Staffordshire and Stoke-on-Trent Integrated Care System

Care Home Resource Pack

Including Recognising and Responding to Deterioration in your Care Home Residents

May 2025

Contents

Useful numbers

Social care

Stoke-on-Trent

Office hours: 0800 561 0015

Out of hours and weekends: 01782 234234

Website: Adult care and wellbeing | Stoke-on-Trent

Staffordshire

Office hours: 0300 111 8010

Out of hours and weekends: 0345 604 2886

Website: Contact us - Staffordshire Cares

Mental Health

South Staffordshire: 0808 561 0015

North Staffordshire: 0800 0 328 728 (option 1)

Website: Crisis mental health access via NHS 111

Palliative / Hospice Services

24-hour helpline: 0300 561 2900

Palliative Care Coordination Centre (PCCC): 0300 123 0989 (option 2)

Website: Palliative Care Co-Ordination Centre

- **Douglas Macmillan Hospice:** 01782 344300
  Website: Dougie Mac
- **Katharine House Hospice:** 01785 254 645
  Website: Katharine House Hospice
- **St Giles:** 0300 330 9410
  Website: St Giles Hospice
- **Compton Care:** 0300 323 0250
  Website: Compton Care

Community Nursing Teams

24 Hours

- **North Staffordshire and Stoke-on-Trent Local Access Point:** 01782 831110
- **Cannock and Seisdon Local Access Point:** 0300 123 9011
- **Burntwood, Lichfield and Tamworth Local Access Point:** 0300 124 0347
- **Stafford Local Access Point:** 0300 124 0343
- **Burton upon Trent:** 0300 323 0930

Community Learning Disabilities Team

- **North Staffordshire and Stoke-on-Trent:** 0300 123 1152
- **South Staffordshire:** 01785 221576

NHS 111

24 Hours

NHS 111 can help if you have an urgent medical problem and you're not sure what to do. In emergency situations where there is an immediate risk to life, you should continue to contact 999 or go to A&E.

Crisis Rapid Response

The **Integrated Care Coordination (ICC) for Urgent Care** provides urgent advice and access to the **Community Rapid Intervention Service (CRIS)**, 7 days a week, 8am – 8pm: 0300 123 0983

999 - WMAS

24 Hours

999 is for life-threatening emergencies like serious road traffic accidents, strokes and heart attacks.

Recognising and Responding to Deterioration in your Care Home Resident

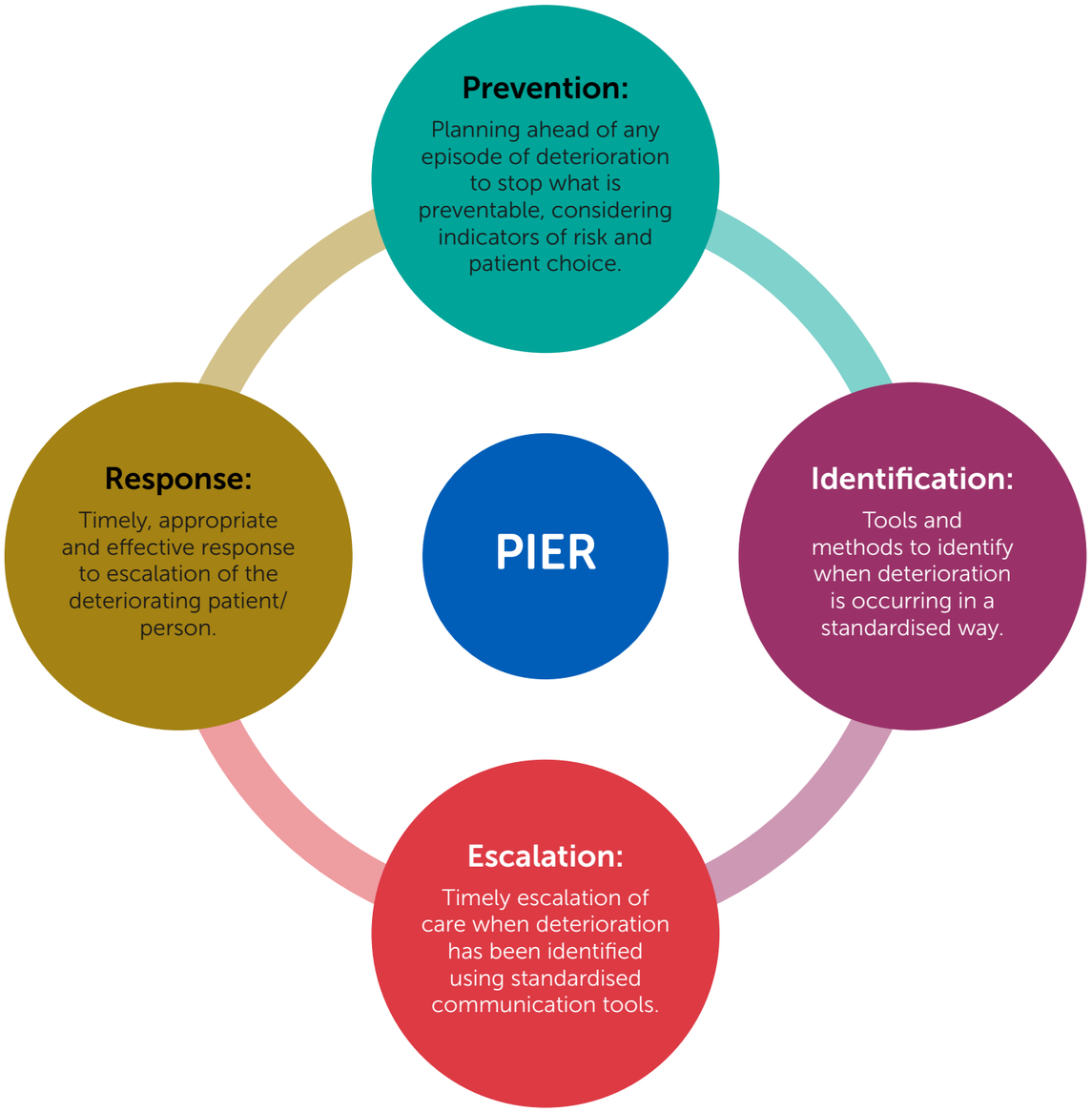
An essential part of supporting any resident within a care home is ensuring they are safe and well and that any changes in their presentation are recognised early and responded to in a timely way. Within Staffordshire and Stoke-on-Trent, we want to offer all care home residents and their carers the right tools and training to recognise any changes and importantly, the help and support that may be required as a result of these changes through health and social care services. We have worked with the Health Innovation West Midlands (HIWM) team and health and social care partners to provide care homes with a set of tools and pathways to respond to deterioration and get the right care at the right time for residents.

