



**Herefordshire  
and Worcestershire**  
Integrated Care System

**NHS**

**Herefordshire and  
Worcestershire**



# Managing Deterioration

Preventing, Recognising and Responding  
to Deterioration in your Care Setting

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# Deterioration Pack Tools

Please use pages 3-8 of this document when escalating a deteriorating patient.



# Care Home Escalation

The following flowchart is to support care home staff identify the best route to facilitate person-centered care for their residents when they deteriorate.

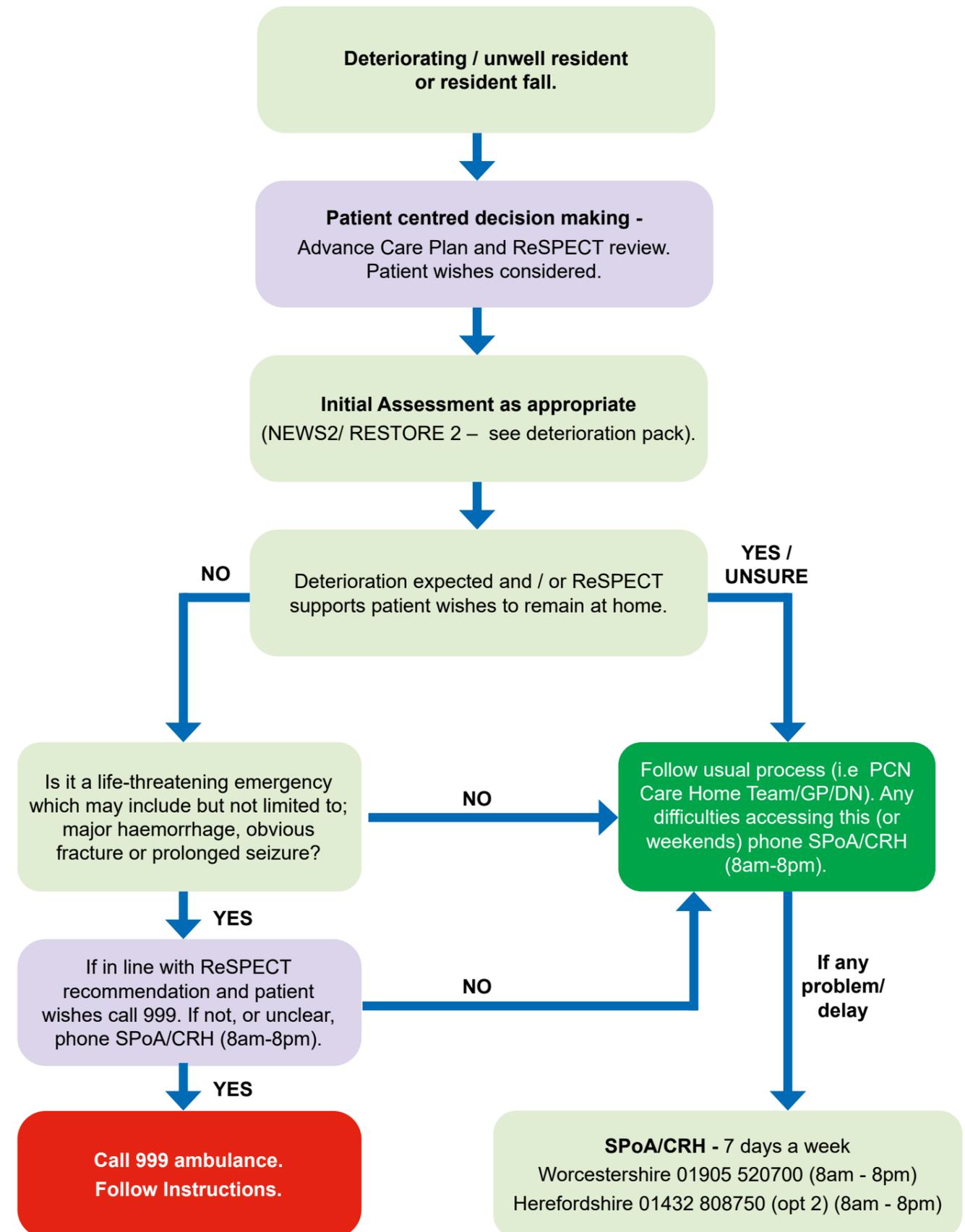
Please follow your usual process (i.e. PCN Care Home Team/GP/DN) where appropriate. The Single Point of Access (SPoA) / Community Referral Hub (CRH) can provide urgent advice and support when you cannot get support from your care home team. Emergency end of life care needs can be supported via your usual process e.g. PCN care home team, GP, DN Teams etc. Please consider the ReSPECT documentation in all decisions.

Please do not delay calling 999 when it is a life-threatening emergency and in line with ReSPECT recommendation and patient wishes. The SPoA/CRH offers rapid support as an alternative to calling 111 or 999 when care home team unable to support/support rapidly if needed.

If it is an expected deterioration and resident potentially requiring end of life care, please follow the wishes noted on the ReSPECT form/care plan where possible and liaise with your care home

In Hours 8am - 8pm:	Out of Hours 8pm – 8am (when care home team or SPoA/CRH unavailable)	Checklist:
<p><b>Usual Care Home Support (local times may vary):</b> Insert local number:</p> <p>_____</p> <p>_____</p> <p><b>Single Point of Access (SPoA) Worcestershire (8am - 8pm):</b> 01905 520700</p> <p><b>Community Referral Hub Herefordshire (CRH)</b> 01432 808750 (opt 2)</p>	<p><b>Nursing Home Residents:</b></p> <ul style="list-style-type: none"> <li>Herefordshire: 111</li> <li>Worcestershire: OOH GP 0330 123 0942 or 111</li> </ul> <p><b>Residential Home Residents:</b></p> <ul style="list-style-type: none"> <li>Herefordshire: 111 unless it is a nursing need and your patient is known to community nursing service 01432 808750 (opt 4)</li> <li>Worcestershire: Urgent Community Response (UCR) 01905 520700 or 111</li> </ul>	<ul style="list-style-type: none"> <li>Review ReSPECT and have to hand</li> <li>Use SBARD tool on page 6 to support communication</li> <li>Family communication</li> <li>Care Plan Updated</li> </ul>

# Care Home Escalation

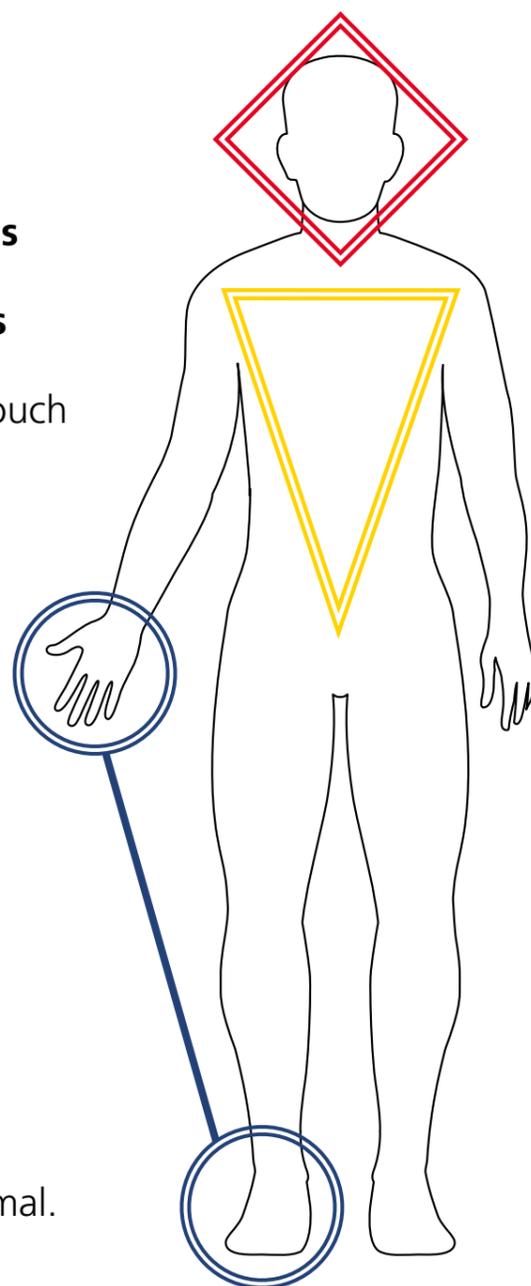


Ask your resident – how are you today?

