Coventry and Warwickshire
Integrated Care System

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Care Home Information Pack

RECOGNISING AND RESPONDING TO DETERIORATION IN YOUR CARE HOME RESIDENTS

People at our heart

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Contents

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 is recognised early and responded too in a timely way. Within Coventry and Warwickshire we want to offer all care home residents and their carers 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. We have worked with the West Midlands Academic Heath Science Network (WMAHSN) team and health and social care partners to provide care homes with a set of tools and pathways to respond to deterioration and more importantly 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. To allow carers and families to recognise deterioration, we have agreed within our system to use a set of tools that any care home can adopt and use to recognise small changes up 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 the staff skilled around clinical management of care home residents, so the tools are designed to allow carers to recognise the changes but then seek the help and support they require.

The aim of the work is to allow for:

Preventing avoidable hospital admissions for residents through being treated within their own home where clinically safe.

Provide clear pathways for escalation when deterioration monitoring tools are utilised as a system approach – providing a level of consistent monitoring and accessibility of service provision for all care home residents across Coventry and Warwickshire.

Provide training and support to all care homes around recognition of deterioration of residents.

Provide clear aligned Coventry and Warwickshire pathways and agree tools to enhance the levels of monitoring, allowing care homes to seek support more rapidly to support their residents but more importantly provide enhanced resident care and management.

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 or behaviour or changes in mental state. They are the early indicators that someone may be becoming unwell
- 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'

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 resident has concerns

Urgent Community Response (UCR)

Urgent Community Response is the collective name for services that improve the quality and capacity of care for people through delivery of urgent, crisis response care within two-hours and/or reablement care responses within two-days.

The two-hour response is designed to reduce preventable hospital admissions through a multi-skilled team approach to people in their usual place of residence with an urgent care need (required within two hours) and involves an assessment and short-term intervention(s), typically lasting up to 48 hours.

Operating Hours

Referrals received:
08:00 to18:00 hours [seven days a week]
with clinical advice only 6pm-8pm

Clinical Hours:
08.00 to 20.00 hours [seven days a week]

Contact

Coventry: 0300 200 0011 (option 3)

Warwickshire: 01926 600818

Please note for care homes using My Resident is Unwell on Docobo, alerts are managed by these same teams in their respective areas.

For urgent end of life and catheter care ONLY there is an overnight service 18:00 to 08:00.

Contact

Coventry: 07836 50509

Warwickshire North: 07584557366
(Nuneaton and Bedworth, North Warwickshire boroughs)

Rugby borough: 07740803855

South Warwickshire: 07775 016618
(Stratford and Warwick Districts)

Referral Criteria

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

Referrers

- General Practitioners (GPs)
- Attending Paramedics (WMAS)
- 999 Clinical Triage
- 111 Clinical Triage
- Health and Social Care Professionals (e.g. district nurses, mental health professionals, allied health professionals and social workers etc)
- Care/Residential/ Nursing homes – based within Coventry and Warwickshire for residents registered with a Coventry or Warwickshire GP
- Housing with care providers

Exclusion Criteria

- Acute medical emergencies such a suspicion of Stroke/ Heart Attack/SEPSIS etc.
- Fall – with obvious bony injury
- Palliative/End of Life residents without an acute medical need
- Head injury – with loss of consciousness/ resident on anti-coagulation medication (such as Warfarin)
- Seizures
- Mental health needs including acute crisis
- Not registered with a Coventry or Warwickshire GP

Referral Criteria

- Acute infection (such as cellulitis, a urinary tract or chest infection etc.)
- Confusion / delirium
- Any loss of consciousness
- Fall with no obvious bony 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
- Urgent equipment needs
- Acute Frailty Acute Palliative Status

Referral pathway

Initial contact to UCR will be via our Integrated Single Point of Access [ISPA] triage service where a multi-disciplinary team of experienced clinicians will complete a comprehensive triage with the referrer to ensure patients meet the service criteria and arrange an appropriate and timely response.

The referral must meet the UCR inclusion criteria. If it is outside the criteria, then UCR triage will signpost the referrer to the most appropriate/alternative service.