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. Deterioration can present in many ways and to allow carers and families to recognise these within our system, we have agreed to use a set of tools that any care home can adopt and use to recognise small changes to more significant changes in residents. These changes are sometimes referred to as soft signs of deterioration.

For residents with learning disabilities or with dementia it is particularly important that carers can identify soft signs of deterioration that the resident may not be able to communicate verbally. The tools can be adapted to use in all settings. They are designed for any carer, including families, to use and will allow the care home teams the ability to make changes or seek support without delay. We recognise that not all care homes have staff skilled around clinical management of residents, so the tools are designed to allow carers to recognise the changes but then seek the help and support they require by using the **Deteriorating Patient Escalation Pathway Contact List**.

The aim of the work is to:

- Prevent avoidable hospital admissions for residents by treating them in their own home, when it is clinically safe to do so
- Provide clear pathways for escalation when deterioration monitoring tools are utilised as a system approach. For supporting people with a learning disability or people who are autistic with their health or care, more information can be found on: **LeDeR - Identifying Deterioration**
- Provide training and support to all care homes around recognition of deterioration of residents.
- Provide clear aligned pathways and agree tools to enhance the levels of monitoring. **For more information, see is my resident unwell**.



Integrated Care Coordination (ICC) for Urgent Care

The ICC for Urgent Care is a multidisciplinary team which acts as a single point of access in Staffordshire and Stoke-in-Trent.

Most often, the best place for a person to receive urgent care is in the community and where possible in their own home/usual place of residence when it is safe and appropriate to do so. The ICC aims to provide the right care, in the right place, at the right time.

More information on Home Care is Best Care campaign can be found at [Home Care is Best Care - Staffordshire and Stoke-on-Trent, ICS].

The ICC supports health and social care registered professionals to manage the escalation of patients with urgent and complex needs at their usual place of residence, to access appropriate care in the most appropriate place, by the most appropriate service. This may be in the community, via an outpatient clinic or even on a virtual ward avoiding unnecessary hospital admissions. Not only does this approach better support patients and help them to avoid a hospital trip or admission where possible, it also helps to protect vital resources like ambulances and emergency department services for those who need them most.

The ICC takes referrals from any registered health or social care professional across Staffordshire and Stoke-on-Trent for patients/people aged 18 and over and makes referrals into services in the community and in the acute hospitals for patients requiring urgent care. This includes physical health, mental health and social care pathways.

Examples of some of the services the ICC refer to are Community Nursing, the Community Rapid Intervention Service, First Contact and Front Door Social Care, and specialist community teams. We are expanding the number of services available all the time.

The ICC can NOT support with the following:

- Trauma or an acute condition requiring hospital admission
- Head injury following a fall where there is suspicion of an injury requiring hospital attendance (NICE (National Institute for Health and Care Excellence) Head Injury Guidance)
- Suspected sepsis
- People in public places.

ICC
Integrated Care Coordination For Urgent Care

The ICC for Urgent Care

0300 123 0983

8am and 8pm, 7 days a week

Community Rapid Intervention Service (CRIS)

The CRIS service provides a viable alternative that can respond rapidly to patients in the community with escalating, sub-acute healthcare needs.

CRIS is an integrated partnership between University Hospitals of North Midlands NHS Trust, Midlands Partnership University NHS Foundation Trust, Staffordshire County Council and Stoke-on-Trent City Council (adult social care). CRIS combines senior hospital consultant decision-making skills with community health and social care admissions avoidance expertise.

CRIS provides rapid assessment, monitoring, and treatment

The aim of CRIS is to provide a rapid response (within 2 hours) to patients with an escalating sub-acute healthcare need in their usual place of residency. Patients will be assessed, monitored, and treated without the need to attend emergency department (ED) or be admitted to hospital. All patients will be reviewed before being discharged back to the care of their GP.

Who can refer?

Patients can be referred to CRIS by:

- GPs
- Paramedics
- Social care staff
- Community services
- NHS 111
- Care/residential/nursing homes.

Referral pathway

The service requires the referring clinician/care staff to have made a clinical assessment of the patient either in person, or by telephone (GPs only) on the day that the referral is made, and the patient is clinically safe to wait for 2 hours for a clinical response.

The types of conditions that might require a CRIS response to prevent an unnecessary hospital admission:

- All referrals from care homes
- Falls with no apparent injury
- Short-term sub-acute illness e.g. infections
- Elderly frail patients at risk of unnecessary hospital admission
- Patients at end of life.

CRIS can NOT support with:

- Any patient with a clinical condition that precludes them from waiting 2 hours
- Any patient who has a non-urgent need and does not need a response within 2 hours
- Patients requiring core primary care intervention
- Patients in mental health crisis
- Under 18s.

Information needed for a good referral

The information needed for a good referral:

- Resident demographics – date of birth, next of kin, contact details, age, etc
- The date they were last seen by their GP
- Their medical history
- If they have a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) and/or ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) document?
- The medication they are taking and if they have end of life medication in their home
- Details of the issue they are having today and what they are usually like
- Details of their usual care needs
- If there are any soft signs of deterioration? Refer to the soft signs 'Stop and Watch' tool
- What their vital signs are – blood pressure, pulse, temperature, respirations. For nursing homes please include a full set of observations: respiration rate (RR), oxygen saturation (Sats), heart rate (HR), blood pressure (BP), temperature and conscious level or Alert, Confused, Verbal, Painful, Unresponsive (ACVPU) score. Having completed the observation calculate a National Early Warning Score (NEWS2) score and include a baseline NEWS2 score if available
- Situation, Background, Assessment, Recommendation, Decision (SBARD); this is the tool staff should be using to escalate concerns to clinicians.

What the care homes can expect from the CRIS

- An open and honest assessment approach from visiting clinicians
- Clinicians will be compassionate and caring in their attitude and the treatment of your residents and staff
- Clinicians will have the courage to challenge situations sensitively, will prescribe medication appropriately, request bloods and samples as appropriate and report to GPs
- Clinicians will be competent in their assessments and will acknowledge any limitations and will refer onto other practitioners
- Clinicians will communicate their findings to care home staff and offer advice as required. The clinician will send a report to the resident's own GP informing them of their visit
- CRIS is committed to assisting care homes in the prevention of unnecessary admissions to hospital.

What the ICC and CRIS expect from care homes

If care homes need advice and support about a resident of concern, we expect that care homes will refer to the **Deteriorating Patient Escalation Pathway Contact List** to ensure that the referral is escalated to the most appropriate service.

We expect on referral to the ICC, care homes will confirm whether the resident has been reviewed by their own GP.