Does your resident show any of the following 'soft signs' of deterioration?

- = Increasing **breathlessness** or **chestiness**
- = Change in **usual drinking / diet habits**
- = A **shivery fever** – feel **hot or cold** to touch
- = Reduced mobility – '**off legs**' / less co-ordinated
- = New or increased confusion/ agitation / anxiety / pain
- = Changes to usual level of **alertness / consciousness / sleeping** more or less
- = '**Can't pee**' or '**no pee**', change in pee appearance
- = **Diarrhoea, vomiting, dehydration**

Any **concerns** from the resident / family or carers that the person is not as well as normal.



**If YES to one or more of these triggers – take action!**

Get your message across

**Raise the Alert** within your home e.g. to a senior carer, registered nurse or manager.

If possible, **record the observations** using a **NEWS2** based system.

**Report your concerns** to a health care professional e.g. Nurse/GP/GP HUB/111/999 **using the SBARD Structured Communication Tool.**

- S** **Situation** e.g. what's happened? How are they? NEWS2 score if available
- B** **Background** e.g. what is their normal, how have they changed?
- A** **Assessment** e.g. what have you observed / done?
- R** **Recommendation** 'I need you to...'
- D** **Decision** what have you agreed? (including any Treatment Escalation Plan & further observations)

Key prompts / decisions

**Don't ignore your 'gut feeling' about what you know and see. Give any immediate care to keep the person safe and comfortable.**

Full Name:  NHS No.

		Date					
		Time					
<b>A+B</b> <b>Respirations</b> Breaths/min 	≥25					3	
	21-24					2	
	18-20						
	15-17						
	12-14					1	
	9-11					3	
≤8							
<b>A+B</b> <b>SpO<sub>2</sub> Scale 1</b> Oxygen saturation (%) 	≥96					1	
	94-95					2	
	92-93					3	
	≤91						
<b>SpO<sub>2</sub> Scale 2'</b> Oxygen saturation (%) Use Scale 2 if target range is 88-92%, e.g. in hypercapnic respiratory failure *ONLY use Scale2 under the direction of a qualified clinician	≥97 on O <sub>2</sub>					3	
	95-96 on O <sub>2</sub>					2	
	93-94 on O <sub>2</sub>					1	
	≥93 on air						
	88-92					1	
	86-87					2	
84-85					3		
≤83%							
<b>Air or Oxygen?</b>	A = Air						
	O <sub>2</sub> L/min					2	
<b>C</b> <b>Blood pressure</b> mmHg Score uses systolic BP only 	≥220					3	
	201-219						
	181-200						
	161-180						
	141-160						
	121-140						
	111-120					1	
	101-110					2	
	91-100						
	81-90					3	
	71-80						
61-70							
51-60							
≤50							
<b>C</b> <b>Pulse</b> Beats/min 	≥131					3	
	121-130					2	
	111-120						
	101-110					1	
	91-100						
	81-90						
	71-80						
61-70							
51-60							
41-50					1		
31-40					3		
≤30							
<b>D</b> <b>Consciousness</b> Score for NEW onset of confusion (no score if chronic)	Alert						
	Confusion					3	
	V						
	P						
U							
<b>E</b> <b>Temperature</b> °C 	≥39.1					2	
	38.1-39.0°					1	
	37.1-38.0°						
	36.1-37.0°						
	35.1-36.0°					1	
≤35.0°					3		
<b>NEWS TOTAL</b>							
Next observation due (Mins/Hrs)							
Escalation of care Y/N							
Initials							

Take observation + calculate NEWS

Authorising clinician  
Signature & Date

ACVPU KEY

**A**  
Alert  
awake & responding, eyes open

**C**  
Confusion  
New onset of confusion (Do not score if chronic)

**V**  
Verbal  
moves eyes / limbs or makes sounds to voice

**P**  
Pain  
responds only to painful stimuli

**U**  
Unresponsive  
unconscious

Photocopy this page if admitting/transferring resident or upload to ambulance EPR

Page 3 of 6 - All pages must be present when printing

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

# Managing Deterioration



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

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

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

P

**PREVENTION:** interventions reducing the risk of deterioration. What do you do to prevent deterioration?

I

**IDENTIFICATION:** the early recognition of physical deterioration through the reliable monitoring, identification and assessment of all patients' – RESTORE2 is the tool of choice in Herefordshire and Worcestershire. Do you use a managing deterioration tool? Do you assess soft signs with your residents? Do you use NEWS2?

E

**ESCALATION:** using standardised protocols and the reliable escalation and communication of deterioration using a 'common language' recognised across the NHS and Social Care. Do you find the escalation table within RESTORE useful? Do you feel empowered by this information? What about SBARD?

R

**RESPONSE:** the timely response and review by appropriately senior clinicians and reliable activation of clinical interventions including acute or end-of-life treatment appropriate to the patient and setting. How do you communicate the 'decision' about what the response should be? What does this look like practically? Digital record, paper records...

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

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



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

Ask your resident – how are you today?

Does your resident show any of the following 'soft signs' of deterioration?

- Increasing **breathlessness** or chestiness
- Change in **usual drinking / diet habits**
- A **shivery fever** – feel hot or cold to touch
- Reduced mobility – 'off legs' / less co-ordinated
- New or increased confusion / agitation / anxiety / pain
- Changes to usual level of **alertness / consciousness / sleeping** more or less
- 'Can't pee' or 'no pee', change in pee appearance
- **Diarrhoea, vomiting, dehydration**

Any **concerns** from the resident / family or carers that the person is not as well as normal.

If YES to one or more of these triggers – take action!

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

## What are 'Soft Signs' of Deterioration?

Soft signs are early indicators that the person you support might be becoming unwell. This could be anything such as a change in physical presentation or behaviour or changes in mental state.

Sometimes it can be obvious that someone is unwell, but at other times it might be much harder to spot.

Often families and friends will pick up on the subtle changes in a resident's behaviour, manner or appearance. These concerns should always be taken seriously, even if you think the person is fine.

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

## Examples of 'Soft Signs'

Changes in physical presentations Soft Signs can be related to many things including:

### Changes in Physical Presentation

- Changes in behaviour or ability
- Changes in mental state
- 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'

### Changes in Mental State

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

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

# Step Two: Using NEWS2 to Collect and Record Observations

## Step Two: Using NEWS2 to Collect and Record Observations

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

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

Full Name:  NHS No.

Date	Time	Score	Observations
<b>A+B Respirations</b> (Breaths/min)			
	≥25	3	
	21-24	2	
	18-20	1	
	15-17	1	
	12-14	1	
	9-11	1	
	≤8	3	
<b>A+B SpO<sub>2</sub> Scale 1</b> (Oxygen saturation %)			
	≥96	1	
	94-95	1	
	92-93	2	
	≤91	3	
<b>SpO<sub>2</sub> Scale 2</b> (Oxygen saturation %)			
	≥97 on O <sub>2</sub>	3	
	95-96 on O <sub>2</sub>	2	
	93-94 on O <sub>2</sub>	2	
	≥93 on air	1	
	88-92	1	
	86-87	1	
	84-85	2	
	≤83	3	
<b>Air or Oxygen?</b>			
	A = Air	2	
	O <sub>2</sub> L/min	2	
	≥220	3	
	201-219	3	
	181-200	3	
	161-180	3	
	141-160	3	
	121-140	3	
	111-120	1	
	101-110	2	
	91-100	2	
	81-90	2	
	71-80	3	
	61-70	3	
	51-60	3	
	≤50	3	
<b>C Blood pressure</b> (mmHg)			
	≥220	3	
	201-219	3	
	181-200	3	
	161-180	3	
	141-160	3	
	121-140	3	
	111-120	1	
	101-110	2	
	91-100	2	
	81-90	2	
	71-80	3	
	61-70	3	
	51-60	3	
	≤50	3	
<b>C Pulse</b> (Beats/min)			
	≥131	3	
	121-130	2	
	111-120	2	
	101-110	1	
	91-100	1	
	81-90	1	
	71-80	1	
	61-70	1	
	51-60	1	
	41-50	1	
	31-40	3	
	≤30	3	
<b>D Consciousness</b>			
	Alert	3	
	Confusion	3	
	V	3	
	P	3	
	U	3	
<b>E Temperature</b> (°C)			
	≥39.1	2	
	38.1-39.0°	1	
	37.1-38.0°	1	
	36.1-37.0°	1	
	35.1-36.0°	1	
	≤35.0°	3	
<b>NEWS TOTAL</b>			
	Next observation due (Mins/Hrs)		
	Escalation of care Y/N		
	Initials		

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Please refer to resource 2

# Step Three: Understanding Who to Contact and When

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

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

# What Support Can Be Accessed Through SPoA/CRH

## What Makes a Good Referral?

### Information Needed for a Good Referral into SPoA/CRH:

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

# What Support Can Be Accessed Through SPoA/CRH

## SPoA/CRH can access a variety of services including:

### Advice and Guidance

A variety of clinicians are available within the SPoA/CRH to give advice, guidance or refer onto another pathway.

