Care Homes
Our Partners in Care

Care Homes and
Domiciliary Care

NHS
Vale of York
Clinical Commissioning Group

Partners in Care

Wednesday 27 November 2019

13.30-16.30

Riccall Regen Centre

Agenda

Care Homes
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Care Homes and Domiciliary Care

1.	Introductions	S Fiori
2.	Skills for Care and Registered Managers Network Update (15)	A Thompson/A Redhead
3.	Fast Track Improvement Team Workshop (25)	L Ruddock/ C Charters
4.	Continence Team Update (15)	A Potter
5.	Urgent Care Practitioners Update (15)	T O'Dowd
6.	Interval and Refreshments Break (10)	
7.	CHAD Team Update (15)	R Instone
8.	Community Equipment Update (15)	P Bolderson/Mediquip
9.	Trusted Transfer Pathway and Discharge Team Update (10)	S Fiori/G Younger
10.	CHC Contracts and Team Update (10)	A Griffiths
11.	React to Falls Prevention (5)	H Degnan
12.	Opportunity for discussion; issues to be raised, Good practice/ learning to share. (10)	Group

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skillsforcare

Angela Thompson

NHS
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Skills for Care update November 2019

Partners in Care

27 November 2019

#CareToRecruit

During October and November we'll be helping employers to recruit people with the right values. The campaign will include:

- the launch of the DHSC national recruitment campaign
- the importance and benefits of recruiting for values, how to get started and tips and advice from other providers
- tips for attracting candidates, the application and selection process
- how the 'seeing potential' and '*I Care…Ambassadors'* projects can help with recruitment.

Follow the campaign at **www.skillsforcare.org.uk/caretorecruit**

#CareToRecruit #everydayisdifferent

DHSC adult social care national recruitment campaign

Advertising will run for longer this year, from October to April.

October activity will include online TV, social media, radio and online advertising.

January activity will include outdoor posters, social media, radio, and online media partnership.

Advertising will signpost interested applicants to **www.everydayisdifferent.com** where they can find out more and search for jobs.

New! Values video animation

Why should you use a values-based approach to recruitment?

Watch our video animation at www.skillsforcare.org.uk/values

Update: ‘A Question of Care’ profiling tool

A QUESTION OF CARE
A career for you?

‘A Question of Care: A career for you’ is an online, interactive video quiz based on real life scenarios from the social care sector.

At the end of the quiz it provides a detailed personal profile that tells people whether they have what it takes to work in social care.

We’re pleased to announce that **two new scenarios** about being a personal assistant and domiciliary care worker have been added.

www.aquestionofcare.org.uk

Free flu vaccine

The NHS offers a free flue vaccine to people who are at risk of catching flu and developing serious complications, including:

- people who are 65 years old or over
- people who have certain medical conditions
- people who are living in long-stay residential care home or other care facility
- people who receive a carer's allowance
- frontline health and social care staff.

THINK: how can you support your staff and the people that use your service to access their free flu vaccine.

Visit **www.skillsforcare.org.uk/flu** for more information.

Core and mandatory training in adult social care

The core and mandatory training guidance covers a variety of topic areas and addresses:

- minimum learning outcomes
- how the topic links to CQC key lines of enquiry
- how the topic links to CQC fundamental standards
- how and when to refresh knowledge.

Access the mandatory training guidance at:

www.skillsforcare.org.uk/coreandmandatory

New learning and development opportunities for managers

New: three new continuing professional development (CPD) modules to support the development of managers in adult social care:

- Understanding Performance Management
- Understanding Self-management Skills
- Understanding Workplace Culture

Employers can claim money from the **Workforce Development Fund (WDF)** towards the cost of learning.

Leadership programmes

Existing leadership programmes:

- Lead to Succeed - for aspiring managers and deputies
- Well-led - for registered and other managers.

Employers can claim money from the **Workforce Development Fund (WDF)** towards the cost of learning.

Find out more at **www.skillsforcare.org.uk/leadersandmanagers**

Find an endorsed provider at **www.skillsforcare.co.uk/findaprovider**

Funded opportunities to complete the new CPD modules and leadership programmes

Endorsed providers: in 2019-20 providers with the licence for the CPD modules, Well-led or Lead to Succeed can offer up to 20 funded places to managers.

Workforce Development Fund (WDF) Partnerships: in 2019-20 partnerships can use up to 30% of their grant to commission the CPD modules, Well-led or Lead to Succeed for the managers they work with.

Don’t forget: you can still access funding for all of these programmes through the traditional WDF route as well.

Becoming a confident mentor - workshop

Being trained as a mentor gives you the opportunity to mentor others, whilst learning new skills, developing greater self-awareness and reflecting on your practice.

The workshops cost £160+VAT. Registered manager members have exclusive **free access** to these workshops.

- **Birmingham –** Thursday 5 December 2019
- **London –** Wednesday 4 March 2020

Book now at **www.skillsforcare.org.uk/events**

Membership organisation for registered managers

Join our growing community for £35 for 12 months

- Copy of ‘Social care manager’s handbook’
- Monthly members’ newsletter
- Free online resources and bookshop discounts
- Discounts on leadership programmes and seminars
- Mentoring opportunities
- Access to a members-only Facebook group

Find out more at **www.skillsforcare.org.uk/membership**

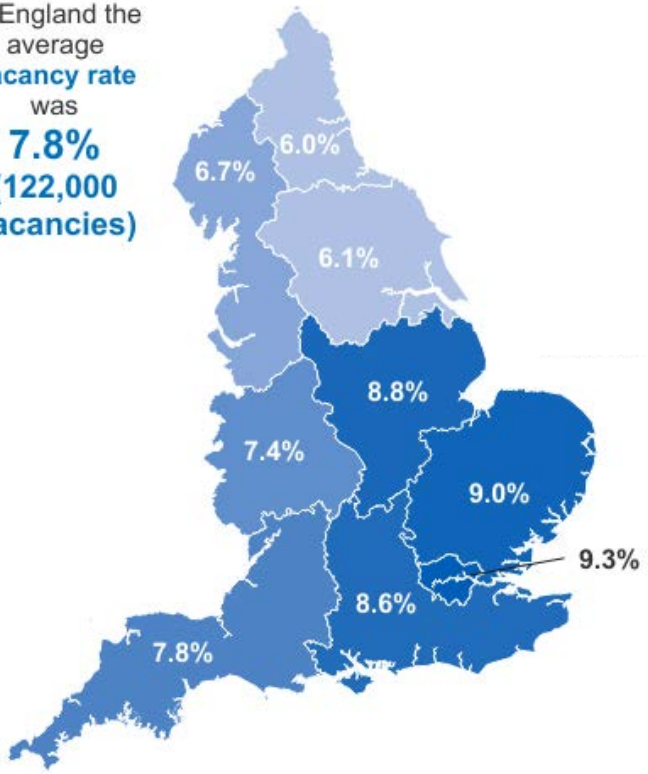
The state of the adult social care sector and workforce in England

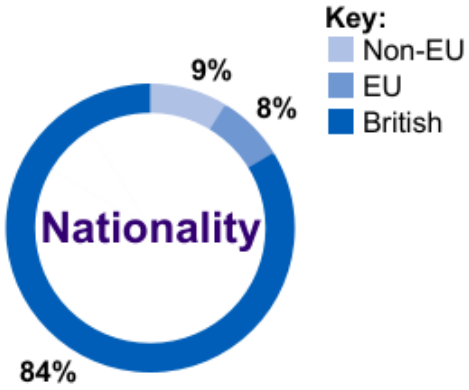
Key findings

1.52m jobs

in adult social care across local authorities, independent sector and jobs working for direct payment recipients in 2018/19.