We expect in the scenario that a resident has been deteriorating and has had multiple hospital admissions, the care home should have open discussions with the resident/family and GP about the preferred place of care and long-term plans for their care, such as do residents/family members wish the resident to be admitted to hospital or remain comfortable at home with available community treatments in the event that they were to deteriorate again.

We expect that prior to the clinician's visit, carers will have the resident's care plan, medication administration record (MAR), a recent urine sample or in exceptional circumstances a very wet continence pad, and the resident available in their room (if possible) so that the clinician can assess the resident promptly.

If the clinician prescribes medication, please ensure that there is a carer or family member who can collect the prescription. Your resident will need to commence on medication promptly to minimise further deterioration and avoid unnecessary hospital admission.

If the care home is unable to administer or hold a stock of homely remedies such as paracetamol, etc, we expect that care staff will inform the visiting clinician, and they can prescribe individually for that resident.

We expect that carers will closely observe residents for early soft signs of deterioration and use Stop and Watch tool.

We expect that carers will contact the ICC/NHS 111/999 as instructed by the clinician.

We expect that care homes will be open and honest about the level of care they can provide and any limitations of care they can provide to residents. This is so residents receive the most appropriate care in the most appropriate place.

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 functionality (mobility/cognition) can irretrievably deteriorate
- Residents with a diagnosis of a learning disability or autism may find such environments anxiety-provoking from fears of clinical interventions and increase levels of agitation or challenging behaviours which could affect the decision on treatment options and their success
- Residents are at risk of catching other hospital acquired infections such as a urine infection, chest infection, gastroenteritis, and norovirus whilst in the hospital environment
- Whilst waiting to be assessed they may be at risk of acquiring pressure ulcers or of worsening pressure ulcers
- Your carers know your residents well and are more likely to be able to encourage residents to eat and drink than nurses within the hospital environment, as your resident will be comfortable in your company, so the risk of dehydration and malnutrition could be less remaining at home than in hospital, if your resident is able to take nutrition orally
- 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
- There is some evidence that 10 days in hospital is the equivalent of 10 years of ageing of the muscles for a person over 80 years old (NHS England, 2017).

Soft Signs of deterioration

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, 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 person's behaviour, manner, or appearance. These concerns should always be taken seriously, even if you think the person is fine
- It's important to understand what is normal for the person.

Examples of 'soft signs'

Changes in physical presentations

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

Changes in mental state

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

Changes in behaviour or ability

- Changes to usual level of alertness such as sleeping more or less
- New or increased confusion, agitation, anxiety, or pain
- Change in usual drinking or diet habits
- Reduced mobility or 'off legs'
- Being very restless or hyperactive.

Or just your own gut feeling that something is wrong, or the resident has concerns.

Frailty

In medical terms 'frailty' is defined as a multi-dimensional condition that is a decline of physical health and cognitive reserves that leads to increased vulnerability. Those at risk have an increased possibility of poor nutrition, falls or hospital admission.

"Frailty is not an illness, but a syndrome that combines the effects of natural ageing with the outcomes of multiple long-term conditions, loss of fitness and reserves" (Lyndon 2014). For care home residents, there are interventions that can slow decline and prevent crises by care home staff recognising the soft signs of deterioration.

The **Rockwood 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.

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.

Falls

Falls are common in older people, and 1 in 2 of those over 80 years old fall at least once per year.

Falls are the most common cause of emergency hospital admission, and people may lose confidence and independence afterwards.

People living in care homes are 3 times more likely to fall than those living at home. They are also older, frailer, and more likely to have limited mobility than people living in the community. This group is especially vulnerable to the impact of falls.

- Falls and fractures in older people are often preventable.
- Reducing falls and fractures is vital for maintaining the health, wellbeing and independence of older people.

There are many risk factors for falls, and it is important that each resident receives an individual falls risk assessment to identify risk factors to reduce their risk.

Building and maintaining strength and balance through targeted exercise and carrying out an assessment of environmental hazards is vital as these have proven to be the most impactful things that you can do to prevent falls. If we play our part, we can all contribute to falls prevention, supporting residents to maintain their health and wellbeing as much as possible.

The Action Falls programme was developed by researchers working jointly with care home staff, clinicians, the public, voluntary and social care organisations. The content is based on **NICE guidelines** for falls prevention. It combines 1 hour of care home staff training with a decision support tool listing risk factors for falls, and actions to prevent them.

The Action Falls programme includes the React to Falls app, which contains tools and actions and is available to download here React to falls - Apps on Google Play.

More information can be found on the NHS website Health A - Z

Learning Disabilities and Soft Signs of Deterioration

The Department of Health and Social Care in the UK defines a learning disability as 'a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood'.

In addition, NICE provides the following guidance:

- Definitions of learning disability generally encompass three core components:
  - Lower intellectual ability (usually an IQ of less than 70)
  - Significant impairment of social or adaptive functioning
  - Onset in childhood.

People with milder learning disabilities may be able to live independently and care for themselves, manage everyday tasks, work in paid employment, communicate their needs and wishes, have some language skills, and may have additional needs that are not clear to people who do not know them well.

People with more severe learning disabilities are more likely to need support with daily activities such as dressing, washing, food preparation, and keeping themselves safe, have limited or no verbal communication skills or understanding of others, need support with mobility, have complex health needs and sensory impairments.

The most common health conditions for people with a learning disability are epilepsy, heart failure, weight management, constipation, pneumonia, and swallowing issues.

For more information: Common health problems that social care staff should be aware of.

What are soft signs of deterioration for residents with a learning disability?

Early signs may be difficult to monitor, however there are tools and guidance available to help you recognise the soft signs of deterioration.

Please see resource section:

- Disability Distress Assessment Tool (DisDAT)
- Keeping Well Part 1-3.
- Pain Rating Scale - Wong-Baker FACES Foundation.

An individual can seem different than usual and overall needs more help than usual. They may need help with walking, transferring or toileting more than usual. Other behavioural signs are an individual talking or communicating less or participating in activities less than usual.

Other physical presentations include:

- Agitation, nervousness, or restlessness more than usual. Tired, weak, confused, or drowsy
- Breathing patterns and breath sounds change
- Heart and circulation may change with pulse rate, dizziness, sweating
- Weight change, eating less than usual (not because of dislike of food). Drinking less than usual. Changes in urine output such as smell and colour. Changes in bowel habits including diarrhoea
- Changes in skin colour or condition including mottling of skin, rashes, blueish tinge to lips.

Common Conditions

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.

Signs and symptoms of sepsis

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.

Signs of sepsis in adults:

- 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.

What to do if you suspect sepsis

Call 999 if someone has one of the sepsis symptoms.

