look at Dycem matting, and adapted cutlery/crockery. • Consider referral to your local healthcare professional.	Y/N	
Difficulty holding cutlery and cups.		Increase independence, client able to grasp utensils.	• Think with the team about why they are finding it difficult, and what could be done? • Consider the need for adaptive cutlery and referral to your local healthcare professional.	Y/N	
Putting food into the mouth too quickly – then having difficulties because of an over-full mouth.		Person slows feeding rate to maximise swallow safety and reduce risk of choking	• Discuss with colleagues about managing this with verbal or physical prompts/reminders. • Giving a smaller spoon • Giving smaller mouthfuls of food/smaller sips of drinks • Cutting food into smaller pieces • Please refer to the Cramming leaflet.	Y/N	
Food/Drink pockets inside cheek.		To ensure the mouth is cleared between	• Remind the person to check their cheeks during the meal and clear any residue.	Y/N	

Appendix D: ICS Dysphagia Management Checklist - City

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SPEECH AND LANGUAGE THERAPY DEPARTMENT – CITYCARE

Observation – time:	Seen?	Aim	Action - time: date if different:	Resolved?	Notes
		mouthfuls and after a meal.	• If assisting, watch to see that a swallow has happened before giving the next mouthful e.g.: movement of Adam's apple.	Y/N	
Difficulty/and or pain chewing.		To make sure food is well chewed and moistened.	• Look in the mouth for swellings, lumps, bleeding gums, ulcers, broken teeth, loose dentures and signs of infection e.g., oral thrush. • Ask the person (if able) if they are having any pain or discomfort chewing. If any of the above are observed, wait until the resident finishes their meal and complete an oral health checklist. • Give food that is easier to chew remembering to check nutritional adequacy.	Y/N	
Food/drink stays in the mouth for a long time.		To make sure food does not build up in the mouth and to prevent aspiration/choking.	• Give verbal reminders to swallow. • Enhance the flavour of the food and drink to stimulate and increase interest. • See Oral Holding leaflet.	Y/N	
Difficulty chewing usual diet texture.		To make sure person can clear food from the mouth effectively.	• Give reminders to chew and if these are not successful give food that is easier to chew.	Y/N	

Appendix D: ICS Dysphagia Management Checklist - City

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SPEECH AND LANGUAGE THERAPY DEPARTMENT – CITYCARE

Observation – time:	**Seen?**	**Aim**	**Action - time:** **date if different:**	**Resolved?**	**Notes**
Food falls from the lips.		To stop food/fluid loss from the mouth.	• Consider motivation for meals, food preferences, and positioning.	**Y/N**	
Coughing when eating.		Avoid aspiration.	• Suggest the person tries tucking chin towards the chest when swallowing. • Consider pacing and whether slowing the pace of eating reduces coughing.	**Y/N**	
Coughing when drinking.		Avoid aspiration.	• Reduce distractions and conversation. • Ensure positioning as upright and mid-line as comfortable. • Encourage small, single sips. • If using spouted beaker or straw, try an open cup (with assistance if needed).	**Y/N**	
Voice sounds gurgly after swallowing.		Clear residue from throat.	• Remind the person to cough or clear their throat between mouthfuls.	**Y/N**	
Mouth is very dry – little or no saliva being made		Moisten mouth adequately to enable safe eating.	• Ensure that the person is well hydrated. • If the person is well hydrated and still producing little/no saliva please discuss this at the weekly home rounds.	**Y/N**	
Mouth is full of saliva that can't be managed		To reduce saliva production to a manageable level.	• Try prompting to swallow more frequently. • Discuss at the weekly Home Round for consideration of cause.	**Y/N**	
Refusing food.		Maintain adequate nutrition.	• If this persists for longer than expected for this individual, please escalate this urgently with your GP or at your weekly home round.	**Y/N**	

Appendix D: ICS Dysphagia Management Checklist - City

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SPEECH AND LANGUAGE THERAPY DEPARTMENT – CITYCARE

Observation – time:	Seen?	Aim	Action - time: date if different:	Resolved?	Notes
Difficulty swallowing medication.		To take medication safely.	• Contact your pharmacist as soon as possible.	Y/N	

General advice:

- Thickeners are a prescription item and must be on a named patient basis only and reviewed if general health changes.
- Please ensure all fluids given with medication is given at the right consistency.
- GUM based thickener i.e., Nutilis clear, should not be used to thicken Nutritional supplements.
- Please refer to a pharmacist or dietitian to ensure nutritional supplements are prescribed at the correct IDDSI level.
- Please be aware that medication can have an impact on eating, drinking and swallowing difficulties as well as increase the risk of aspiration pneumonia. Please discuss any concerns with your local healthcare professional.
- An open cup is preferable to a beaker with a lid unless otherwise directed. It increases dignity and allows for a more natural pattern of drinking. Lids are generally only advised for people with movement/mobility disorders, or who are being given drinks in a compromised position. Please contact your SLT for further advice if required.

Appendix D: ICS Dysphagia Management Checklist - City

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CityCare

SPEECH AND LANGUAGE THERAPY DEPARTMENT – CITYCARE

Integrated Care System

Care Home observation notes:

Appendix D: ICS Dysphagia Management Checklist - City

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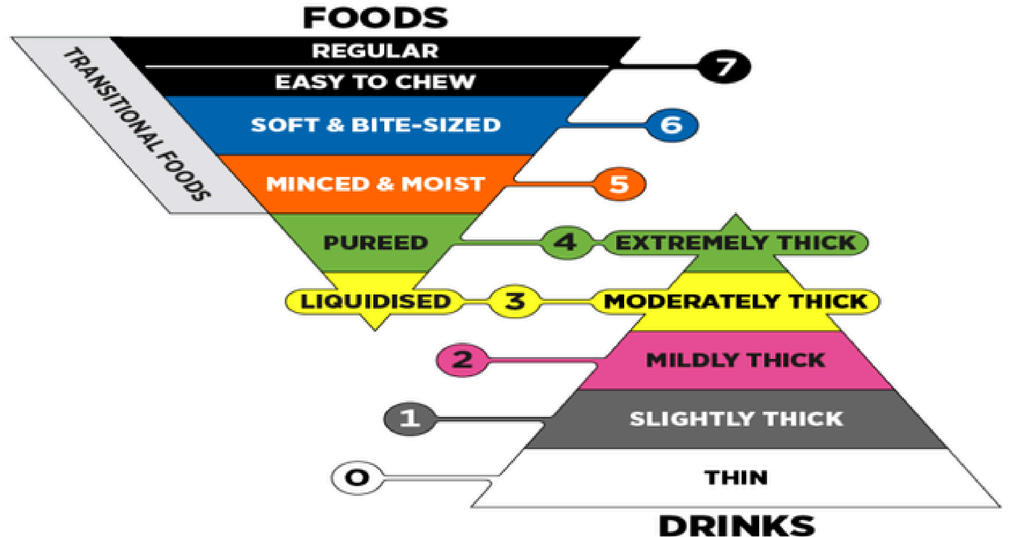
SPEECH AND LANGUAGE THERAPY DEPARTMENT – CITYCARE



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Derivative works extending beyond language translation are NOT PERMITTED.

Appendix E: ICS Dysphagia Management Checklist NHT - Mid Notts and South

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Nottinghamshire Healthcare
NHS Foundation Trust

SPEECH AND LANGUAGE THERAPY DEPARTMENT – NOTTINGHAMSHIRE

Dysphagia Management Checklist: 'How to' Guide

1. WHAT IS IT FOR?

- This checklist is to support care home staff to identify swallowing difficulties (Dysphagia) and other difficulties with eating and drinking.
- Provide suggestions which may resolve the difficulties observed
- Provides advice on how to refer and which professionals to refer to if the difficulties are not resolved.

2. WHEN SHOULD IT BE USED?

- With any new care home residents
- Anyone with new signs of difficulty
- Anyone with worsening or changing difficulties

3. HOW DO YOU USE IT?

1. Observe the resident having a meal and taking a drink
2. Use the checklist to record any difficulties they are having by ticking in the 'seen' column. (Make notes in the boxes provided)
3. Try the suggested strategies in the Action column to see if the difficulty can be resolved
4. If the difficulty is not resolved, or the aim is unachievable e.g., the patient is unable to achieve upright position due to contractures, please seek advice from a relevant healthcare professional or make a referral to the appropriate service

3. HOW TO REFER?

Contact your local healthcare professional (i.e., GP, Nurse Practitioner, Enhanced Health in Care Homes team etc) to make a referral. Include a copy of this checklist within the referral form.