They can support patient centred decision making for complex patients, including those approaching end of life.

They may be able to offer prescriptions, including emergency end of life medications.

### Virtual Ward

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

The virtual ward is a multi disciplinary team. The team includes doctors, nurses, physios, occupational therapists and support staff.

### Same Day Emergency Care (SDEC)

Patients can be referred to speciality services directly, avoiding the emergency department.

### Urgent Community Response (UCR)

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

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

## When it's an Emergency

### MEDICAL EMERGENCIES

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

Such situations include:

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

- Pain or discomfort in chest
- Lightheadedness, nausea, or vomiting
- Jaw, neck, or back pain
- Discomfort or pain in arms or shoulder
- Shortness of breath
- Sweating and clamminess, grey colour

#### 2. Where the individual is displaying signs consistent with having a stroke:

The poster features a yellow background with the NHS logo at the top right. On the left, there are four horizontal panels, each with a close-up image of a person's face and a question: 'FACE: Has their face fallen on one side? Can they smile?', 'ARMS: Can they raise both arms and keep them there?', 'SPEECH: Is their speech slurred?', and 'TIME: To call 999 If you see any single one of these signs'. A hand is shown holding a smartphone with '999' on the screen. On the right side, the text reads 'WHEN STROKE STRIKES, Act F.A.S.T.' and 'Act F.A.S.T. help us help you'.

#### 3. Prolonged seizure where the patient does not have a care plan in place to manage it or their breathing is compromised.

#### 4. Where the resident has sustained a significant injury - e.g. fracture, head injury.

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

### Potential Harm to your Resident from an Unnecessary Hospital Admission:

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

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

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

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



# Keeping Residents Well



## What is Frailty?

**Frailty is a condition of increased vulnerability to health stressors due to the gradual loss of physiological reserves and leads to a higher risk of adverse outcomes such as falls, delirium, and hospitalisation.**

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

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

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.

Patients with severe dementia may need help with all personal care needs.



## Why is Keeping Active So Important?

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

### Small Changes Can Make Big Differences

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

Moving – standing up from their chair several times a day, moving in bed, brushing their teeth and washing their face at the sink

Meaningful activities – walking about for any reason - including for people with dementia - can be meaningful and beneficial even if the purpose isn't always obvious

For more information on supporting a person with dementia who likes to walk, please visit [www.alzheimers.org.uk/about-dementia/stages-and-symptoms/dementia-symptoms/dementia-walking-about](http://www.alzheimers.org.uk/about-dementia/stages-and-symptoms/dementia-symptoms/dementia-walking-about)

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

## Planning Activities Within the Home

Activities are important to keep physically and mentally well.

People's daily activities should be meaningful and support people to have optimal health and wellbeing. People should be asked 'what's important to you?' For example, a retired chef may wish to be supported to complete some form of meal prep if they wish, a hairdresser may wish to have a role in a care home salon.

Thinking how you can adapt the task most so a person can be supported to have an active role in their daily activities and things that are important and enjoyable to them.



The World Health Organisation defines a fall as: “an unexpected event in which the participant comes to rest on the ground, floor, or lower level”. Falls and the consequences of falls can significantly impact a person’s wellbeing, mobility and confidence. Older people living in care homes are three times more likely to fall than older people living in their own homes, with the results of these falls often being more serious. The risk of falling can never be completely removed, but by being able to identify risk factors action can be taken to remove or reduce risk where possible.

## The Most Common Falls Risks:

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

**Are these factors affecting any of your residents’ falls risk?**

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

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



### REACT TO FALLS

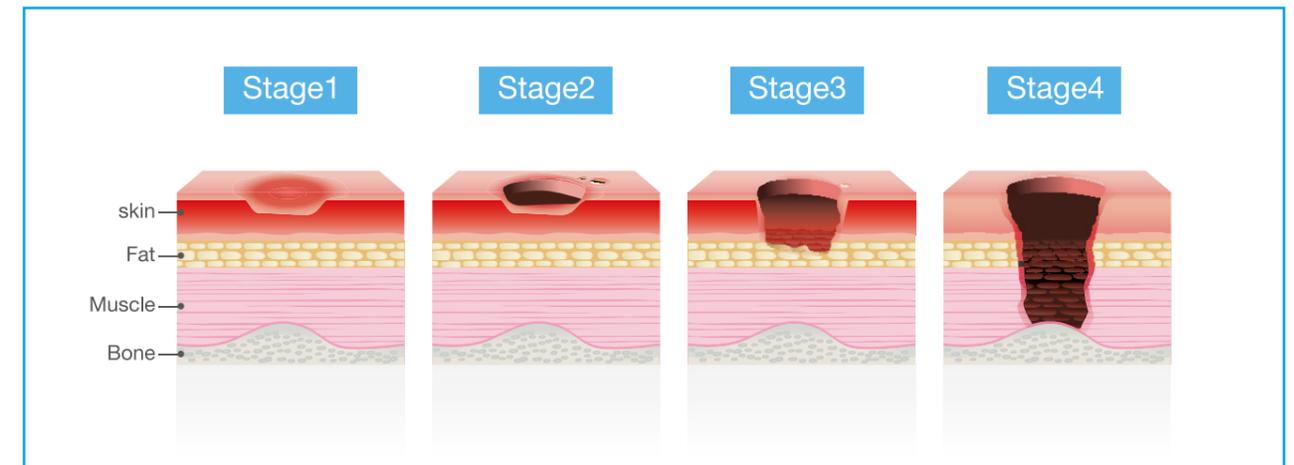
For further training and support please access the free evidence based online training tool REACT TO FALLS <https://reactto.co.uk/react-to-falls>

## What is a Pressure Ulcer?

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair its blood supply. This is sometimes made worse when in combination with moisture or shearing due to a persons movement. Pressure ulcers are also sometimes referred to as bedsores, pressure sores or pressure injuries.

All patients are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity. Without care, pressure ulcers can become very serious causing pain and significant illness.

Pressure ulcers are assessed by depth and should be categorised according to European Pressure Ulcer Advisory Panel classification. <https://epuap.org/pressure-ulcers-classification/>. These can be stages or categories



When skin and tissue are directly compressed between two hard surfaces such as a bony prominence (bottom or spine) and your bed, or chair, the blood supply is disrupted, and the area is starved of oxygen and nutrients and tissue damage begins. Pressure ulcers can occur over a short period of time if a large amount of pressure is applied, but they can also occur over a longer period of time when less pressure is applied. Pressure ulcer prevention and treatment should follow NICE guidelines - [www.nice.org.uk/guidance/cg179](http://www.nice.org.uk/guidance/cg179)

## The Skin Tolerance Test (Blanch Test)



Normal skin response to pressure, like your elbow when you lean on it.