More information can be found on the NHS website Health A - Z

Chest infections

Possible causes

- Bacteria or viral infection
- Coughing and sneezing spread the illness
- Aspiration due to difficulty / poor swallowing, allowing fluid, food or saliva to enter the lungs
- Poor posture
- Smoking
- Some long-term health conditions make people more at risk such as those with asthma, heart disease, diabetes, kidney disease, chronic obstructive pulmonary disease
- Obesity
- Bed bound residents
- Consolidation (sputum becoming congested in the lungs)
- Immunocompromised residents such as those on chemotherapy
- Over 65 years old.

Signs and symptoms of a chest infection

- Temperature - feels hot and shivery
- Uncontrollable shivering
- Nausea (feeling sick)
- Vomiting
- Chest pains
- Any increased confusion, disorientation or drowsiness
- Any notable changes of colour to skin, lips or nails (cyanosis)
- Breathing faster than normal
- Persistent cough
- Bringing up thick yellow or green sputum
- Noisy breathing
- Fast heartbeat
- Poor appetite.

Management of residents with a chest infection

- Give medication as prescribed (may be given antibiotics)
- Assist with good posture as sitting upright can help the resident to bring up secretions
- Encourage deep breathing
- Observe any sputum production for any changes in colour and consistency
- Encourage fluids
- Infection control management such as use of tissues to 'Catch It, Bin It, Kill It' and good hand washing for residents, staff and visitors
- Rest.

Prevention

- Ensure visitors who have potential illness do not visit until well
- Ensure that residents who are eligible, have their seasonal flu vaccination
- Strict hand washing by residents, staff and relatives
- Provision of clean tissues and receivers for disposal
- Early recognition of residents with any swallowing problems should be referred to the Speech and Language Team (SALT) and advice adhered to
- Support the resident to quit smoking.

For residents with learning disabilities, more information can be found on the LeDeR - Respiratory

More information can be found on the NHS website Health A - Z

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. 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 mild.

Signs and symptoms of flu

Any of these symptoms may be present

- A high temperature of 38C or above
- Tiredness and weakness, and feeling so exhausted and unwell that a resident has to stay in bed
- A 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, such as norovirus.

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, wear gloves and aprons 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 tissue when sneezing or coughing
- Infection control management such as use of tissues to 'Catch It, Kill It, Bin It'' and good hand washing for residents, staff, and visitors
- Report an outbreak as per the UK Health Security Agency national guidance.

Care of your resident with flu

- Allow residents to rest
- Keep them warm (be wary of high temperatures)
- Push fluids to avoid dehydration and light diet as tolerated
- Offer regular paracetamol and/or ibuprofen depending on the resident's allergies and/or intolerances. Ensure these are documented.

Complications of flu

- Chest infection
- Pneumonia
- Sepsis
- Dehydration
- Worsening of existing conditions, such as diabetes (raised blood sugars), COPD, heart failure and chronic kidney disease.

When to call the ICC and NHS 111

ICC 8am-8pm and NHS 111 24 hours

- Those residents who develop a cough, shortness of breath or who cough up blood
- Those residents who do not improve and are not eating or drinking.

When to call 999

Residents with chest pain, severe breathing difficulties, cannot complete sentences and/or become drowsy and unresponsive.

Prevention

Annual flu jab is the best prevention against flu. Although not 100% effective as there are different strains of flu, however, offers some protection to your residents.

More information can be found on the NHS website Health A - Z

Coronavirus disease (COVID-19)

Eligibility for COVID-19 treatment

The National Institute for Health and Care Excellence (NICE) has updated the guidance on eligibility criteria for COVID-19 treatment. Care home residents with the following risk factors are eligible for treatment:

- Age 70 years or above
- Diabetes
- Heart failure
- Body mass index (BMI) of 35 kg/m² or above
- Patient on organ transplant waiting list
- Risk factors as defined in the original guidance issued in March 2023.

Testing requirements for COVID-19

If a care home resident gets COVID-19 symptoms and they are eligible for treatment, they should have a lateral flow device test (LFD) immediately, even if the symptoms are mild. If the test is negative but they continue to have the symptoms, they should have another test on each of the next two days (three tests in total over three days). Note that the test on third day is only needed if the test on the second day is negative. As soon as a positive result is observed treatment should be sought for the resident.

Access to lateral flow tests

Individuals who are potentially eligible for COVID-19 treatment can get free LFD tests from pharmacies. Not all pharmacies provide this service and therefore care home staff should contact their usual pharmacy and ascertain where they can get the free LFD tests. Note that pharmacies will provide free tests only to individuals who meet the COVID-19 treatment eligibility criteria as explained above. Care home staff should keep enough LFD tests that would be sufficient to test all potentially eligible residents at the care home if the need arises (minimum of three tests per resident who is eligible for treatment).

Access to COVID-19 treatment

COVID-19 treatment in Staffordshire and Stoke-on-Trent is provided by the COVID-19 Medicines Delivery Unit (CMDU). Care home staff can directly contact the CMDU if one or more of residents has COVID-19 infection symptoms and they have had a positive LFD test. Treatment works best if it is started within 5 days of onset of symptoms and therefore care home staff should contact the CMDU as soon as the infection has been confirmed. Care home staff should email NSGPFEDCMDU@StaffsStokeCCGs.nhs.uk with the following details:

- Patient name, date of birth and NHS number
- Contact phone number for the care home manager or staff member taking responsibility for the referral
- What clinical condition the referrer thinks may make them eligible for antiviral treatment
- What was the date of their positive COVID-19 test and onset of COVID-19 symptoms.

The CMDU will contact the care home, usually within 24-48 hours of receiving the email. However, please note that at times of high COVID-19 prevalence this can be longer.

If **oral** treatment is indicated, then the CMDU clinician will issue an electronic prescription. Care home staff should contact the pharmacy they normally use to get the prescription dispensed.

If **intravenous** treatment is indicated, then the CMDU will agree arrangements with the care home on how the treatment will be provided.

Note: The best way to prevent COVID-19 infection in other residents is to follow infection prevention and control policies and procedures guidance.

5 Supporting information on risk factors for progression to severe COVID 19 | Nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19 | Guidance | NICE

More information can be found on the NHS website Health A - Z

Urinary Tract Infection (UTIs)

Possible causes of UTIs

- Reduced fluid intake (dehydration)
- Urinary and/or faecal incontinence and/or poor hygiene
- Obstruction or blockage of the urinary tract such as kidney stones, or in men an enlarged prostate
- Weakened immunity such as residents who are receiving chemotherapy, either oral or intravenous, 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.

Signs and symptoms of UTIs

- Pain or burning sensation when passing urine (dysuria)
- Passing urine more often and may develop urinary incontinence
- Offensive cloudy urine or blood in urine
- Lower, dull abdominal pain
- Dull ache in lower back, groin, or side
- Feeling generally unwell
- High temperature of 38C or above, or feels hot and shivery
- Uncontrollable shivering
- Nausea and/or vomiting
- Diarrhoea
- Agitation or restlessness
- Difficulty concentrating
- Hallucinations or delusions
- Becoming unusually sleepy or withdrawn.