Appendix E: ICS Dysphagia Management Checklist NHT - Mid Notts and South

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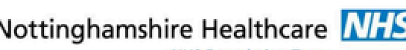

SPEECH AND LANGUAGE THERAPY DEPARTMENT – NOTTINGHAMSHIRE

DYSPHAGIA MANAGEMENT CHECKLIST

- Please use this checklist as you **watch the person have their usual meal.**
- Identify the areas of need by placing a tick in the 'Seen' column, if noted during the meal.
- Please use the 'Care Home notes' section to note your observations.
- 'Local Healthcare Professional' could be a GP, Care Home team, Advanced Nurse Practitioner, etc.
- For support completing the checklist, please refer to the guidance leaflet provided.
- **This checklist can be used as often as required but should never be used to overrule the advice of a healthcare professional.**

If any of the problems observed persist after the actions have been completed, request a referral to your SLT team and enclose a copy of the completed checklist. Alternatively, if all the observations have been resolved through the recommended actions, a referral to SLT is not required

Glossary of terms:

Dysphagia - The term we use to describe difficulty with swallowing

Aspiration - Aspiration is when something enters the airway or lungs by accident.

Choking – when someone cannot breathe because something is blocking the airway. If someone is choking, they require immediate help to clear the obstruction.

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Nottinghamshire Healthcare NHS
NHS Foundation Trust

SPEECH AND LANGUAGE THERAPY DEPARTMENT – NOTTINGHAMSHIRE

Checklist for Management of Eating, Drinking and Swallowing Difficulties

Name of patient:................................ **DOB:**............................... **Date:**............................

Person completing observation: .... **IDDSI consistencies observed:**..........................

Watch the person have a meal: where you notice something, look on the checklist for recommended action:

Observation – time:	Seen	Aim	Action - time: date (if different):	Resolved?	Notes
Pain on swallowing			Pain on swallowing must not be ignored. Please refer urgently via your weekly Home Round or GP.	Y/N	
Too drowsy to eat		Person is awake enough to eat/drink	• If levels of alertness are variable, allow them to rest when tired, and encourage food and drink when alert. • Do ordinary strategies work (calling their name, shaking gently, orientating them, giving them something to take an interest in, little and often approach)? • Think as a team about why this person might be drowsy (medical factors/ill health, social issues - insufficient interest to maintain alertness, end-of-life issues, medication). • Consider a referral for a health review from your local healthcare professional.	Y/N	
Poor positioning: - head dropped down, making eating difficult - asymmetrical position (twisted or leaning to one side) - leaning back a long way, neck extended		Person can maintain the best possible sitting/head position to eat/drink	• Consider altering their position by attention to seating/cushions. • Consider trialling Nose Cut Out cups • Nose Cut Out Cup - Blue - NRS Healthcare Pro • Nose Cut Out Cup (mobilitysmart.co.uk) • Does the positioning need specialist help? Please speak to your local healthcare professional	Y/N	

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SPEECH AND LANGUAGE THERAPY DEPARTMENT – NOTTINGHAMSHIRE

Observation – time:	Seen	Aim	Action - time: date (if different):	Resolved?	Notes
Difficulty holding cutlery and cups		Increase independence, client able to grasp utensils	• Think with the team about why the person is having difficulty and what could be done? • Consider the need for adaptive cutlery, referral to your local healthcare professional	Y/N	
Putting food into the mouth too quickly – then having difficulties because of an over-full mouth		Person slows feeding rate to maximise swallow safety and reduce risk of choking	• Discuss with colleagues about managing this with verbal or physical prompts/reminders. • Giving a smaller spoon • Giving smaller mouthfuls of food/smaller sips of drinks • Cutting food into smaller pieces • Please refer to the Cramming leaflet.	Y/N	
Food/Drink pockets inside cheek		To ensure mouth is cleared between mouthfuls and after meal	• Remind the person to check their cheeks during the meal and clear any residue. • If assisting, watch to see that a swallow has happened before giving the next mouthful e.g.: movement of Adam's apple.	Y/N	
Difficulty and/or pain chewing		To make sure food is well chewed and moistened.	• Look in the mouth for swellings, lumps, bleeding gums, ulcers, broken teeth, loose dentures and signs of infection e.g., oral thrush. • Ask the person (if able) if they are having any pain or discomfort chewing. • If any of the above are observed, wait until the resident finishes their meal and complete an oral health checklist. • Give food that is easier to chew remembering to check nutritional adequacy	Y/N	