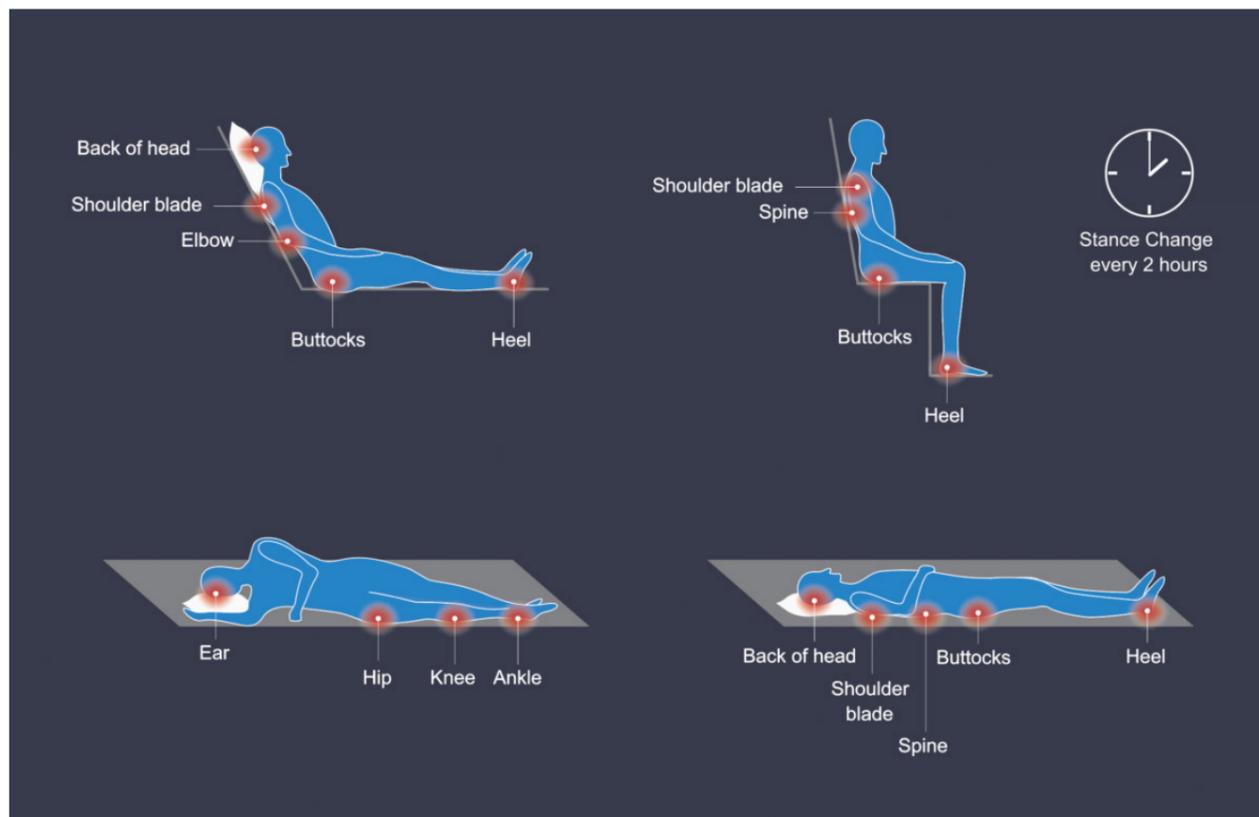


Press finger over reddened area for 5 seconds, then lift up finger.



If the area blanches, it is not a stage 1 pressure ulcer. If it stays red, it is a stage 1 pressure ulcer.

### Resource 3



### Resource 4

Also be mindful of other areas such as Nose, Fingers, Knees and Ankles

Please note it can be difficult to recognise pressure damage in darker skin tones – look for all signs other than redness that can be difficult to spot

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

### Moisture Skin Damage:

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

### Causes of Moisture Damage:

- Heat/sweat
- Urine
- Faeces
- Wound leakage
- Drool
- Being immobile

### Cognitive impairment:

- Improper use of equipment
- Medication
- Illnesses / co-morbidities UTI's
- No access to facilities

### To Help Prevent Moisture Damage:

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

Please visit <https://reactto.co.uk/react-to-moisture> for more information, videos, and resources. If you have any concerns about a resident with moisture/pressure damage or need general advice, please speak to your local District Nursing Team or Care Home Team who will be able to help and advise.

Are you aSSKINg the right questions to stop pressure ulcers?	
<b>A</b>	<b>Assess skin</b> – Holistic assessment of a patient using a validated tool such as Waterlow / Braden or Purpose T.
<b>S</b>	<b>Skin assessment and care</b> – Perform early and regular skin inspections, checking temperature, texture, pain and altered sensation.
<b>S</b>	<b>Surface selection and use</b> – Provide appropriate pressure – redistribution devices AND ensure the patient is repositioned at regular intervals.
<b>K</b>	<b>Keep moving</b> – Mobility is key! Encourage regular movement to relieve pressure over bony prominences.
<b>I</b>	<b>Incontinence and increased moisture</b> – Keep skin clean, dry and protected from moisture.
<b>N</b>	<b>Nutrition and Hydration</b> – Assess nutritional status and keep patients well hydrated.
<b>G</b>	<b>Give information</b> – Provide simple and clear information to patients, carers and keep MDT informed.

Adequate nutrition and hydration is important to keep people well. Good food and hydration are essential for general wellbeing. So, as a care worker, ensuring that your residents receive adequate amounts of nutrition and hydration is a fundamental aspect of holistic care. Below is a list of resources to support you in managing the risk of malnutrition and dehydration of your residents:

**Malnutrition**

Malnutrition means poor nutrition. Most commonly this is caused by not eating enough (undernutrition) or not eating enough of the right food to give your body the nutrients it needs. <https://reactto.co.uk/react-to-malnutrition-and-dehydration>. Malnutrition Universal Screening Tool (MUST): MUST is a commonly used, validated tool to screen your residents for risk of malnutrition. Considering BMI and weight loss, it gives a more comprehensive picture of risk than looking at weight alone. [www.bapen.org.uk/must-and-self-screening/must-calculator/](http://www.bapen.org.uk/must-and-self-screening/must-calculator/)

**Dysphagia**

Dysphagia is a term used to describe difficulties swallowing food and / or fluids which can lead to 'aspiration', where food and fluid enter the lungs. [www.e-lfh.org.uk/programmes/dysphagiaguide/](http://www.e-lfh.org.uk/programmes/dysphagiaguide/)

**Hydration**

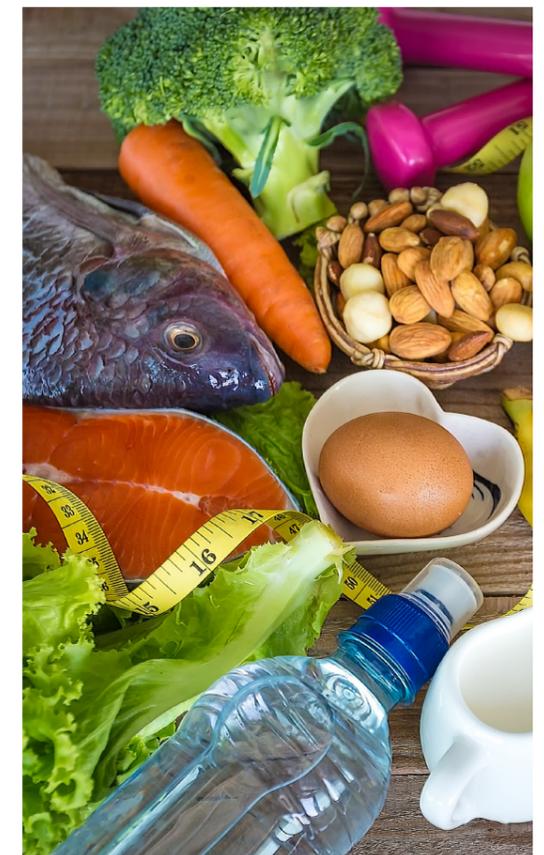
Good hydration is achieved by drinking enough fluid to replace normal day to day needs and unexpected fluid losses (such as diarrhoea or vomiting). Each individual resident will have different fluid needs depending on their size, age and environment (such as needing more in hot weather). All fluids (except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

**International Dysphagia Diet Standardisation Initiative (IDDSI)**

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

**The Eatwell Guide**

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



## The Role of the Home Round (Care Homes Only)

### What is a Home Round?

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

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

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

Before the Home Round takes place:

You may be contacted by your local practice to identify which residents you would like to discuss that week.