Management of residents with UTIs

- 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 it in
- Wipe front to back after using the toilet
- Wash genitals every day.

UTIs can have more serious complications in certain residents including:

- Kidney disease
- Type 1 diabetes or type 2 diabetes
- Immunocompromised residents such as those on chemotherapy
- Patients with kidney stones or a catheter
- Over 65 years old.

Catheters

A resident with a catheter can be more at risk of developing a UTI. In people with catheters the symptoms of a UTI could include:

- 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.

Management of UTIs in residents with catheters

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.

Encourage the resident to drink plenty of water/fluids unless the catheter is blocked, and the resident is showing signs of discomfort from a full bladder.

Maintain accurate fluid balance of input and output as appropriate.

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

More information can be found on the NHS website Health A - Z

Prevention of UTIs in residents with catheters

- Always check position of catheter avoiding kinks, pulling on the tube or crushing by bed rails
- Keep catheter tubing clean
- Maintain drainage system
- Change leg bags weekly and use disposable night bag.

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

To Dip or Not to Dip Training Handbook

To Dip or Not To Dip Training Animation

What's in a cup?

A fluid volume ready reckoner to with fluid balance chart completion.

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 it affects people of all ages, however people with learning disabilities have an increased risk of constipation. Long-term constipation can lead to faecal impaction.

This is where poo has built up in the last part of the large intestine (rectum).

Possible causes of constipation

- Not eating enough fibre, which is found in fruits, vegetables and cereals
- Not drinking enough fluids
- Not moving enough and spending long periods sitting or lying down
- Being less active and not exercising
- Often ignoring the urge to go to the toilet
- Changing your diet or daily routine
- A side effect of medicine
- Stress, anxiety or depression
- Rarely, constipation may be caused by a medical condition.

Signs and symptoms

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
- 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.

Management of residents with constipation

- 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 poo more regularly.

Prevention

- Monitor bowel movements 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
- Making simple changes to diet and exercise.

For residents with learning disabilties, more information can be found on the LeDeR - Constipation

More information can be found on the NHS website Health A - Z

Gastroenteritis (Diarrhoea and vomiting) in adults

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 local IPC (infection prevention and control) team 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. diff G infection).

Signs and symptoms of a gastroenteritis

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

Management of residents with gastroenteritis

- Good infection control
- Isolate the resident from other residents to prevent spread
- Effective hand washing technique
- Ensure carers wear gloves and aprons when attending to the affected resident (barrier nursing)
- Do not share commodes or toilets
- Ensure laundry is washed separately as per your internal care home protocols
- Offer regular fluid preferably water, or diluted juice and soup
- Residents may need oral rehydration solutions to replace salt, glucose and other important minerals via prescription from a clinician
- If tolerated, try a light diet and small meals often. Avoid fatty or spicy foods
- Please obtain a 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.

Residents require urgent referral to the ICC 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.

Gastroenteritis can have more serious complications in certain residents including:

- Older residents
- Those residents with underlying health conditions including kidney problems, diabetes, or heart failure (as they will most probably be taking water 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.

More information can be found on the NHS website Health A - Z

Dehydration

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.

Signs and symptoms

Signs and symptoms of mild dehydration can include:

- 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.

Signs and symptoms of more severe dehydration can include:

- 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.

Management of residents with dehydration

- Offer regular clear fluids or diluted juice hourly regular sips are better than full glasses if residents are nauseous
- Oral rehydration solutions can be used to replenish salts and fluid
- Maintain a fluid input and output chart. If a resident uses pads, describe the weight of filled pad e.g. pad as wet or heavy as normal
- Observe the colour of urine
- If resident has not passed urine in the last eight hours, notify a clinician for advice
- Offer 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.

Prevention of gastroenteritis and dehydration

- Good hand washing techniques
- Storing and cooking food as per care home policy
- Informing visitors and relatives not to visit if they have gastroenteritis symptoms
- Isolate residents who develop gastroenteritis from other residents
- Offering regular fluids
- Increase fluid intake during warm weather for residents.

Thorough fluid balance saves lives

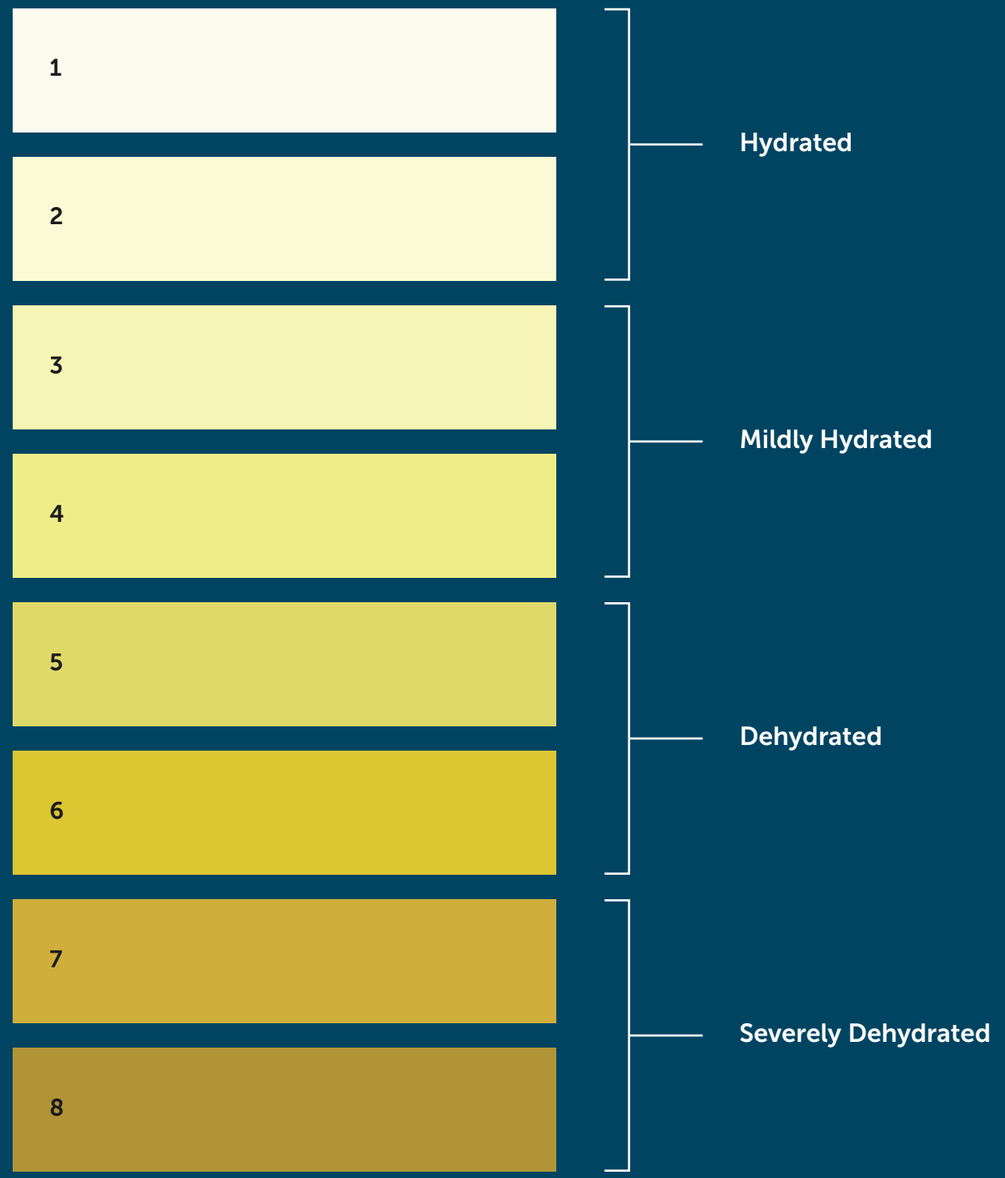
- Monitor for symptoms and signs of dehydration
- Make sure you know what is expected fluid intake for your patient
- Make sure you know what is expected urine output for your patient.