In England the average **vacancy rate** was **7.8% (122,000 vacancies)**





8% (115,000) of the workforce in England held an **EU nationality**

The state of the adult social care sector and workforce in England

Key findings

Care worker real term median hourly pay

24% of jobs were on **zero-hours contracts**

25% were **aged 55 and above**

66% of leavers **remained in adult social care** in 2018/19

The average **turnover rate** was **30.8%** (440,000 leavers in last 12 months)

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Fast Track Improvement Team Workshop

Lynda Ruddock and Chris Charters

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NHS
York Teaching Hospital
NHS Foundation Trust

Continence Team Update

Ann Potter

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NHS
Yorkshire Ambulance Service
NHS Trust

Urgent Care Practitioner Update

Tim O'Dowd

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Coffee Time!

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Tees, Esk and Wear Valleys NHS Foundation Trust

Care Home and Dementia Team Update

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Tees, Esk and Wear Valleys
NHS Foundation Trust

Dementia Screening in Care Homes

A case finding project commissioned by the CCG

making a difference together

Why are we doing this?

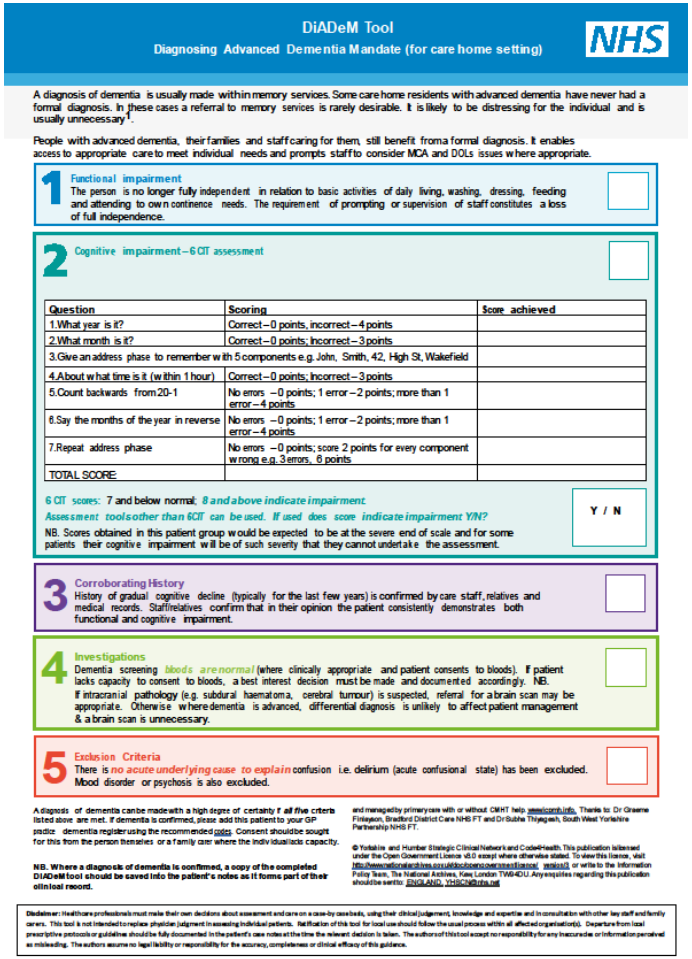
- Number of cases of dementia is lower than expected in the Vale of York

- Will enable better informed care for residents
  - Advanced Care Plans
  - Greater understanding
  - Possibility of medication

How are we doing this?

1. • Care home data
2. • Screen for dementia
3. • Liaise with GP

The DiADeM Tool



DiADeM Tool

Diagnosing Advanced Dementia Mandate (for care home setting)

NHS

A diagnosis of dementia is usually made within memory services. Some care home residents with advanced dementia have never had a formal diagnosis. In these cases a referral to memory services is rarely desirable. It is likely to be distressing for the individual and is usually unnecessary[1].

People with advanced dementia, their families and staff caring for them, still benefit from a formal diagnosis. It enables access to appropriate care to meet individual needs and prompts staff to consider MCA and DOLs issues where appropriate.

1 Functional impairment

The person is no longer fully independent in relation to basic activities of daily living, washing, dressing, feeding and attending to own continence needs. The requirement of prompting or supervision of staff constitutes a loss of full independence. ☐

2 Cognitive impairment – 6 CIT assessment ☐

Question	Scoring	Score achieved
1.What year is it?	Correct – 0 points, incorrect – 4 points	
2.What month is it?	Correct – 0 points; Incorrect – 3 points	
3.Give an address phase to remember with 5 components e.g. John, Smith, 42, High St, Wakefield		
4.About what time is it (within 1 hour)	Correct – 0 points; Incorrect – 3 points	
5.Count backwards from 20-1	No errors – 0 points; 1 error – 2 points; more than 1 error – 4 points	
6.Say the months of the year in reverse	No errors – 0 points; 1 error – 2 points; more than 1 error – 4 points	
7.Repeat address phase	No errors – 0 points; score 2 points for every component wrong e.g. 3 errors, 6 points	
TOTAL SCORE		

6 CIT scores: 7 and below normal; *8 and above indicate impairment.*

Assessment tools other than 6CIT can be used. If used does score indicate impairment Y/N? Y / N

NB. Scores obtained in this patient group would be expected to be at the severe end of scale and for some patients their cognitive impairment will be of such severity that they cannot undertake the assessment.

3 Corroborating History ☐

History of gradual cognitive decline (typically for the last few years) is confirmed by care staff, relatives and medical records. Staff/relatives confirm that in their opinion the patient consistently demonstrates both functional and cognitive impairment.