Information needed for a good referral to our service

- 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 **DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)**, 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 – examples can be found in Appendix B
- 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

What the care homes can expect from Urgent Community Response (UCR)

- An open and honest assessment approach from our visiting clinicians
- Clinicians will be compassionate and caring in their attitude and 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 with Care Homes and offer advice to carers and nurses as required
- We are committed to assisting your homes in the prevention of unnecessary admissions to hospital especially

What the Urgent Community Response service expects from care homes

- In the event that care homes need advice and support about a resident of concern we expect that care homes will refer to the service guides in Appendix A to ensure that the referral is escalated to the most appropriate service
- We expect that on referral to the Urgent Community Response service the care homes will be able to inform the service if the resident has been reviewed by their own doctor
- We expect that in the scenario that a resident has been deteriorating and has had multiple hospital admissions that the care home should have open discussions with the resident/family and Doctors re: 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 clinicians visit, the carers will have the care home resident's care plan, medication record sheet, 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 is able to collect the prescription. Your resident will need to commence on medication promptly in order 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 you will inform the visiting Clinician and they can then prescribe individually for that resident
- We expect that carers will closely observe residents for signs of deterioration (early soft signs of deterioration as shown in your deterioration tool)
- We expect that carers will contact the Urgent Community Response service / 111 / 999 as instructed by the visiting clinician
- We expect that care homes will be open and honest about the level of care they can provide and any limitations of the care they can provide to residents in order that your residents will receive the most appropriate care in the most appropriate place. Please inform clinicians if you think you are not able to maintain your resident in the home whilst receiving treatment

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 its success.
- Residents are at risk of acquiring (catching) other hospital acquired infections (urine infections, chest infections, gastroenteritis (diarrhoea and vomiting/ norovirus/c-diff)) 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, as long as your resident is able to take nutrition orally.

Ultimately it is thought 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 an over 80 person.

Frailty

In medical terms 'Frailty' is defined as a multidimensional condition that is considered to be 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.

The Rockwood Frailty Scale

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 Well - 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 Vulnerable - While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up" and/or being tired during the day.

5 Mildly Frail - 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 Moderately Frail - 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 (cuing, standby) with dressing.

7 Severely Frail - 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 Very Severely Frail - 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.

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

Chest infections

Possible causes

- Bacteria or viral infection
- Coughing and Sneezing spread the illness
- Potential aspiration of food / fluid due to poor swallow function and/or environmental factors, behaviour and cognition
- 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
- Individuals with profound and multiple learning disability (PMLD)

Signs and symptoms of a Chest infection

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

Management of residents with Chest infection

- Give medication as prescribed (may be given antibiotics)
- Assist good posture as sitting upright can help the resident to bring up secretions, especially when eating and drinking
- Encourage deep breathing
- Observe any sputum production for any changes in colour and consistency
- Encourage fluids
- Infection control management use of tissues to Catch it Bin it Kill it and good hand washing for residents/staff/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/ relatives
- Providing of clean tissues and receiver for disposal
- Early recognition of residents with any swallowing problems, for example coughing or throat clearing when eating and drinking. Adhere to and/or seek advice from the Speech and Language Therapy (SALT) Team.
- Support to quit smoking

More information on chest infection 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 persons 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.

Signs and symptoms of Flu (any of these symptoms may be present):

- 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 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. noro virus) actions as appropriate of results

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, gloves/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 tissues when sneezing or coughing
- Attempt to develop a "use it and bin it" policy for tissues
- Report an outbreak as per the Health Protection Agencies / Your Care Home Policies

Care of your resident with Flu:

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

Complications of Flu:

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

When to call Urgent Community Response (and 111 after 8PM and until 8AM)

- 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 or any **FAST** positive signs (signs of a stroke)

More information on FAST positive signs can be found here: Symptoms of stroke | Know the FAST test | Stroke Association

Finally a word on prevention:

Annual flu jab (not 100% effective as there are different strains of flu, however offers some protection to your residents).

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

Urinary Tract Infection (UTI's)

Possible causes of UTIs

- 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 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

Management of residents with UTI's

- 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
- Wash genitals every day

NOTE: If a urine sample is needed for a resident with incontinence pads, specific urine collection packs are available to facilitate this.

Do NOT dipstick urine in ANY patient over the age of 65yrs

Signs and symptoms of UTIs

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

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
- Care home residents with kidney stones or a catheter.
- Over 65 years old

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

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 UTI's 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.

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

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.

Prevention of UTI's in residents with catheters

- Always check position of catheter
- Keep catheter tubing clean
- Maintain drainage system
- Change leg bags weekly and use disposable night bags

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

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 it affects people of all ages, however it is more common in individuals with learning disabilities. 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

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

More information on DisDat can be found here: St Oswald's Hospice | Distress and Discomfort Assessment Tool (DisDAT) (stoswaldsuk.org)

St Oswald's Hospice

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 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)

Signs and symptoms of a Gastroenteritis

- Repeated watery diarrhoea
- Vomiting
- Feeling sick
- Loss of appetite
- Cramp like 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 (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
- Residents may need oral rehydration solutions to replace salt, glucose and other important minerals via prescription from Nurse or GP
- If tolerated try 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

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.