If the urine output has been less than 0.5ml/kg/h in the last 6 hours, ask for an urgent medical review.

More information can be found on the NHS website Health A - Z

The Urine Colour Chart

The Urine Colour Chart is a very quick and easy way to assess the hydration status of a resident. If the urine is any of the colours that suggest dehydration, monitor and record their fluid intake and output wherever possible and encourage an increase in fluids. If they do not improve, develop more signs of dehydration, or become more unwell, contact a clinician for advice as soon as possible.



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.

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
- Obesity
- Poorly controlled diabetes
- Having chickenpox or shingles
- Lymphoedema (fluid in limb)
- Previous cellulitis
- Circulatory problems.

Signs and symptoms of cellulitis

- Temperature above 38C or feels hot and/or shivery
- Nausea and/or vomiting
- Painful swelling and hot to touch area
- Area is wet or leaking fluid; this might look clear or like yellow pus and may smell offensive
- Wound dressing has become very wet or stained with yellow or bloodstained discharge
- Any increased confusion, disorientated or drowsiness
- Fast heart rate
- Poor appetite
- Rapid breathing
- Blistering to the red area
- Dizziness
- Reduced urine output
- Looking pale
- Feeling cold, and clamminess to skin
- Altered consciousness.

Management of residents with cellulitis

- 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

- Refer to signs and symptoms
- Facial cellulitis
- Abscess formation
- Increased redness, swelling and/or pain
- Stomach upset or diarrhoea from antibiotics
- Septicaemia.

Prevention

- Strict hand hygiene
- Well controlled blood glucose in diabetic patients
- Try and prevent any trauma to skin
- Ensure clothing not causing any restriction of movement
- Promote good skin care, use of moisturisers and encouraging fluid intake
- Treating any breaks in the skin appropriately
- Keeping nails short and clean (use of cotton gloves may be useful for residents who are scratching the area).

More information can be found on the NHS website Health A - Z

Mental Health Information

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 for changes that are out of character for the individual.

Delirium

Delirium is a state of mental confusion that can happen when someone becomes medically unwell. It is also known as an 'acute confusional state'. Medical problems, surgery and medications can all cause delirium. It often starts suddenly but usually lifts when the condition causing it gets better.

Possible causes

- Pain
- Constipation
- Change in environment
- Urinary retention
- Sensory deprivation
- Sleep deprivation
- Dehydration
- Infection
- Changes to medication
- Trauma.

Signs and symptoms of delirium

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

Risk factors for developing delirium

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

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
- Tell residents 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 visit and bring in familiar objects
- Low stimulus environment, limit noise and inappropriate television programmes and music
- Maintain good hydration.

Management

- Refer to the ICC for further advice and information
- Refer to own GP or community mental health teams
- Going into hospital tends to make delirium much worse.

Resources used by NHS bodies in Hartlepool, Stockon-on-Tees and Tees, Esk and Wear Valleys helps provide prompts to detect and manage delirium.

More information can be found on the NHS website Health A - Z

Dementia

The word 'dementia' describes a set of symptoms that may include problems with memory, thinking or reasoning, and 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, or disinhibition
- **Mood disturbance** – fluctuating moods, or depression
- **Psychotic symptoms** – delusions or hallucinations
- **Can occur in 50-80% of people with dementia.**

More information can be found on the NHS website Health A - Z

Dementia and Down's syndrome

People with Down's syndrome have a higher risk of developing dementia. A person with Down's syndrome may have similar symptoms as someone without Down's syndrome. However, there can be some differences around changes in behaviour and personality.

More information, guidance and support can be found here:

Dementia and Down's syndrome - Alzheimer's Society

How social care staff can support people with learning disabilities and dementia - Public Health England

For residents with learning disabilities, more information can be found on the LeDeR - 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
- 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 or 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 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 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.

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

- 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 teams.

More information can be found on the NHS website Health A - Z

ReSPECT plans, Palliative Care and End of Life Care

ReSPECT plans

What is a ReSPECT plan?

ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a personalised recommendation for clinical care in emergencies where the person is not able to make decisions or express their wishes for themselves.

Who is ReSPECT for?

This plan can be for anyone but will have increasing importance 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.

Who makes the recommendations?

The ReSPECT process is designed to support conversations between the person and their health professionals (and other people important to them) to understand their priorities of care. These priorities are used to develop an agreed plan that records what types of care or treatment may not be offered and what alternatives exist.

It is important to understand that the ReSPECT plan cannot be used to demand treatments that are not likely to be of benefit and would not be offered.

In an emergency where the person is not able to say what is important to them, clinical decisions will be made by health professionals trying to act in their best interests and for their benefit. In an emergency if the person has capacity and can participate in decisions, they should.

ReSPECT plans can only be completed by doctors or advanced clinical practitioners (ACPs). ACPs can include such staff as advanced nurse practitioners, matrons, clinical pharmacists and paramedics.

Why is this available?

In an emergency, health or care professionals may have to make rapid decisions about treatment, and the person may not be well enough to discuss what is important to them. This plan allows the person to guide those looking after them on what treatments they would or would not want to be considered for and to have recorded those treatments that could be important or those that would not work for them.