4 Investigations ☐

Dementia screening *bloods are normal* (where clinically appropriate and patient consents to bloods). If patient lacks capacity to consent to bloods, a best interest decision must be made and documented accordingly. NB. If intracranial pathology (e.g. subdural haematoma, cerebral tumour) is suspected, referral for a brain scan may be appropriate. Otherwise where dementia is advanced, differential diagnosis is unlikely to affect patient management & a brain scan is unnecessary.

5 Exclusion Criteria ☐

There is *no acute underlying cause to explain* confusion i.e. delirium (acute confusional state) has been excluded. Mood disorder or psychosis is also excluded.

A diagnosis of dementia can be made with a high degree of certainty if *all five* criteria listed above are met. If dementia is confirmed, please add this patient to your GP practice dementia register using the recommended codes. Consent should be sought for this from the person themselves or a family carer where the individual lacks capacity.

NB. Where a diagnosis of dementia is confirmed, a copy of the completed DiADeM tool should be saved into the patient's notes as it forms part of their clinical record.

and managed by primary care with or without CMHT help www.icanh.info. Thanks to: Dr Graeme Finlayson, Bradford District Care NHS FT and Dr Subha Thyagesh, South West Yorkshire Partnership NHS FT.

Disclaimer: Healthcare professionals must make their own decisions about assessment and care on a case-by case basis, using their clinical judgement, knowledge and expertise and in consultation with other key staff and family carers. This tool is not intended to replace physician judgment in assessing individual patients. Ratification of this tool for local use should follow the usual process within all affected organisation(s). Departure from local prescriptive protocols or guideline should be fully documented in the patient's case notes at the time the relevant decision is taken. The authors of this tool accept no responsibility for any inaccuracies or information perceived as misleading. The authors assume no legal liability or responsibility for the accuracy, completeness or clinical efficacy of this guidance.

Integrated Care Team are covering

- Ivy Lodge
- Meadowbeck
- Minster Grange
- Red Lodge
- South Park
- The Oaks
- The Lodge
- Haxby Hall
- Armarna House
- Birchlands Care Home
- Broadway Lodge
- Chocolate Works
- Connaught Court
- Ebor Court
- Fulford Nursing Home

Rachel Instone (CHAD)

- Appletree Care Home
- Derwent House
- Grimston Court
- Handley House
- Lamel Beeches
- Lime Tree House
- Mulberry Court
- Prospect House
- Rosevale
- Somerset House
- Wishing Well
- Abbey Lea
- Carentan House

Rachel Instone (CHAD)

- Firth House
- Hambleton Court
- Highfield Nursing Home
- Hilltop Manor
- Lake and Orchard
- Mansion House
- Meadow Lodge
- Riccall House
- Temple Manor
- The Grange
- Tudor House
- Westwood Care Home
- Oak Trees Care Home
- St Catherine's

Rachel Instone (CHAD)

- William Wilberforce
- Wold Haven
- Osborne House
- Beaumont
- Denison House

Contact details

Rachel Instone: rachel.instone@nhs.net

Mobile: 07876817616

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Community Equipment Update

Pam Bolderson

NHS
Vale of York
Clinical Commissioning Group

Partners in Care Forum

In aid of Alzheimer's Society United Against Dementia

27th November 2019

Pam Bolderson (CCG)
Darren Clark (Medequip)

In December 2016 Medequip began providing the Integrated Community Equipment Service for:

North Yorkshire County Council
NHS Vale of York CCG
NHS Harrogate and Rural District CCG
NHS Hambleton, Richmondshire & Whitby CCG
NHS Scarborough and Ryedale CCG
NHS Airedale, Wharfedale and Craven

The service specification states:

Standard Equipment shall not be supplied to nursing and residential homes, short break settings, hospice, schools or colleges and places of work; with the exception whereby short term lean (less than 6 months) of standard equipment can be provided to service users to enable hospital discharge/interdependence or for short term illness/mobility and following any re-enablement / rehabilitation plan

Delivery

- Medequip offer a 24 hour / 365 day service for delivery, inspection and replacement service on all Beds / PAC Mattress and Seating / Toileting and Hoists

- Deliveries are by prescribed order from a NHS / Healthcare professional

- Repairs on the above equipment can be reported 24 hours per day by service users / family / carers in addition to NHS / Healthcare professional

Equipment over 6 months

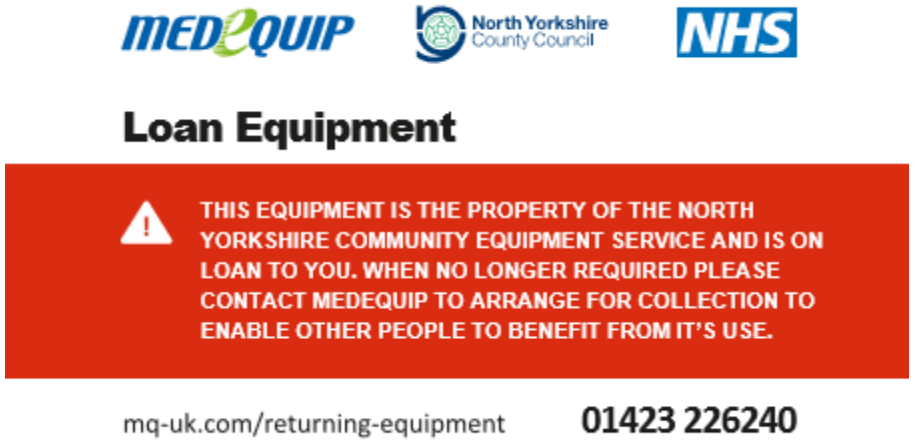
There are currently over 7000 items in care homes across North Yorkshire which have been on loan for longer than 6 months

There is a significant financial benefit for the NHS that equipment that is no longer in use or has a loan period of over 6 months to be re used

Medequip re-use on average 93% of all returned equipment again & again

Medequip are actively canvassing the return of equipment we may have already written to you

Return
Recycle
Reuse



Returning Equipment

How?

Contact Medequip to request a collection

Call **01423 226240**

Email **north.yorks@medequip-uk.com**

Discharge Hub Update

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Trusted Transfer Pathway Standards

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Aims and intended benefits:

- Essential health and care information regarding residents to be accessible in a standardised format
- Improved communication and relationships between Hospital & Care Homes
- Smoother admission and discharge processes
- Improved ability to provide person-centred care during hospital admission

An evaluation report outlined the benefits of the Hospital Transfer Pathway:

length of hospital stay decreased by 4.4 days (NH) & 4.1 days (RH)

The HTP can help reduce long and short stays in hospital and has benefits in lowering the risk of harm to patients from deconditioning associated with hospital stays

(Sutton CCG Vanguard)

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What does it look like?

Trusted Transfer Document

This is my Trusted Transfer of Care Document

My name is: Click here to enter text.

If I have to go to hospital this document needs to go with me, it gives the hospital staff important information about me, when I am well.