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

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

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.

Signs and symptoms of mild dehydration can include:

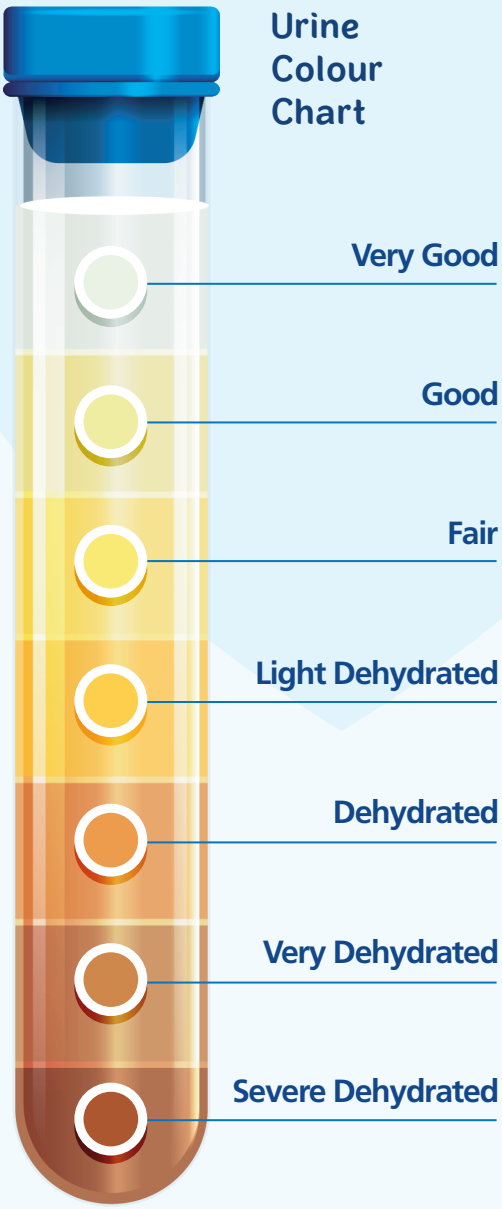
- Thirst or a dry mouth
- Dark-coloured urine
- Dizziness and light headedness, particularly after standing up, which does not go away after a few seconds
- Feeling sick
- Lack of energy (lethargy)
- Headaches

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 as previously stated can be used to replenish salts and fluid
- Maintain a fluid input and output chart. If resident uses pads describe the weight of filled pad ie: is pad as wet/heavy as normal?
- Observe 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 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

Thorough fluid balance saves lives

- 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!

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

Cellulitis (red skin)

Cellulitis (sel-u-LIE-tis) 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 (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

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

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

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

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

Coventry and Warwickshire
Care Home Information 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 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, 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

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

Management

- Refer to the Urgent Community Response team for further advice and information
- Going into hospital tends to make delirium much worse

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

www.yhscn.nhs.uk/about/index

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

Coventry and Warwickshire
Care Home Information Pack

Palliative Care & End of Life Care

Palliative Care & End of Life Care

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. These are likely to involve a number of conversations over time and with whoever the person wishes to involve.

When advance care planning is done well, people feel they have had the opportunity to plan for their future care. They feel more confident that their care and treatment will be focused on what matters most to them if, at a future point, they are unable to fully participate in decision making.

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

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

Links to Palliative Care Resources

WEST MIDLANDS PALLIATIVE CARE

West Midlands Palliative Care

www.westmidspallcare.co.uk

Marie Curie
Care and support through terminal illness

Palliative Care Knowledge Zone

www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone

skillsforcare

Skills for Care

www.skillsforcare.org.uk/Developing-your-workforce/Care-topics/End-of-life-care/End-of-life-care.aspx

ReSPECT plan

ReSPECT stands for
Recommended Summary Plan for Emergency Care and Treatment.

ReSPECT records overall emergency treatment plans, including whether CPR is recommended or not. Version 3 was introduced in 2020. 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.

These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment.

Care home resident preferences and clinical recommendations are recorded on a non-legally binding form which can be reviewed and adapted if circumstances change.