Many treatments that can be life-sustaining for some people carry a risk of causing harm, discomfort or loss of dignity. Many people choose not to accept that risk if the likelihood of benefit from treatment is small. The ReSPECT plan is to record preferences and agreed realistic recommendations for emergencies, whatever stage of life the person is at.

If the person lacks capacity to contribute to the ReSPECT process, this must take place with their legal proxy (if they have one) or otherwise with a close family member with capacity recorded appropriately for the decisions undertaken using the principles of the Mental Capacity Act (2005).

Paper versions of the form must be kept by or with the person and should be accessible immediately to any professional needing to make an immediate decision in a crisis. Although digital versions of plans may be used, a printed copy of the current plan must be kept in an accessible place with the person with whom it is written.

ReSPECT plans should not just be a form; the plan cannot and must not be filled in without involving the person or those important to them (with consent). Plans must not be part of a blanket approach to resuscitation and emergency care decisions. All conversations and decisions must be individual to the person involved. Any decisions must not be based on inappropriate generalisations such as 'learning disability'. Plans are not specifically a 'do not admit to hospital' order or 'do not attempt cardiopulmonary resuscitation' (DNACPR) order. DNACPR status and recommendations about ceilings of care may be included as part of the overall recommendations, but they also may not.

It is important that the people caring for the person understand ReSPECT plans, what they are for and how they are used. This will help them to identify people who may benefit from a ReSPECT plan, and who to speak to to get one made. Also, it will ensure they know what to do if an emergency arises and how a ReSPECT plan can help ensure that the person about whom the plan is written gets the best possible care.

Although care home staff may not be able complete a ReSPECT plan, it is likely that these staff will know residents better than the doctor or ACP completing the plan. Care staff may be able to help explain what the plan is for to the resident and their family (with consent). It is important that the people who know the person help the doctor or ACP completing the plan anticipate future problems.

Examples of this include if the person is prone to urine or chest infections, then the plan should include what to do in these situations. Other issues to anticipate are what to do if a person stops eating and drinking, what to if a person falls, if the person has a temperature or has problems toileting. If the person is for end of life care, it is important that this be documented clearly including what to do and who can be called to give advice in these circumstances.

It is very likely that staff from the care home or agency staff mat be looking after the person when the emergency arises, and it is important the ReSPECT plan be clear enough to help them make the right decisions.

If the person has a DNACPR form, this only applies to resuscitation, and it does not imply any further decisions about treatment. It may be that there is a ReSPECT document as well as other forms of documentation or a decision recorded elsewhere. If an existing DNACPR form remains valid and appropriate and no further recommendations are required, it can still be used.

If a ReSPECT plan is present then no assumptions should be made about what a ReSPECT plan may say, it should be read, and the recommendations made used to guide decisions in an emergency. A person with a ReSPECT plan may be for CPR and full active treatment, so please check. If there is any doubt seek advice from an appropriate clinician i.e. GP, ACP etc.

If you are told a patient has a ReSPECT plan, your immediate response should be "what does it say?"

Checking ReSPECT plans

It is in everyone's interests that ReSPECT forms are checked at every opportunity; this means that when you need it in an emergency it will be useful and useable. Checking a plan can be done by anyone who knows the person well. Please remember if there is a problem with the plan it will need to be reported to a suitable clinician for a formal review (see following section).

- Does the patient have a ReSPECT plan?
- Does the patient have a separate DNACPR form? If so, does the ReSPECT form indicate CPR not recommended? If not escalate to a doctor or ACP urgently
- Is the form at the front of the patient's record? It must be in a place where everyone knows where to find it quickly
- Are the demographics completed sufficiently to match the plan to the right person? (I.e. name, address, DoB, NHS number)
- Are plans dated and signed?
- Does the ReSPECT plan indicate CPR recommended or not recommended? This would indicate whether to attempt CPR in an emergency, a separate DNACPR form is not required
- Do the clinical recommendations on a ReSPECT plan fit the plan of care you're delivering? If you feel it does seek clinical advice, i.e. has the person's condition changed, making the plan out of date or are the recommendations not useful in the person's current circumstances, i.e. 'ward-based care' when they are in a care home
- Ask yourself the question, would the recommendations on the plan help the person receive the right care in an emergency?
- Does the person and/or family have any concerns or questions about the documents? If so, seek clinical advice
- Clinical advice should be sought from those who are closest to the person, whether that is a GP, ACP etc.

ReSPECT review

After checking a plan, it may indicate that the plan needs reviewing; this should only be done by a GP or ACP.

The recommendations on the plan should be reviewed formally, and confirmed or rewritten:

- If the person or those close to them requests this
- If the person's condition changes
- If the person moves from one care setting to another.

Consider carefully whether the person (or if they lack capacity, their representatives) should be involved – if in doubt, involve them.

The frequency of the review of ReSPECT recommendations is determined by each individual circumstance, e.g. frequent review in an acute illness but not in an advanced, irreversible terminal illness. As long as the plan remains valid, appropriate and useful it does not need to be rewritten and can be confirmed in box 9 on the plan. If a plan needs to be altered, it needs to be rewritten, not just amended. If in doubt clinical advice should be sought from those who are closest to the person, whether that is the GP, ACP etc.

Always consider: Is a ReSPECT plan valid, is it appropriate and useful?

Guidance on how to use a ReSPECT plan in an emergency

- Grab the plan and read it quickly
- Have you understood it?
- If you have been checking the plan regularly, you will already know the plan is valid, appropriate and useful, if you haven't then made sure it is both valid and appropriate
- Are the recommendations on the plan relevant to the situation you find yourself in?
- If they are, then use the recommendations to inform your decision on how to handle the situation
- If they aren't, then you will still need to decide based on the situation in which you find yourself in
- If in doubt, then act in what you feel is the right thing to do in the circumstances. This could be speaking to the contacts on the ReSPECT plan, seeking further advice, calling a doctor or a nurse, or an ambulance. If the plan was written based on the needs of the person in the first place, it is less likely you will find yourself in this position
- Whenever you see a ReSPECT plan ask yourself the question 'how helpful would this be in an emergency?' This will mean it is more likely you will be able to use it successfully when you need it. If in doubt, seek advice
- If the patient has died and the ReSPECT document supports the decision, i.e. CPR not recommended etc., it is not necessary to call 999. Follow your usual process for verification of death. The clinicians should be those close to the patient's care. If this is not possible, then it would be reasonable to request that the patient's GP verify the death.

Please remember that if you call 999 the call handler will instruct you to commence CPR regardless of the circumstances and regardless of the decision in place. If you feel CPR is the correct decision, then call WMAS.