If my care provider calls to discuss my care the following password will confirm their identity: Click here to enter text.

The Situation, Background, Assessment & Response (SBAR) tool explains the reason why I have been transferred to hospital.

Attached to my Document are:

Original - Do Not Attempt CPR ☐

Advanced Care Plan Yes/No/N/A

Date last seen by a Health Professional: Click here to enter a date.

Copy of Consent form	☐	Advanced Decision to refuse treatment (ADRT)	Yes/No/N/A
Body Map	☐	Lasting Power of Attorney (LPA) Included	Yes/No/N/A
Copy of current MAR Chart	☐	Deprivation of Liberty Safeguard (DoLS) in place	Yes/No/N/A

Copy of Inter Health and Social Infection Control Transfer Form ☐

This document belongs to me and should follow me throughout my hospital stay.

Please return it with attached documents when I am discharged.

Clinical staff should refer to this document for important information about me.

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Trusted Transfer
(to include Red Bag for Scarborough, Ryedale and Whitby patients)

What it means for you: HOSPITAL STAFF

On arrival

- Review the information in the Trusted Transfer of Care Document
- Care Homes are being encouraged to send original documentation where relevant and all should be returned on discharge (in Red Bag where applicable)

During the stay

- Trusted Transfer of Care Document and Red Bag (if applicable) stays with the patient's notes
- Contact the care home within 48 hours of admission to start discharge planning communications

On Discharge

- Ensure Transfer of Care Document variance sheet is updated and if Red Bag in use ensure contents are complete
- Include **discharge letter, ORIGINAL DNA CPR and all medication**
- Include any further documentation that may be of relevance i.e. advice sheets, follow up appointments

- **The Trusted Transfer Document/Red Bag must stay with the patient at all times from when they leave the care home until they return**
- **Patient documentation must be kept securely at all times**

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Procedure for Residents from Care Homes attending Hospital with a Trusted Transfer Document

Operational Procedure for York Teaching NHS Hospitals Foundation Trust (YTHFT) Staff (York and Scarborough Hospital site)

NOTE: The Trusted Transfer Document will be transported in a Red Bag for Scarborough, Ryedale and Whitby patient.

Front of House Areas: Emergency Department/Outpatients

- **The Trusted Transfer Document/ Red Bag for SRCCG should be kept with the patient at all times and follow the patient through their hospital stay.**
- Relevant information for professionals will be located at the front section of the Trusted Transfer Document. This section will include DNAR where relevant, reason for referral and information about the individuals baseline if the patient does not require admission.The Trusted Transfer Document and accompanying documents must return with the patient to the care home (in the Red Bag for Scarborough, Ryedale and Whitby patients)).

All Wards

- When the patient arrives on the ward staff should refer to the information in the Trusted Transfer Document which will enable accurate information to be included in clinical assessments
- All staff should have access to the Trusted Transfer Document and accompanying information.
- The Trusted Transfer Document should be kept with the patient's notes to enable easy access to background and baseline information to support their decision making for care and treatment.
- Following Senior Medical review if the patient does not require admission to a base ward and is able to return home, the variance sheet should be completed to document any changes. If a DNACPR has been completed during the admission the original Form should accompany the Trusted Transfer Document and accompanying documentation (and placed in the Red Bag for Scarborough, Ryedale and Whitby patients).
- **The complete Trusted Transfer documentation should accompany the patient on transfer and be returned home with the patient**

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CHC Contracts & Team Update

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React to Falls Prevention

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Leaves are supposed to fall. People are not!

REACT TO FALLS PREVENTION

Every year around 1 third of people over 65 experience one or more falls

Care home residents are three times more likely to fall than elderly people living in their own homes

Injury rates are considerably higher for care home residents, with up to 20% of falls resulting in a hip fracture

This equates to almost 1 in 3 people admitted to an acute hospital with a hip fracture coming from a care home

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REACT TO FALLS PREVENTION

Falls can have a devastating effect on individuals and those around them.

Physical Impact

Psychological Impact

Financial Impact

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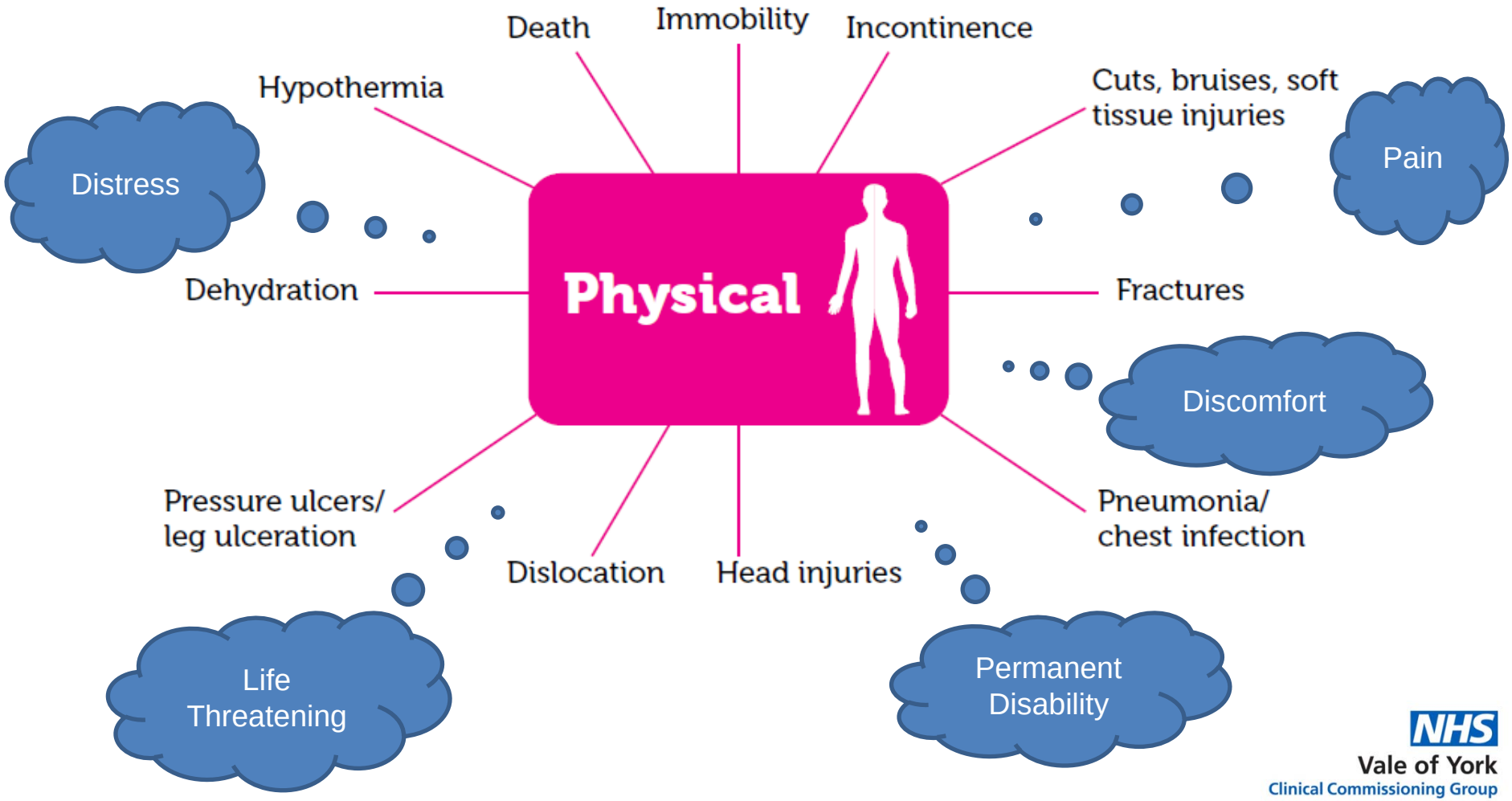
REACT TO FALLS PREVENTION