You might be asked to undertake further tasks to support the Home Round, this could be undertaking basic observations or completing a Dysphagia Checklist



## The Role of the Home Round (Care Homes Only)

### What should be Discussed at the Home Round:

- New residents (admitted to the home within the last 7 working days)
- Residents who have had a recent stay in hospital and have returned to the care home (within the last 7 working days)
- Elective admissions
- Any urgent or emergency activity that has not resulted in admission since the last home round, i.e., UCR, Out of Hours, ED attendance
- Residents due their annual birthday review
- Residents who have had a fall since the last home round (all falls – injury / non injury)
- Residents whose mobility and transfer ability have declined, or a resident who hasn't fallen but has nearly done so
- ReSPECT plan review – those who require a ReSPECT form or update, or those newly admitted to the home
- End of life management - initiate EPaCCs if identified as EOL
- Residents who have had an ambulance called for them but no admission Speech and language changes – concerns around dysphagia / aspiration Changes to mental health / behaviours
- Unplanned weight loss or weight gain
- General resident deterioration – this may have been noted through application of a managing deterioration tool such as RESTORE2
- A resident whose status has changed from being there for respite or temporary to permanent

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

Your aligned Practice must ensure that there are processes in place to enable all residents who require reviews within your care home to be completed in a proactive manner as appropriate.

Reviews could be:

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

# Common Conditions

- Chest Infections
- Flu
- Covid-19
- UTI's
- Catheters and UTI's
- Constipation
- Gastroenteritis
- Cellulitis
- Sepsis



# Chest Infections

## What is a Chest Infection?

A chest infection is an infection of the lungs or large airways. Some chest infections are mild and clear up on their own, but others can be severe and life threatening.

## Possible Causes of Chest Infection Can Include:

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



# Chest Infections

## P = PREVENTION

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

## I = IDENTIFICATION

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

## E = ESCALATION

If you notice any of the above soft signs in your resident please complete a NEWS2 observation and refer to the NEWS2 escalation tool (see page 12).

## R = RESPONSE

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

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

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

**More information on chest infections: [www.nhs.uk/conditions/chest-infection/](http://www.nhs.uk/conditions/chest-infection/)**

## What is Flu?

Flu is a highly contagious disease that is transmitted through the air in millions of tiny droplets from an infected person's nose or mouth. These droplets can survive for up to 24 hours and infect people of all ages who breathe in the droplets or touch a surface that the droplets have landed on and then a recipient touches that surface (indirect contact) and then infects themselves on touching their eyes/ mouth.

Flu can lead to serious illnesses, such as pneumonia, particularly in the vulnerable and young. Tiredness symptoms can last for up to several weeks. Flu symptoms can develop rapidly and will stop residents from completing their normal daily activities whilst a cold usually develops gradually and mainly affects the nose and throat and is usually fairly mild.

## P = PREVENTION

- Annual flu vaccine
- Pneumococcal vaccine
- Covid vaccine

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

## I = IDENTIFICATION

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

## E = ESCALATION

If you notice any of the above soft signs in your resident please complete a NEWS2 observation and refer to the NEWS2 escalation tool (see page 12)

## R = RESPONSE

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

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

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

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

## How to Manage a Flu Outbreak in your Care Home:

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



## Complications of Flu:

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

More information on flu: [www.nhs.uk/conditions/flu/](http://www.nhs.uk/conditions/flu/)



## What is a Covid-19?

Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus.

Most people infected with the virus will experience mild to moderate respiratory illness and recover without requiring special treatment. However, some will become seriously ill and require medical attention. Older people and those with underlying medical conditions like cardiovascular disease, diabetes, chronic respiratory disease, or cancer are more likely to develop serious illness. Anyone can get sick with COVID-19 and become seriously ill or die at any age.

## P = PREVENTION

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

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

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

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

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

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

## I = IDENTIFICATION

COVID-19 symptoms can include:

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



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

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

## E = ESCALATION

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

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

## R = RESPONSE

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

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

**More information on Covid-19: [www.nhs.uk/conditions/covid-19/](http://www.nhs.uk/conditions/covid-19/)**

# Urinary Tract Infection (UTI)

## What is a UTI?

Urinary tract infections (UTIs) affect your urinary tract, including your bladder (cystitis), urethra (urethritis) or kidneys (kidney infection).

## Possible Causes of UTI's Can Include:

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

## P = PREVENTION

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

## I = IDENTIFICATION

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

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

## E = ESCALATION

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

UTIs can have more serious complications in certain residents including:

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

## R = RESPONSE

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

**More information on UTI's: [www.nhs.uk/conditions/urinary-tract-infections-utis/](http://www.nhs.uk/conditions/urinary-tract-infections-utis/)**

# Catheters and UTI's

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

## P = PREVENTION

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

## I = IDENTIFICATION

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

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

## E = ESCALATION

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

## R = RESPONSE

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

**More information on catheters:**  
[www.nhs.uk/tests-and-treatments/urinary-catheters/](http://www.nhs.uk/tests-and-treatments/urinary-catheters/)

## Liquid Measures (mls)

	Orange Juice Carton 85 mls		
	Disposable plastic cup 175 mls		½ disposable cup 85 mls
	Clear plastic glass 180 mls		½ plastic glass 90 mls
	Plastic feeder beaker 200 mls		Small cup & saucer 175 mls
	Mug 220 mls		Large mugs (lilac & blue) 250 mls

Resource 5

## What is Constipation?

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

### P = PREVENTION

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

### I = IDENTIFICATION

It's likely to be constipation if:

- They have not had a poo at least 3 times during the last week
- The poo is often large and dry, hard or lumpy
- They are straining or in pain when they have a poo often requesting to go to the toilet but unable to pass anything
- They may also have a stomach ache and feel bloated or sick

If you're caring for someone with dementia or a learning disability, constipation may be easily missed. Look out for any behaviour changes, as it might mean they are in pain or discomfort. Constipation can often be recognised by a change in an resident's usual bowel habits.

### E = ESCALATION

Escalate ongoing issues to the ward round ensuring that you can provide a diary using the Bristol Stool Chart (see page 43).

### R = RESPONSE

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

More information on DisDat can be found at: [stoswaldsuk.org](http://stoswaldsuk.org)  
More information on constipation: [www.nhs.uk/conditions/constipation/](http://www.nhs.uk/conditions/constipation/)

# The Bristol Stool Chart

Type 1		Separate hard lumps
Type 2		Sausage-shaped but lumpy
Type 3		Sausage-shaped with cracks on the surface
Type 4		Looks like smooth and soft sausage or snake
Type 5		Soft blobs with clear-cut edges
Type 6		Mushy, fluffy pieces with ragged edges
Type 7		Liquid consistency with no solid pieces

**It's important to know what healthy poo looks like. Share this chart with the people you care for to help them identify whether they may be experiencing constipation. If a poo does not look like type 3 or type 4 it could be constipation. Contact the GP surgery of the person you are caring for.**

# Gastroenteritis

## What is Gastroenteritis?

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

## Possible Causes of Gastroenteritis:

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

## P = PREVENTION

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

## I = IDENTIFICATION

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

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

## E = ESCALATION

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

## R = RESPONSE

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

# Gastroenteritis and Dehydration

## Gastroenteritis can have 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 Crohn's disease or Ulcerative Colitis
- Those residents who have a weakened immune system such as those on chemotherapy and older residents

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

## Causes of Dehydration:

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

## P = PREVENTION

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

## I = IDENTIFICATION OF MILD DEHYDRATION:

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

## I = IDENTIFICATION OF MORE SEVERE DEHYDRATION:

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

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

# Gastroenteritis and Dehydration

## E = ESCALATION

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

If 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.

## R = RESPONSE

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

## Urine Colour Chart

Are you drinking enough? Let your wee help you see!



Its important to note that some medications, vitamin supplements and food can alter the colour of your urine.