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SPEECH AND LANGUAGE THERAPY DEPARTMENT – NOTTINGHAMSHIRE

Observation – time:	Seen	Aim	Action - time: date (if different):	Resolved?	Notes
Food/drink stays in the mouth for a long time		To make sure food does not build up in the mouth and to prevent aspiration/choking.	• Give verbal reminders to swallow. • Enhance the flavour of the food and drink to stimulate and increase interest. • See Oral Holding leaflet.	Y/N	
Difficulty chewing usual diet texture		To make sure person can clear food from the mouth effectively	• Give reminders to chew and if these are not successful give food that is easier to chew. • Any consideration for textures lower than Level 6 soft and bite-sized diet, **must** be referred to Speech and Language Therapy. • Discuss via the next weekly Home Round or with your Local Healthcare Professional • Refer to the leaflets provided in this checklist	Y/N	
Food falls from the lips		To stop food/fluid loss from mouth	• Consider motivation for meals, food preferences and positioning.	Y/N	
Coughing when eating		Avoid aspiration	• Suggest the person tries tucking chin towards the chest when swallowing. • Consider pacing and whether slowing the pace of eating reduces coughing	Y/N	

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SPEECH AND LANGUAGE THERAPY DEPARTMENT – NOTTINGHAMSHIRE

Observation – time:	**Seen**	**Aim**	**Action - time: date (if different):**	**Resolved?**	**Notes**
Coughing when drinking		Avoid aspiration	• Reduce distractions and conversation. • Ensure positioning as upright and mid-line as comfortable. • Encourage small, single sips. • If using a spouted beaker or straw, try an open cup (with assistance if needed) • Try naturally thicker drinks (smoothies, tomato juice, hot chocolate made with full-fat milk) or discuss the use of thickener to slightly thick level 1 with your healthcare professional (1 scoop in 200mls)	**Y/N**	
Voice sounds gurgly after swallowing		Clear residue from throat	• Remind the person to cough or clear their throat between mouthfuls.	**Y/N**	
Mouth is very dry – little or no saliva being made		Moisten mouth adequately to enable safe eating	• Ensure that the person is well hydrated. • If the person is well hydrated and still producing little/no saliva please discuss this at your weekly Home Round.	**Y/N**	
Mouth is full of saliva that can't be managed		To reduce saliva production to a manageable level	• Try prompting to swallow more frequently. Discuss at your weekly Home Round for consideration of cause.	**Y/N**	
Refusing food		Maintain adequate nutrition	• If this persists for longer than expected for this individual, please escalate this urgently with your GP or at your weekly home round	**Y/N**	

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Difficulty swallowing medication		To take medication safely	• Contact your Pharmacist as soon as possible.	Y/N	

General advice:

- Thickeners are a prescription item and must be on a named patient basis only and reviewed if general health changes.
- Please ensure all fluids given with medication is given at the right consistency.
- GUM based thickener i.e., Nutilis clear, should not be used to thicken Nutritional supplements.
- Please refer to pharmacist or dietitian to ensure nutritional supplements are prescribed at the correct IDDSI level.
- Please be aware that medication can have an impact on eating, drinking and swallowing difficulties as well as increase the risk of aspiration pneumonia. Please discuss any concerns with your local healthcare professional.
- An open cup is preferable to a beaker with a lid unless otherwise directed. It increases dignity and allows for a more natural pattern of drinking. Lids are generally only advised for people with movement/mobility disorders, or who are being given drinks in a compromised position. Please contact your SLT for further advice if required.

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SPEECH AND LANGUAGE THERAPY DEPARTMENT – NOTTINGHAMSHIRE

Integrated Care System

Care Home observation notes:

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The IDDSI Framework

Providing a common terminology for describing food textures and drink thicknesses to improve safety for individuals with swallowing difficulties.

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