Figure 2: physical consequences of a fall and/or a prolonged length of time lying on the floor



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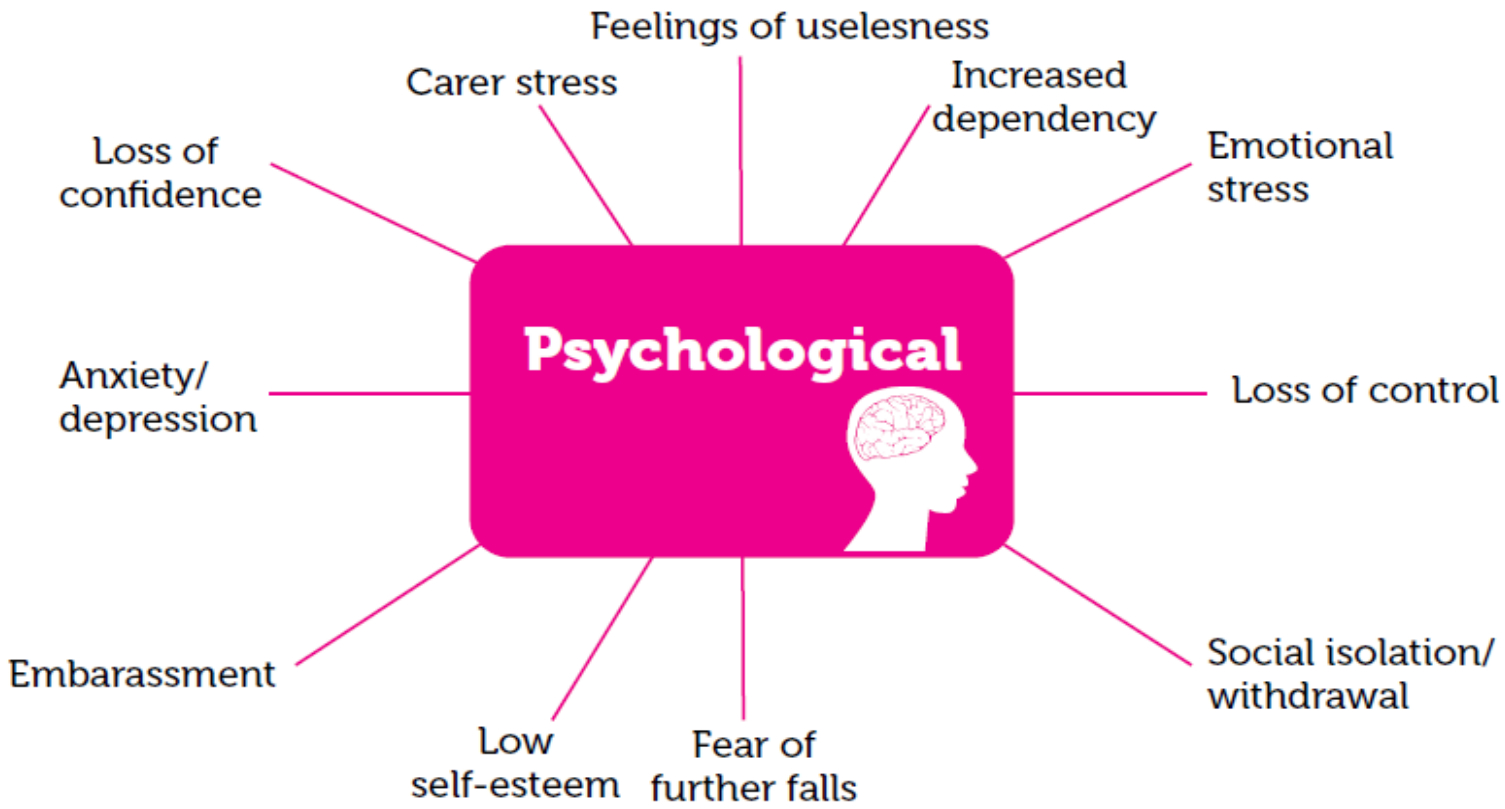
REACT TO FALLS PREVENTION

Figure 3: psychological consequences of a fall and/or a prolonged length of time lying on the floor