**More information on gastroenteritis:**  
[www.nhs.uk/symptoms/diarrhoea-and-vomiting/](http://www.nhs.uk/symptoms/diarrhoea-and-vomiting/)

Resource 6

## What is Cellulitis?

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

## Possible Causes:

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

## P = PREVENTION

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



## I = IDENTIFICATION

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

## E = ESCALATION

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

## R = RESPONSE

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

## Complications:

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

More information on cellulitis: [www.nhs.uk/conditions/cellulitis/](http://www.nhs.uk/conditions/cellulitis/)

## What is Sepsis?

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



## P = PREVENTION

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

## I = IDENTIFICATION

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

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

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

## E = ESCALATION

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

**ALWAYS CHECK RESPECT FORMS BEFORE CALLING 999**

## R = RESPONSE

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

**More information on sepsis: [www.nhs.uk/conditions/sepsis/](http://www.nhs.uk/conditions/sepsis/)**

# Mental Health

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.



## What is Delirium?

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

## Risk Factors for Developing Delirium:

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

## P = PREVENTION

Prevent delirium by improving sensory environment:

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

## I = IDENTIFICATION

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

## E = ESCALATION

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

## R= RESPONSE

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

More information on delirium: [www.nhs.uk/symptoms/confusion/](http://www.nhs.uk/symptoms/confusion/)



## What is 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

## 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

## What is Sundowning?

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: [www.nhs.uk/conditions/dementia/](http://www.nhs.uk/conditions/dementia/)



# Depression

## What is 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](http://www.alzheimers.org.uk)

More information on depression:  
[www.nhs.uk/mental-health/conditions/depression/](http://www.nhs.uk/mental-health/conditions/depression/)

# Palliative and End of Life Care



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

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

### Universal Principles for Advance Care Planning:

1. The person is at the heart of developing and agreeing with their advance care plan, including choosing who else should be involved.
2. They have personalised conversations about future care, focused on what matters most to them and their individual needs.
3. Outcomes of advance care planning are agreed through shared decision-making in partnership with relevant professionals.
4. A shareable advance care plan records what matters to the person, along with their preferences and decisions about future care and treatment.
5. The person is given the opportunity—and encouraged—to review and update their plan as needed.
6. Anyone involved in advance care planning can speak up if these principles are not being upheld.

When we think about advance care planning locally, we use our advance statement called 'My Wishes' and ReSPECT, and we should also consider anticipatory medications as part of the planning process.

If you have an NHS email account, please use the link below to access the local Care in the Last Year of Life: Palliative and End of Life Care Toolkit or use the below QR Code.

<https://icsacademyexchange.totaracloud.com/login/index.php>



Herefordshire and  
Worcestershire

## My Wishes

This Advance Statement sets out your preferences, wishes, beliefs and values for a time when you may not be able to let people around you know what is important to you. Please note, this is not a legal document.

Name: \_\_\_\_\_

I prefer to be known as: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

NHS Number: \_\_\_\_\_

This plan was last updated on: \_\_\_\_\_

### Part A - About Me

#### Section 1: What matters to me

##### 1.1 Important things that matter to me right now:

Name:

DOB:

Page 1 of 8

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

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

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

The image shows a screenshot of the ReSPECT form. It is titled 'ReSPECT Recommended Summary Plan for Emergency Care and Treatment'. The form is divided into several sections:

- 1. This plan belongs to:** Includes fields for Full name, Date of birth, Address, Preferred name, Date completed, and NHS/CHI/Health and care number.
- 2. Shared understanding of my health and current condition:** Includes a summary of relevant information, details of other care planning documents, and a checkbox for having a legal welfare proxy in place.
- 3. What matters to me in decisions about my treatment and care in an emergency:** Includes a slider to indicate whether 'Living as long as possible matters most to me' or 'Quality of life and comfort matters most to me', and fields for 'What I most value' and 'What I most fear / wish to avoid'.
- 4. Clinical recommendations for emergency care and treatment:** Includes three columns for 'Prioritise extending life', 'Balance extending life with comfort and valued outcomes', and 'Prioritise comfort', each with a clinician signature line. Below this is a section for 'Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate'. At the bottom, there are three boxes for CPR recommendations: 'CPR attempts recommended Adult or child', 'For modified CPR Child only, as detailed above', and 'CPR attempts NOT recommended Adult or child', each with a clinician signature line.

## Anticipatory Prescribing

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

All patients that are recognised as gold standard framework (GSF) amber and/ or red should have anticipatory medications prescribed in the event of deterioration.

## Medication and Equipment Considerations at End of Life

- Review medications: Are any current medications no longer beneficial and can they be safely discontinued?
- Alternative formulations: Are essential medications available in liquid or soluble form to aid administration?
- Equipment readiness: Does the care home have the necessary equipment to administer medication? This includes a syringe driver that has been serviced within the last year and in-date consumables.
- Who provides care: Nurses in nursing homes can deliver this care. For residents in residential care settings, community nursing teams will provide support and expertise.

[www.resus.org.uk/professional-library/2025-resuscitation-guidelines](http://www.resus.org.uk/professional-library/2025-resuscitation-guidelines)

**ReSPECT Recommended Summary Plan for Emergency Care and Treatment**

Full name: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 NHS/CHI/Health and care number: \_\_\_\_\_

1. This plan belongs to:  
 Preferred name: \_\_\_\_\_  
 Date completed: \_\_\_\_\_

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

2. Shared understanding of my health and current condition  
 Summary of relevant information for this plan including diagnoses and relevant personal circumstances: \_\_\_\_\_

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

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

3. What matters to me in decisions about my treatment and care in an emergency  
 Living as long as possible matters most to me  Quality of life and comfort matters most to me

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

4. Clinical recommendations for emergency care and treatment  
 Prioritise extending life  Balance extending life with comfort and valued outcomes  Prioritise comfort

clinician signature: \_\_\_\_\_ clinician signature: \_\_\_\_\_ clinician signature: \_\_\_\_\_

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

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

clinician signature: \_\_\_\_\_ clinician signature: \_\_\_\_\_ clinician signature: \_\_\_\_\_

www.respectprocess.org.uk

5. Capacity for involvement in making this plan  
 Does the person have capacity to participate in making recommendations on this plan?  Yes  No  
 If no, in what way does this person lack capacity? \_\_\_\_\_  
 Document the full capacity assessment in the clinical record. If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

6. Involvement in making this plan  
 The clinician(s) signing this plan is/are confirming that (select A, B or C, OR complete section D below):  
 A This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.  
 B This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.  
 C This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):  
 1 They have sufficient maturity and understanding to participate in making this plan  
 2 They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.  
 3 Those holding parental responsibility have been fully involved in discussing and making this plan.  
 D If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7. Clinicians' signatures  

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time

 Senior responsible clinician: \_\_\_\_\_

8. Emergency contacts and those involved in discussing this plan  

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
<input type="checkbox"/>			optional

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

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

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

www.respectprocess.org.uk

**ReSPECT Recommended Summary Plan for Emergency Care and Treatment**

### Discussion guide

People have different views about what care or treatments they would want if they were suddenly ill and could not make choices. ReSPECT conversations allow a person and their health professionals to plan together for such a future emergency. If a person does not have capacity to participate, ReSPECT conversations should include their legal proxy (if they have one), family members or other carers.

- Ensure that all involved in the conversation understand the purpose of ReSPECT.
- Start the ReSPECT process with one or more conversations between each person and their health professionals to establish and record in section 2 a shared understanding of the person's present condition or situation and how these might change...
- Next, discuss, agree and record in section 3 those things that the person thinks would matter most to them (values and fears) if they suddenly became less well, both in their daily lives and as a possible outcome of future emergency care and treatment.
- Then discuss, agree and record in section 4 recommendations about those types of care or realistic treatment that:
  - would be wanted (to try to achieve the goals of care),
  - would not be wanted,
  - that would not work in this person's situation.
 As part of this, discuss, agree and record a recommendation about CPR.

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

Using the scale may help you to discuss and agree priorities. Use the discussed / agreed goals of care to guide further planning discussions

www.respectprocess.org.uk

**ReSPECT Recommended Summary Plan for Emergency Care and Treatment**

### Guidance for people with a ReSPECT form

Now you have a ReSPECT form, what next?  
 Keep it somewhere easy to find

Make sure your ReSPECT form will be easy to find if you were to become ill and need emergency care. Keep it in a prominent place when you are at home, and take it with you if you are out and about. It will help if your family or carers know where to find your ReSPECT form in case you are unable to access it yourself in an emergency.