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 Resources

Resuscitation Council UK

Resuscitation Council

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

ReSPECT

Education Resource

https://learning.respectprocess.org.uk

Gold Standard Framework

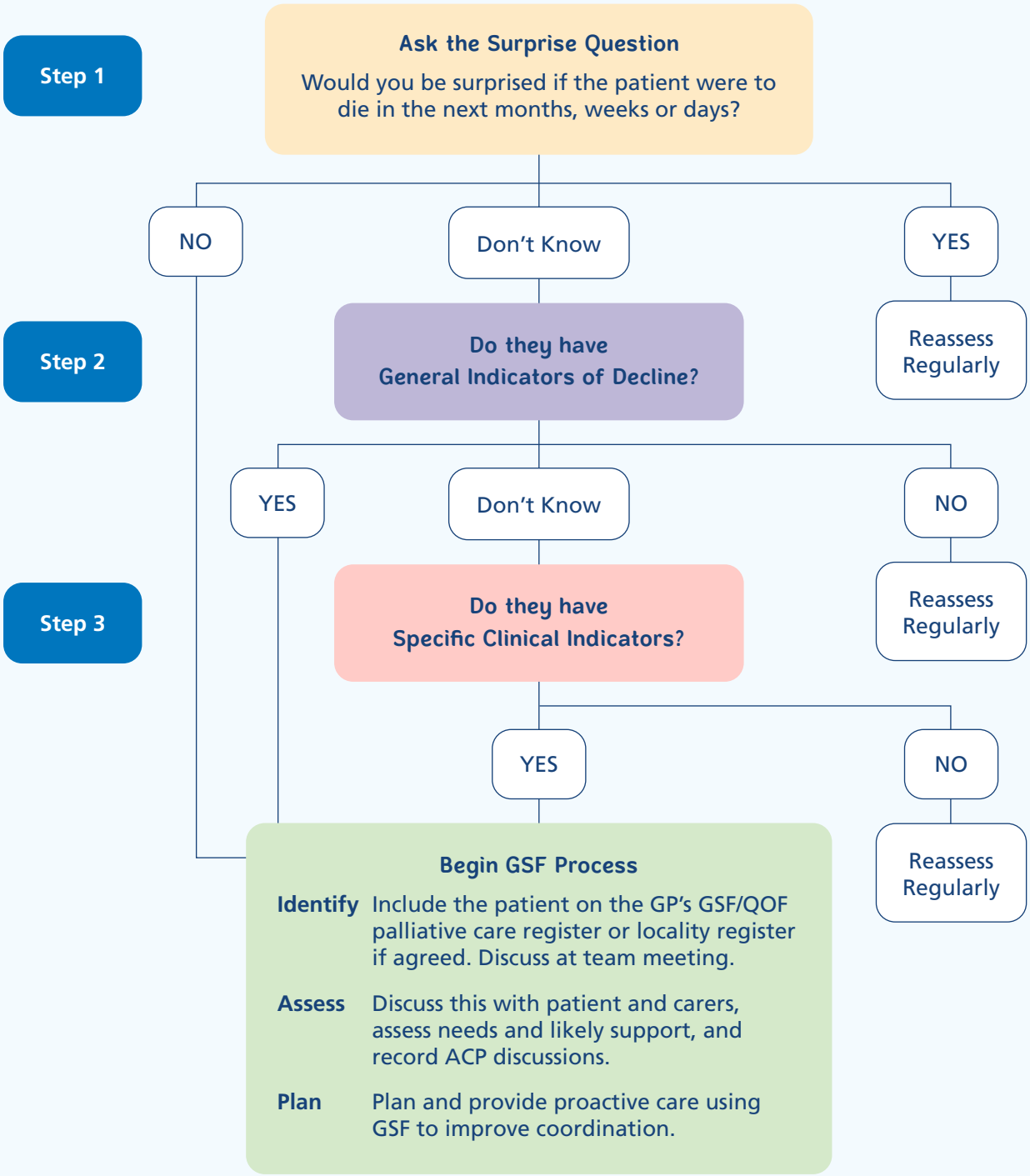
The GSF centres guidance to support early identification of care home residents nearing the end of life leading to improved proactive resident centred care.