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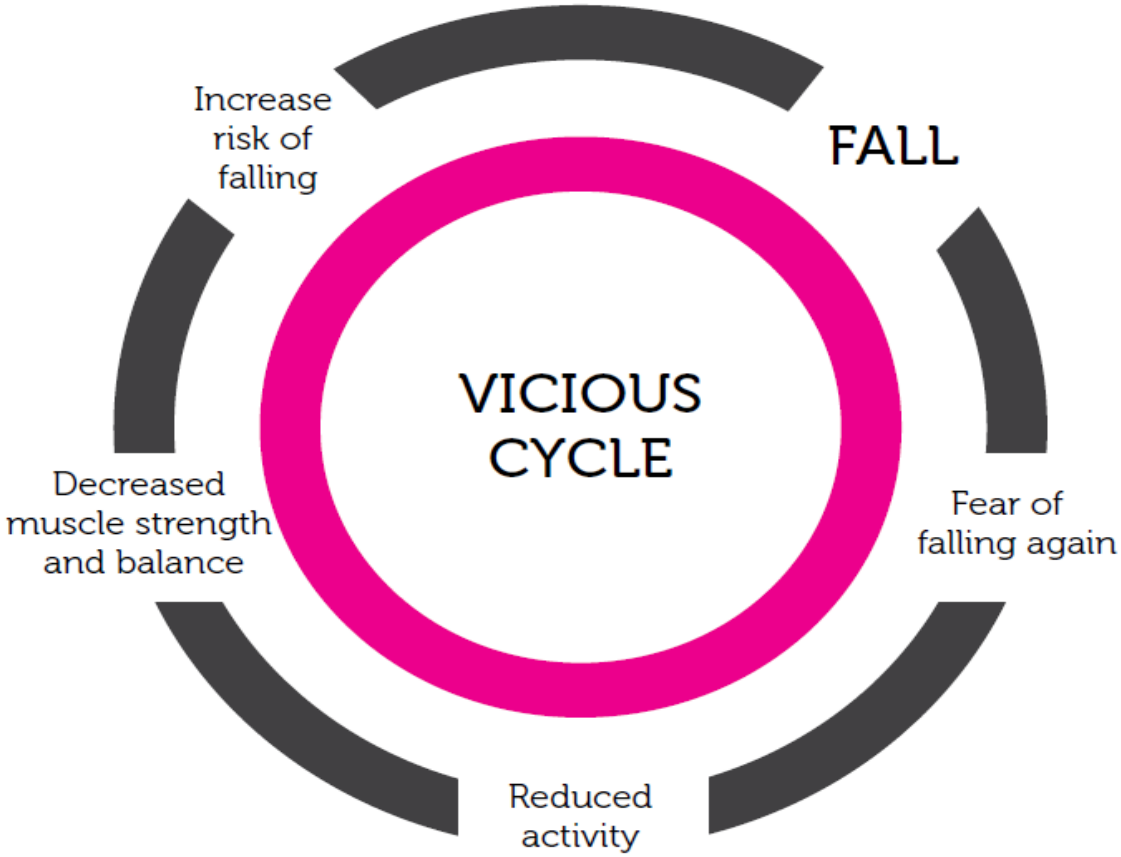
REACT TO FALLS PREVENTION

Figure 4 The vicious cycle of falls



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REACT TO FALLS PREVENTION

Cost

In addition to the pain, distress, discomfort and psychological impact a fall can have on the individual; they also have a huge financial implication to health and social care organisations with an estimated cost to the NHS of……

£6,000,000 a day!

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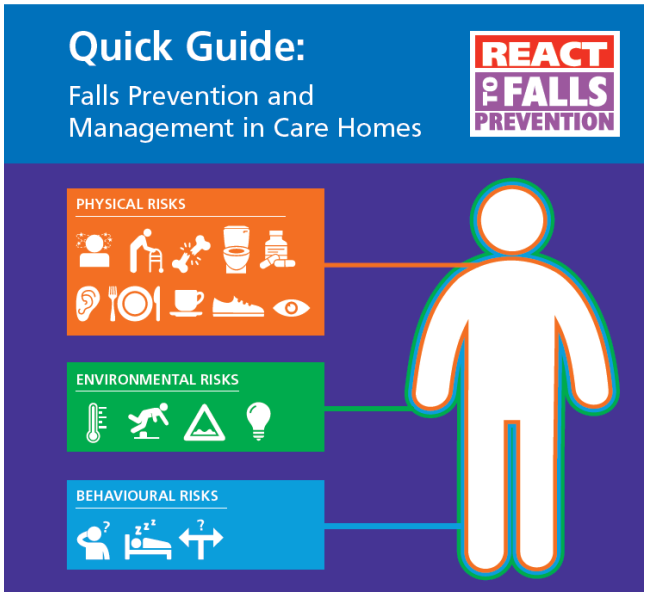
REACT TO FALLS PREVENTION

As outlined in NHS England's falls Prevention and management in care homes (2019):

"Everyone working in a care home has a key role in identifying and reducing the risks of falls as part of supporting the health and wellbeing of residents."

NHS



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REACT TO FALLS PREVENTION

How do we ensure that care home staff are equipped with the skills and tools necessary to identify those at risk of falling and take appropriate measures to reduce these risks?

So…

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REACT TO FALLS PREVENTION

Reacting to Falls Prevention; the NHS VOY CCG way!

- Development of a Multi-faceted approach, peripatetic approach to prevent and manage falls for each care home resident
- Supporting care homes to promote best practice
- Promoting React to Falls Prevention principles which support carers in recognising when an individual is at an increased risk and the steps that can be taken to reduce these risks

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The approach

REACT TO FALLS PREVENTION

Care homes are encouraged to:

- Review falls policies/risk assessment tools/care plans/falls evaluation methods
- Implement ‘Days between falls boards’
- Use the falls prevention prompt to assist in recognition of falls risks
- Encourage all staff to be involved with falls prevention and management
- Ensure that all staff attend React to Falls Prevention Training

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REACT Framework

REACT TO FALLS PREVENTION

REACT stands for:

Review medical history and physical health

Encourage and support care leaders to review residents' history of falls (frequency and patterns); any medical and physical health such as low blood pressure, dizziness, fractures/osteoporosis, foot problems, nutrition/hydration, illness or infection, both on admission, regular basis and /or as condition changes; referring to other professionals as required. This should include reviewing residents medications, are they taking 4 or more different types, do they have any side effects such as drowsiness, sedation, increased toilet needs. Have they had a recent medication review with a GP or Pharmacist?

Environment and Equipment

The environment should be clear of clutter & hazards with suitable lighting. Call bells should be accessible and working and alarm sensors considered where appropriate. Consideration should be given to the suitability of footwear and clothing.. Floor patterns should be kept to a minimum and surfaces not too slippery or difficult to push aids on, such as thick pile carpets.

Activity

Residents should be supported to continue to be active, make their own life-style choices and mobilise safely with assistance/support/supervision as required. Ensuring appropriate mobilisation aids are used and referral to appropriate services – GP, Occupational or Physiotherapy, Podiatry, District Nurses and voluntary sector organisations.

Communication and understanding

All residents should be supported with communication and comprehension, recognising and supporting residents that are confused/disorientated or otherwise impaired; ensuring that communication aids are clean, functioning, and being used appropriately. Vision and hearing tests should be up to date.

Toilet

Residents should be supported with continence/toileting as appropriate, promoting regular toileting and ensuring continence assessments are completed. Any changes in toilet habits need to be recognised and appropriate signage for the toilet in place as required. The use of commodes considered for night time use as required.