ReSPECT for learning disabilities

For people with learning disabilities, more information on ReSPECT can be found:

- ReSPECT Guidance.pdf
- ReSPECT Worksheet.pdf
- Six Part Story Method.pdf
- Making a plan for your health and care if you become very ill - 6 principles for everyone
- LeDeR - End of Life Care.
- Resuscitation Council - ReSPECT for healthcare professionals

Deterioration at end of life and 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 bedbound 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.

Symptom control

Good palliative care is not just about supporting someone in the last months, days and hours of life, but about enhancing the quality of life for residents and those close to them at every stage of deterioration/ disease progression.

Palliative care focuses on the person, not the disease, and applies a holistic approach to meeting the physical, practical, functional, social, emotional and spiritual needs of care home residents and carers facing progressive illness and bereavement.

If unsure, discuss with senior colleagues and following discussion with the GP, if required, seek specialist palliative care advice via:

- **Palliative and End of Life Care Hospice Advice Line, 24-hour helpline: 0300 5612900**
- **Palliative Care Co-ordination Centre: 0300 123 0989 (Option 2) pccc@mpft.nhs.uk**

Anticipatory prescribing

Anticipatory prescribing enables prompt symptom relief at whatever time the care home resident develops distressing symptoms. Although each resident has individual needs, many acute events during the palliative period can be predicted, and management measures put in place.

Consider

- Is there a supply of medication in the care home, should the resident be unable to swallow the medication?
- Has the care home got the equipment needed to administer the medication?
- Ensure both are available to the registered nurse for use where appropriate.

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.

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 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.

It should also be explained 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.

- 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 a deceased person's personal possessions to their loved ones
- Staff supporting each other following the death of a resident, who has been cared for by the care home team.

Deteriorating Patient Escalation Pathway Contact List

Do you need advice or support for a **deteriorating** care home resident?

Escalating		Clinical		Need		
Social Care	**Mental Health**	**Palliative / Hospice Services**	**Community Nursing Teams**	**111**	**Crisis Rapid Response**	**999 - WMAS**
Stoke-on-Trent (Office hours): **0800 561 0015** (Out of hours and weekends): **01782 234234** **Website:** Adult care and wellbeing | Stoke-on-Trent **Staffordshire** (Office hours): **0300 111 8010** (Out of hours and weekends): **0345 604 2886** **Website:** Contact us - Staffordshire Cares - Staffordshire County Council	**South Staffordshire** **0800 561 0015** **North Staffordshire** **0800 032 8728** option **1** **Website:** Crisis mental health access via NHS 111 - Staffordshire and Stoke-on-Trent, Integrated Care Board	**24-hour helpline:** **0300 561 2900** **Palliative Care Coordination Centre (PCCC):** **0300 123 0989** option **2** **Website:** Palliative Care Co-Ordination Centre: Midlands Partnership University NHS Foundation Trust **Douglas Macmillan Hospice:** **01782 344300** **Website:** Dougie Mac | Hospice Services in Stoke & Staffordshire **Katharine House Hospice:** **01785 254645** **Website:** Katharine House Hospice - Free Care for Local People **St Giles:** **0300 330 9410** **Website:** St Giles Hospice | We're here for you, because you're here for us **Compton Care:** **0300 323 0250** **Website:** Compton Care | Care & Support for families living with life limiting conditions	**24 Hours** North Staffordshire and Stoke-on-Trent Local Access Point: **01782 831110** Cannock and Seisdon Local Access Point: **0300 123 9011** Burntwood, Lichfield and Tamworth Local Access Point: **0300 124 0347** Stafford Local Access Point: **0300 124 0343** Burton upon Trent: **0300 323 0930** **Community Learning Disabilities Team:** (North Staffordshire and Stoke-on-Trent) **0300 123 1152** (South Staffordshire) **01785 221576**	**24 Hours** NHS 111 can help if you have an urgent medical problem and you're not sure what to do. In emergency situations where there is an immediate risk to life, you should continue to contact 999 or go to A&E.	**The Integrated Care Coordination (ICC) for Urgent Care** and access to the **Community Rapid Intervention Service** (CRIS), 7 days a week, 8am – 8pm **0300 123 0983**	**24 Hours** 999 is for life-threatening emergencies like serious road traffic accidents, strokes and heart attacks.

Resources

Deteriorating Patient Escalation Pathway Contact List

Look, Think, Call Poster

Integrated Care Coordination (ICC) Poster

Deterioration Tools

- Stop and Watch – Early Warning Tool
- RESTORE2
- Situation, Background, Assessment, Recommendation, Decision communication (SBARD) - Is my resident unwell?
- Disability Distress Assessment Tool (DisDAT)
- **Keeping Well - A tool for supporters of people with learning disabilities who live in their own homes**
  Part 1 - Important Information
  Part 2 - What feels different today
  Part 3 - What to do next

Health conditions

- For more information on Health Conditions visit the NHS website: www.nhs.uk
- For more information on washing your hands, visit the NHS website: www.nhs.uk/live-well/best-way-to-wash-your-hands/
- MPFT Delirium Wheel

Falls

- For further information regarding the course content and how to access the training, please follow the link:
  Action Falls Train the Trainer Course
- We also have a free Action Falls Toolkit which is available to download here:
  arc-em.nihr.ac.uk/arc-store-resources/action-falls-toolkit-0
- Falls Prevention and Response Guide:
  Falls Prevention and Response Guide Care - Staffordshire County Council
- Falls Prevention Service: Midlands Partnership University NHS Foundation Trust
- Post Falls Guidance Pack for Care Providers

ReSPECT and end of life

- Resuscitation Council
- ReSPECT Guidance.pdf
- ReSPECT Worksheet.pdf
- Six Part Story Method.pdf
- Making a plan for your health and care if you become very ill - 6 principles for everyone
- Gold Standard Framework
- ReSPECT form

MiDoS for Care

- Information and resource are available, including access to MiDoS via:
  MiDoS For Care - Staffordshire County Council

Social Care Academy

- Social Care Academy for Staffordshire and Stoke-on-Trent - Training

Learning disabilities information and resources

- North Staffordshire Combined Healthcare NHS Trust Learning Disability Assessment and Treatment
- Learning Disabilities: Midlands Partnership University NHS Foundation Trust
- Health Passport - Staffordshire and Stoke-on-Trent, ICS
- Annual Health Checks - Staffordshire and Stoke-on-Trent, ICS
- Deteriorating Health - Learning Disability Matters

This resource bank may be of use to health and care professionals supporting people with a learning disability or people who are autistic with their health or care:

- LeDeR - Resource Bank
- Dementia and Down's syndrome | Alzheimer's Society
- How social care staff can support people with learning disabilities and dementia
- How social care staff can recognise and manage pain in people with learning disabilities
- Pain Rating Scale - Wong-Baker FACES Foundation

Staffordshire and Stoke-on-Trent Integrated Care System