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

the gold standards framework


Step 1
Ask the Surprise Question
Would you be surprised if the patient were to die in the next months, weeks or days?
NO
Don't Know
YES
Reassess Regularly
Step 2
Do they have General Indicators of Decline?
YES
Don't Know
NO
Reassess Regularly
Step 3
Do they have Specific Clinical Indicators?
YES
NO
Reassess Regularly
Begin GSF Process
Identify Include the patient on the GP's GSF/QOF palliative care register or locality register if agreed. Discuss at team meeting.
Assess Discuss this with patient and carers, assess needs and likely support, and record ACP discussions.
Plan Plan and provide proactive care using GSF to improve coordination.


A (Blue)
'All'
Stable from diagnosis
Year plus prognosis
B (Green)
'Benefits' - DS1500
Unstable/advanced disease
Months prognosis
C (Yellow)
'Continuing Care'
Deteriorating
Weeks prognosis
D (Red)
'Days'
Final days/terminal care
Days prognosis
Navy
'After Care'

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

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

Coventry: 07771 564 474

Warwickshire: 01926 600818

Further information can be found at:

Palliative Care Knowledge Zone (mariecurie.org.uk)

Marie Curie
Care and support through terminal illness

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

Resources to support the identification of palliative care emergencies:

Recognising Emergencies

www.mariecurie.org.uk

REDMAP

A 6-step guide to future care planning conversations with people whose health is deteriorating, and their families.

www.spict.org.uk/red-map

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 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.

- 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
- Staff supporting each other following the death of a resident, who has been cared for by the care home team

Marie Curie
Care and support through terminal illness

Marie Curie Knowledge Zone resources

www.bit.ly/MarieCurie-CareAfterDeath

Bereavement Support

Bereavement Advice Centre | Free Helpline | Freephone 0800 634 9494

Several local hospices also offer bereavement support.

Please see the service guide in Appendix A for contact details.

Coventry - Page 34 & Warwickshire - Page 36.

Coventry and Warwickshire
Care Home Information Pack

Contact Numbers & Information

Appendix A:
Service Guides - Coventry (1 of 2)

Social Care

During office hours

02476 833003

Out-of-office hours an emergency duty social worker is available from 5.30pm Monday to Thursday and from 5pm on Friday until 8.30am

02476 832222

Mental Health

24/7 365 Days/Year

Mental Health Access Hubs

08081 966798

FOR ADVICE ONLY

Mental Health Duty Worker

02476 707968

Email: IPU18-21.DutyCallsCoventry @covwarkpt.nhs.uk

Palliative / Hospice Services

Monday to Friday, Weekends and Bank Holidays
A patient referral to the team can be made by any health or social care professional

Palliative Care - CWPT Service

02476 237001

CWPT Family Support

02476 237056

Myton Hospice Care Home Support Line

02476 936786

Community Nursing Teams

8am to 8pm

Contact your local team via the integrated single point of access (ISPA)

0300 200 0011

Services offered by this team include:

- Palliative End of Life Care and support
- Continence support and advice
- Wound care
- Leg Ulcer
- Hospital admission avoidance
- Facilitating discharge planning
- Administering medication to those in need of support or assistance
- Management of complex long term conditions
- IV therapy

Appendix A:
Service Guides - Coventry (2 of 2)

GP

Contact your GP on your enhanced care home team for telephone advice, surgery appointments or home visits.

- Management of Long Term Conditions
- General Medical Conditions
- Treatment of Medical needs
- Ongoing medical or psychiatric needs
- New palliative patients

Call 111 after 20.00hrs, on Weekends and Bank Holidays for out of hours GP support and access to out of hours GP services.

111

24 Hours

If you need medical help or support which is **NOT A 999** emergency which may include:

- Resident not appearing to be usual self
- Breathing problems
- Worsening confusion
- Signs of infection
- Falls with no sign of broken bones

Also call 111 for advice if:

- You think your resident needs to go to A&E
- You don't know who to call
- You need health information and reassurance of what to do next

Urgent Community Response

If you need a 2 hour clinical response for acutely unwell residents who require rapid intervention to avoid hospital attendance.

- Signs of infection
- Reduced eating and drinking that day
- Resident does not appear their usual self that day

Single Point of Access (ISPA)

0300 200 0011

For Urgent Care Response select option 3

OR

Use My Resident is Unwell on Docobo to generate an alert to the team

7 Days a Week 8am to 8pm

Note: For Crisis End Of Life and Catheter Care ONLY calls can be made overnight 8pm to 8am

999 - WMAS

24 Hours

Call 999 in a medical or life threatening emergency such as:

- Loss of consciousness
- Severe chest pain or suspected heart attack
- Choking
- Fits
- Severe breathing problems
- Severe loss of blood
- Serious accident
- Suspected or obvious broken bones
- Severe burns or scalds
- Stroke
- Serious head injury
- Diabetic emergency