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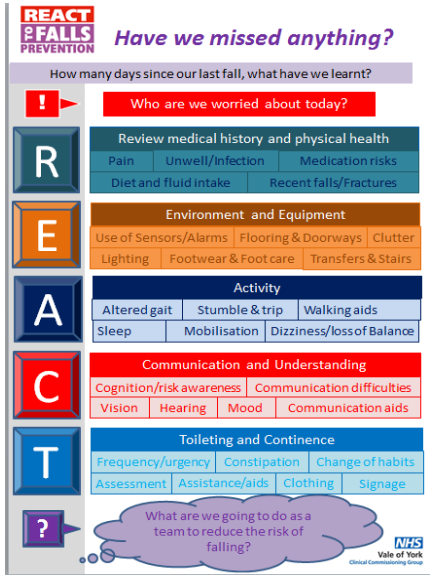
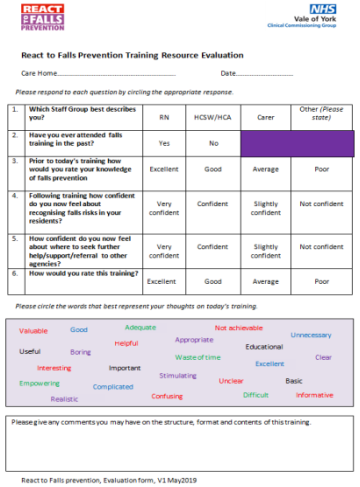
Resources:

www.reactto.co.uk





Training

REACT TO FALLS PREVENTION

Staff

Residents

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REACT TO FALLS PREVENTION

The Key messages are: Be Proactive

- React to Falls before they happen
- Support residents to continue to be active, mobilise and make their own lifestyle choices
- Falls risk factors are individual to each resident
- Managing falls is a continuous process
- Prevention of falls is everyone's business
- Involve residents in the prevention of falls

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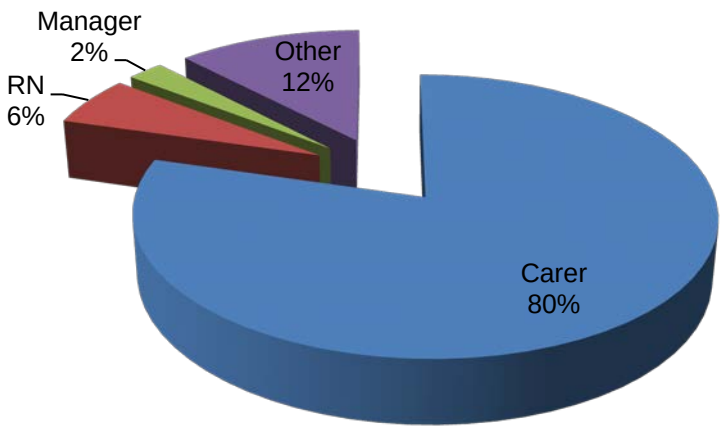
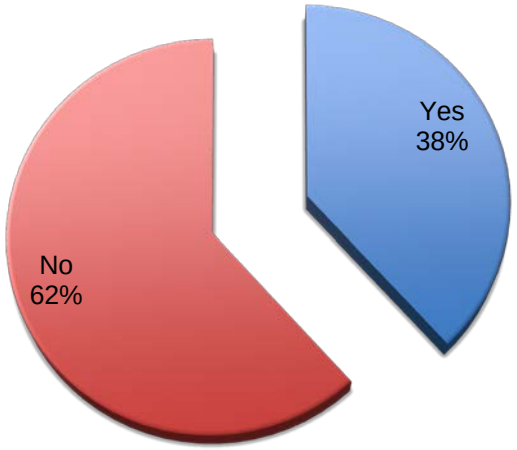
So Far……..

- 30 Care homes participating
- 426 care staff trained

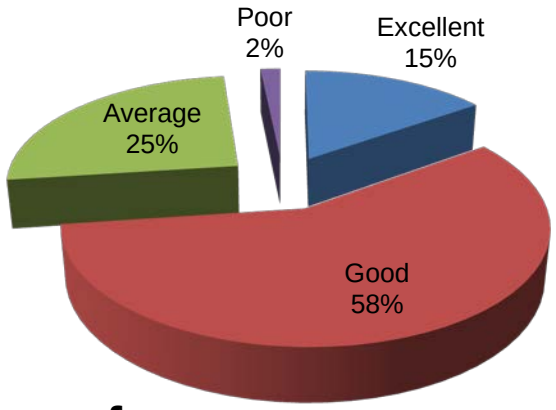
Staff Group



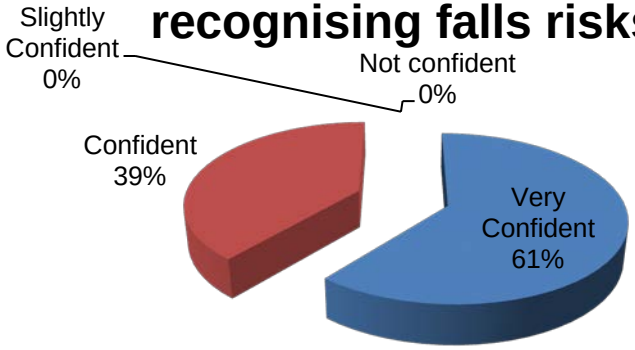
Previous Falls Training?



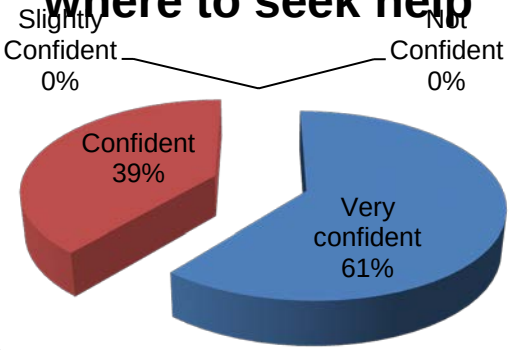
Knowledge prior to training



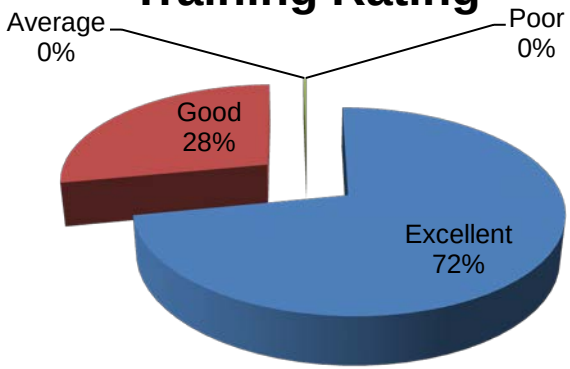
Post training confidence of recognising falls risks