Take it to medical appointments  
 So that your health professionals know your preferences, take the form with you to medical appointments or if you are admitted to hospital. It is your form to keep hold of, though it may be scanned for record keeping or audit.

Review your plan with your health professionals  
 You can and should review with your health professionals the recommendations on the form if your health condition, circumstances or wishes change. This is to make sure that the plan is kept up to date so that clinicians can make the best possible decisions about your care in an emergency.

Tell your close family, friends and carers about your plan  
 If your family, friends and carers know about your plan before you need emergency care, they will be able to advise any clinicians treating you and show them your ReSPECT form. Remember to tell family, friends and carers what has changed, if your ReSPECT form is updated.

Frequently asked questions for patients, carers, and treating clinicians.

Is it legally binding?  
 No. A person's ReSPECT form contains recommendations to guide immediate decision-making by health or care professionals who respond to them in an emergency. However, they should have valid reasons for not following the recommendations on a ReSPECT form. The ReSPECT form is not an Advance Decision to Refuse Treatment (ADRT).

Is ReSPECT the same as a DNACPR (Do Not Attempt CPR) form?  
 No. A person's ReSPECT form makes recommendations about emergency treatments that could be helpful and should be considered, as well as those that are not wanted by or would not work for them. It includes a recommendation about CPR, but that may be a recommendation that CPR is attempted, or a recommendation that it is not attempted.

Who needs to sign the form?  
 The health professional must sign the form to confirm their responsibility in adhering to best practice, following the ReSPECT process and for complying with capacity and human rights legislation. Patients, or their legal proxy and/or family members, can sign the form if they wish but do not have to. Signing the form allows patients or their legal proxy/family members to demonstrate that they have been actively involved in the discussion and recommendations about the person's care and treatment.

How do I get advice or more information?  
 You can get more information at www.respectprocess.org.uk, or by asking your GP or hospital doctors.

## Gold Standards Framework

The Gold Standards Framework (GSF) is a nationally recognised approach designed to improve the quality of care for people nearing the end of life. It provides practical tools and training to help care homes identify residents who may be deteriorating, plan ahead, and ensure that care is proactive rather than reactive. By adopting GSF principles, teams can improve communication, reduce unnecessary hospital admissions, and support residents to live well until the end of life in their preferred place of care. Even if your home has not used GSF before, the principles - such as early recognition of decline, advance care planning, and coordinated teamwork - can make a significant difference to outcomes and experiences for residents and their families.

The Gold Standards Framework (GSF) principles are already widely used in primary care and by many GP practices to support proactive, person-centred end-of-life care. Hospitals are also working towards embedding GSF principles into their processes, meaning that care homes, GPs, and hospitals will increasingly share a common approach to planning and delivering high-quality care for people nearing the end of life.

A - BLUE	B - GREEN	C - YELLOW	D - RED
'All' from diagnosis	'Benefits' - DS1500	'Continuing Care	'Days
Stable	Unstable /	Deteriorating	Terminal phase /
Year plus prognosis	Advanced disease	Weeks prognosis	Final days
	Months prognosis		Days prognosis

## Understanding the GSF Colour Coding System

The Gold Standards Framework uses a colour-coded system to help care teams quickly identify a resident's stage of illness and level of need.

**GREEN** – The resident is stable with no immediate concerns.

**AMBER** – There are signs of decline or increasing frailty; planning ahead is important.

**RED** – The resident is in the final days or weeks of life and needs intensive support.

This system supports early recognition of deterioration, better communication within the team, and timely planning for end-of-life care. Even if your home does not formally use GSF, adopting this simple colour approach can make it easier to prioritise care and avoid crises.



[www.goldstandardsframework.org.uk](http://www.goldstandardsframework.org.uk)

**Note: Digital ReSPECT is due to be launched Winter 25/26**

# Deterioration at End of Life and Recognising the Dying Resident

The last days or hours of a person's life is when someone is "actively dying". Everyone's experience of dying is different, but there are often signs that can help you to recognise when someone is 'actively dying'

## These include:

- Condition deteriorating rapidly (day by day or hour by hour)
- Spending most of the time in bed
- Profound tiredness and weakness
- Complete dependence for personal care
- Minimal interest in food or drink
- Difficulty swallowing tablets or oral medication
- Reduced responsiveness and limited ability to communicate
- Increased sleepiness or drowsiness
- Decreased urine output
- New onset of urinary or faecal incontinence
- Delirium, with restlessness, confusion, or agitation
- Changes in breathing pattern (e.g., Irregular or laboured)
- Noisy chest secretions
- Skin becoming mottled and cool to the touch
- Expressing that they feel they are dying

## What Does Good Palliative Care Look Like?

Good palliative care is about providing compassionate support during the final stages of life while also enhancing quality of life for residents and those close to them at every stage.

It focuses on the person rather than the illness, addressing their physical, practical, functional, social, emotional, and spiritual needs. The goal is to ensure comfort, dignity, and holistic care for individuals living in care homes.

# Deterioration at End of Life and Recognising the Dying Resident

## Anticipatory Prescribing

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

All patients that are recognised as gold standard framework (GSF) amber and/ or red should have anticipatory medications prescribed in the event of deterioration.

## Medication and Equipment Considerations at End of Life

- Review medications: Are any current medications no longer beneficial and can they be safely discontinued?
- Alternative formulations: Are essential medications available in liquid or soluble form to aid administration?
- Equipment readiness: Does the care home have the necessary equipment to administer medication? This includes a syringe driver that has been serviced within the last year and in-date consumables.
- Who provides care: Nurses in nursing homes can deliver this care. For residents in residential care settings, community nursing teams will provide support and expertise.

## Resources to Support the Identification of Palliative Care Emergencies:

<https://icsacademyexchange.totaracloud.com/login/index.php>



# Deterioration at End of Life & Recognising the Dying Resident

## End-of-Life Care for Residents with Learning Disabilities or Dementia

Identifying when someone with a learning disability or dementia is entering the final stage of life can be challenging, as they may display general signs and symptoms of dying for a long time. Using pictures or prompts can help the person understand changes in their condition and express any worries they may have.

### Common signs and symptoms that may indicate deterioration include:

- Loss of fine motor skills (mouth, eyes, fingers, feet)
- Reduced intake of food and fluids
- Increased need for assistance with all aspects of care
- Drowsiness or reduced awareness
- Noticeable weight loss or a gaunt appearance
- Difficulty swallowing
- Spending more time in bed
- Limited awareness of surroundings most of the time
- Agitation or restlessness, or very little movement
- Difficulty connecting or engaging with others

People with a learning disability or dementia may show some of these signs and symptoms for months or even years, which can make it difficult to know when they are approaching the end of life. However, if these symptoms worsen significantly over a short period—such as two to three weeks, or even days or hours, it is important that a doctor or nurse assesses the person.

If the clinician believes the person is deteriorating or nearing the end of life, and that it would be in their best interests to remain in their own home, a care home, or a hospice, this should be discussed with their family. Families should be given a clear explanation of why the deterioration is happening and what care will be provided.

When death is expected, transferring someone with communication difficulties to hospital is usually not helpful. Hospital admission at this stage can make the experience more traumatic, less supported, and may lead to complications such as infections.

<https://icsacademyexchange.totaracloud.com/login/index.php>



# Care After Death

Providing care after death is a significant and sensitive process. While the practical steps are straightforward, it requires skilled communication, compassion, and respect for both the person who has died and their loved ones.

### Essential considerations include:

- Ensuring staff are trained to verify expected death, reducing delays caused by waiting for external clinicians
- Honouring the spiritual and cultural wishes of the deceased and their loved ones
- Preparing the residents body respectfully for transfer to the mortuary or funeral director
- Offering loved ones, the opportunity to participate in the process and supporting them if they wish
- Maintaining the privacy and dignity of the deceased at all times
- Protecting the health and safety of everyone who comes into contact with the body
- Respecting wishes regarding organ and tissue donation
- Returning personal possessions to loved ones or involving them in collecting belongings
- Supporting staff emotionally after the death of a resident cared for by the team



# Medicines Optimisation



# Guidance for the Management of Medicines in Social Care Establishments

## Care Homes should follow the NICE good practice guidance:

Managing medicines in care homes: [www.nice.org.uk/guidance/sc1](http://www.nice.org.uk/guidance/sc1)

All patients should be managed in accordance with Herefordshire and Worcestershire Medicines and Prescribing Guidance available via the following resources:

- **Herefordshire and Worcestershire Formulary** - [www.hereworcsformulary.nhs.uk/](http://www.hereworcsformulary.nhs.uk/)
- **Clinical and Prescribing Policies, Guidance and Pathways** - <https://herefordshireandworcestershire.icb.nhs.uk/documents/clinical-and-prescribing-policies-guidance-and-pathways>



# Infection Prevention and Control



## Risk Assessment

Care Homes need to ensure risk assessment processes are in place to prepare for and manage any infectious outbreak. An outbreak is two or more linked cases of the same illness in the same setting over a specified time period. Outbreaks should be reported to the IPC team or UK HSA out of hours so that early support and advice can be given to prevent the spread of infection to others in the setting.