Appendix A:
Service Guides – Warwickshire (1 of 2)

Social Care

During office hours

01926 410410

Out-of-office hours an emergency duty social worker is available from 5.30pm Monday to Thursday and from 5pm on Friday until 8.30am

01926 886922

Palliative / Hospice Services

7 days a week 8am to 8pm
Contact your local specialist palliative care team. A patient referral to the team can be made by any health or social care professional

01926 600818

8.30am - 4.30pm
Mary Ann Evans Hospice at home

07740 803744

Myton Hospice

01926 492518

Shakespeare Hospice

01789 266852

Shipston Home nursing

01608 664850

Monday to Friday
SALT Rapid Response Community Dysphagia Service

01926 495321 Ext 3624

- Severe / complex swallowing difficulties
- Oral feeding difficulties

Mental Health

24/7 365 Days/Year
Mental Health Access Hubs

08081 966798

FOR ADVICE ONLY
Mental Health Duty Worker

South Warwickshire:

0300 3034017 **(Stratford area)**

01926 450660 **(Warwick Leamington area)**

Email 18-21dutycallssouthwarwickshire@covwarkpt.nhs.uk

North Warwickshire and Rugby:

EMAIL ONLY RugbyDuty@covwarkpt.nhs.uk

Community Nursing Teams

7 days a week 8am to 8pm
Contact your local team

01926 600818

Services offered by this team include:

- Palliative End of Life Care and support
- Continence support and advice
- Wound care
- Leg Ulcer
- Hospital admission avoidance
- Facilitating discharge planning
- Administering medication to those in need of support or assistance
- Management of complex long term conditions
- IV therapy

Appendix A:
Service Guides – Warwickshire (2 of 2)

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If you need a 2 hour clinical response for acutely unwell residents who require rapid intervention to avoid hospital attendance.

- Signs of infection
- Reduced eating and drinking that day
- Resident does not appear their usual self that day

Single Point of Access (ISPA)

01926 600818

7 Days a Week 8am to 8pm

OR

Use My Resident is Unwell on Docobo to generate an alert to the team

For Crisis End Of Life and Catheter Care ONLY

8pm to 8am

Overnight Rapid Response Service

North: 07584 557366

Rugby: 07740 803855

South: 07775 016618

111

24 Hours

If you need medical help or support which is **NOT A 999** emergency which may include:

- Resident not appearing to be usual self
- Breathing problems
- Worsening confusion
- Signs of infection
- Falls with no sign of broken bones

Also call 111 for advice if:

- You think your resident needs to go to A&E
- You don't know who to call
- You need health information and reassurance of what to do next

999 – WMAS

24 Hours

Call 999 in a medical or life threatening emergency such as:

- Loss of consciousness
- Severe chest pain or suspected heart attack
- Choking
- Fits
- Severe breathing problems
- Severe loss of blood
- Serious accident
- Suspected or obvious broken bones
- Severe burns or scalds
- Stroke
- Serious head injury
- Diabetic emergency

Appendix B: Deterioration tools

The tools listed below are used across health and social care to help understand and communicate signs of deterioration. It is recommended that only ONE deterioration tool is used within a care home for consistency and to avoid confusion.

Restore 2 (including NEWS2) & Restore 2 mini

RESTORE2™ Recognise Early Soft Signs, Take Observations, Respond, Escalate

RESTORE2™ mini Recognise Early Soft Signs, Take Observations, Respond, Escalate

www.hantsiowhealthandcare.org.uk/your-health/schemes-and-projects/restore2

Is my resident unwell?

Academic Health Science Network
North East and North Cumbria

www.bit.ly/ahsn-is-my-resident-unwell

Stop and Watch

Stop and Watch
Early Warning Tool

INTERACT® Version 3.0 Tool

www.in.gov/health/files/INTERACT_Stop_and_Watch_Early_Warning_Tool.pdf

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Keeping Well tool for supporters of people with LD

Part One

www.bit.ly/keeping-well-part1

Part Two

www.bit.ly/keeping-well-part2

Part Three

www.bit.ly/keeping-well-part3

Coventry and Warwickshire

Care Home Information Pack

RECOGNISING AND RESPONDING TO DETERIORATION IN YOUR CARE HOME RESIDENTS

Coventry and Warwickshire
Integrated Care System

west midlands
ACADEMIC HEALTH SCIENCE NETWORK

People at
our heart