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

## Standard Precautions

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

## Useful Resources

### Visiting in care homes during outbreaks:

[www.gov.uk/guidance/supporting-safer-visiting-in-care-homes-during-infectious-illness-outbreaks?utm\\_medium=email&utm\\_campaign=govuk-notifications-topic&utm\\_source=5208034b-673e-4317-bdf5-874ebcbd6adc&utm\\_content=immediately](http://www.gov.uk/guidance/supporting-safer-visiting-in-care-homes-during-infectious-illness-outbreaks?utm_medium=email&utm_campaign=govuk-notifications-topic&utm_source=5208034b-673e-4317-bdf5-874ebcbd6adc&utm_content=immediately)

### Acute respiratory outbreaks in care homes:

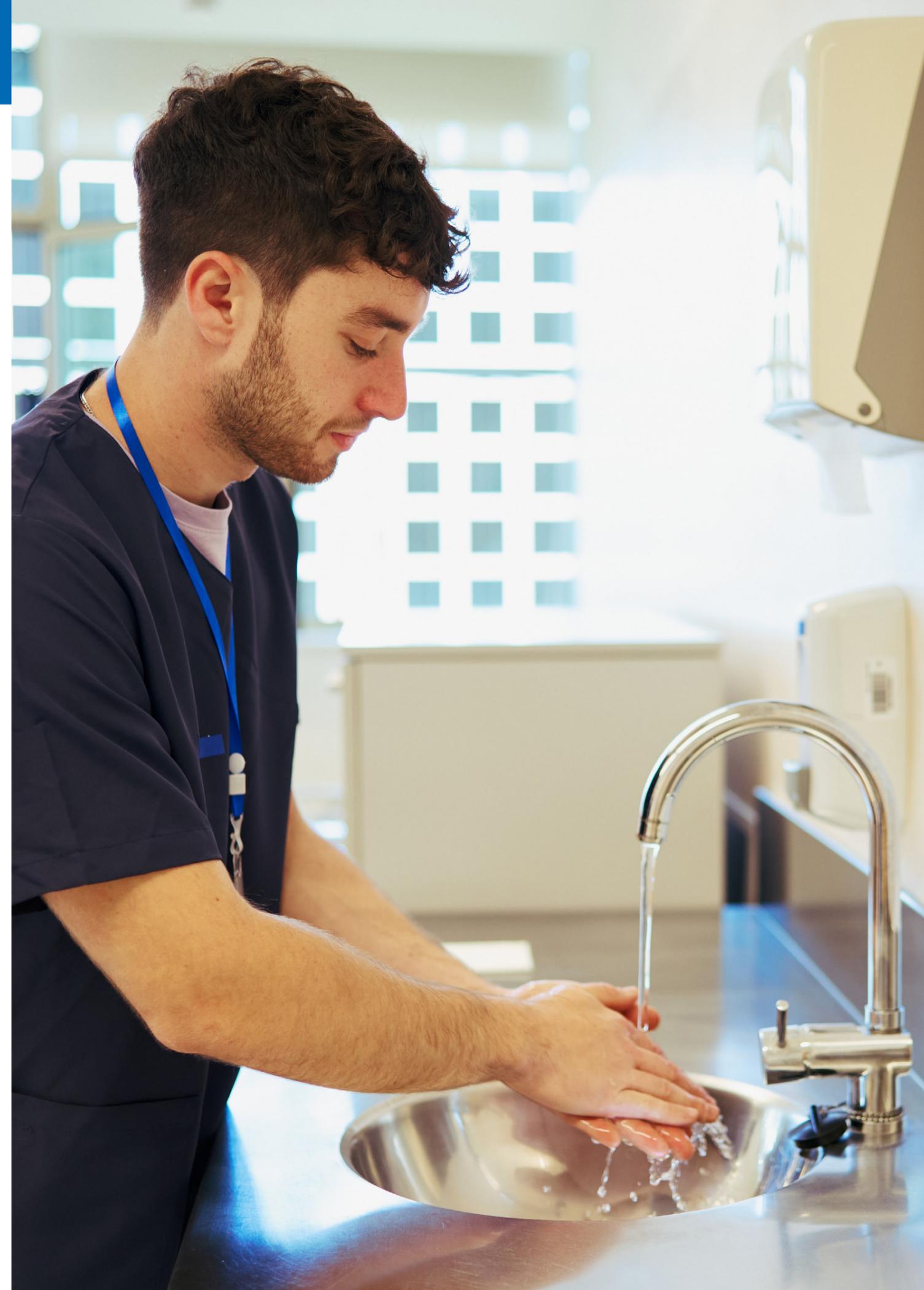
[www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-acute-respiratory-infection/infection-prevention-and-control-ipc-in-adult-social-care-acute-respiratory-infection-ari](http://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-acute-respiratory-infection/infection-prevention-and-control-ipc-in-adult-social-care-acute-respiratory-infection-ari)

### Infection prevention and control (IPC) in adult social care settings:

[www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings](http://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings)

### National infection prevention and control manual for England:

[www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/](http://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/)



## Resource Links

<b>Resource 1</b>	RESTORE2 Mini	<a href="https://www.healthinnovationoxford.org/wp-content/uploads/2024/06/RESTORE2-Mini-Observation-Chart-1.pdf">https://www.healthinnovationoxford.org/wp-content/uploads/2024/06/RESTORE2-Mini-Observation-Chart-1.pdf</a>
<b>Resource 2</b>	Full RESTORE 2	<a href="https://www.healthinnovationoxford.org/wp-content/uploads/2024/04/RESTORE2-Observation-Chart.pdf">https://www.healthinnovationoxford.org/wp-content/uploads/2024/04/RESTORE2-Observation-Chart.pdf</a>
<b>Resource 3</b>	Blanch Test	<a href="http://www.slideshare.net/slideshow/cdzgpdf/252557850">www.slideshare.net/slideshow/cdzgpdf/252557850</a>
<b>Resource 4</b>	Pressure Ulcer Diagram	<a href="http://www.alzheimersla.org/for-families/caring-for-a-person-with-memory-loss/basic-activities-of-daily-living/pressure-ulcers/">www.alzheimersla.org/for-families/caring-for-a-person-with-memory-loss/basic-activities-of-daily-living/pressure-ulcers/</a>
<b>Resource 5</b>	Liquid Measures	<a href="http://www.researchgate.net/figure/Poster-displayed-on-ward-showing-volumes-of-common-fluid-containers_fig3_306407176">www.researchgate.net/figure/Poster-displayed-on-ward-showing-volumes-of-common-fluid-containers_fig3_306407176</a>
<b>Resource 6</b>	Urine Colour Chart	<a href="https://i0.wp.com/images.sampletemplates.com/wp-content/uploads/2015/10/15152400/Healthy-Urine-Color-Chart.jpg">https://i0.wp.com/images.sampletemplates.com/wp-content/uploads/2015/10/15152400/Healthy-Urine-Color-Chart.jpg</a>

## Thank You

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This pack has been reviewed and endorsed through the NHS Herefordshire and Worcestershire ICB governance and approval process, including the Clinical Leads Group and the Clinical Assurance Sub Committee (CASC).



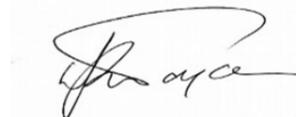
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# **Managing Deterioration**

Preventing, Recognising and Responding  
to Deterioration in your Care Setting