Post training confidence, where to seek help



Training Rating



REACT TO FALLS PREVENTION

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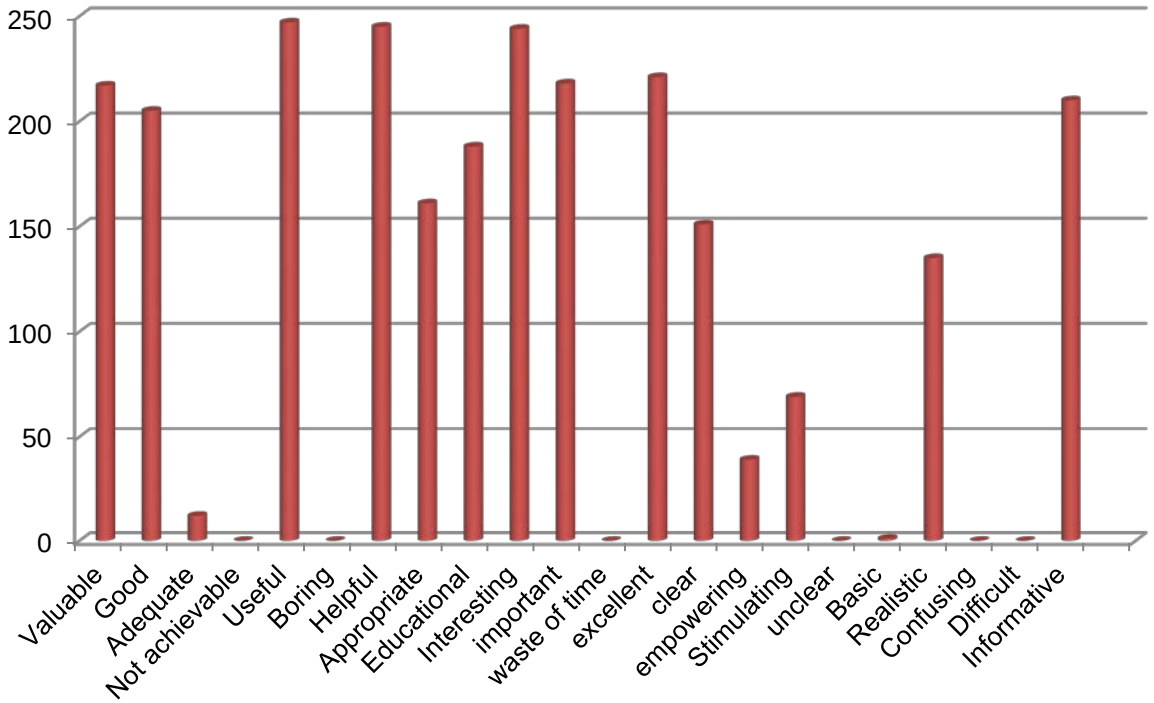
REACT TO FALLS PREVENTION

Participant views



Top 7

- Useful
- Helpful
- Interesting
- Excellent
- Important
- Informative
- Valuable

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REACT TO FALLS PREVENTION

worked well for all different roles. Demonstration/activity very engaging

Very helpful and realistic in care homes.

Really useful to use glasses/ ear muffs/ trousers/ slippers to experience how a resident might feel. Great presentation & group activity.

Very interesting to use the glasses to see how vision is affected and contributes to falls risks.

All staff should be told on daily basis which clients are at risk of falls. Learnt a lot today. Helps to recognise all aspects of awareness

Gained knowledge vital to job

Simple, effective, clearly given information

Interesting and fun. Kept us interested, enjoyed the activity. Fantastic well received and informativ

This session is beneficial to any roles in a health care sector, creates more awareness

Good mix of video and discussion. Great interaction

Proactive use of costume was a good learning tool

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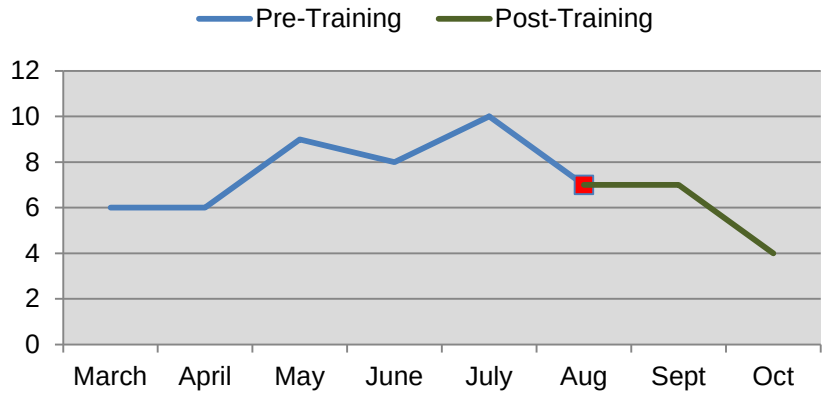
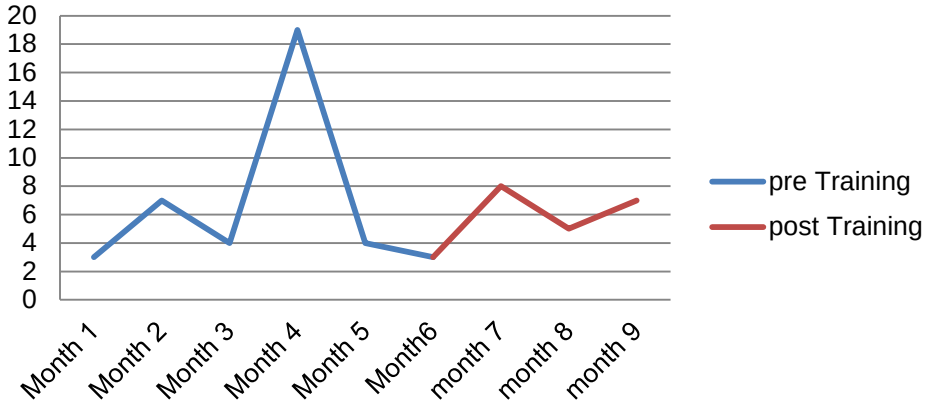
Data collection

REACT TO FALLS PREVENTION

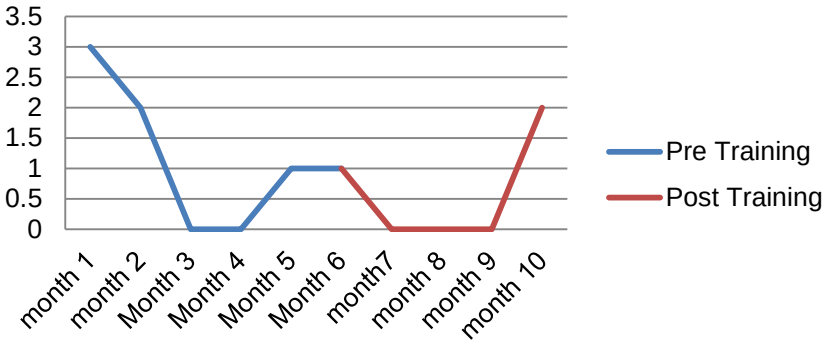
Number of Falls by Month - Care Home 1



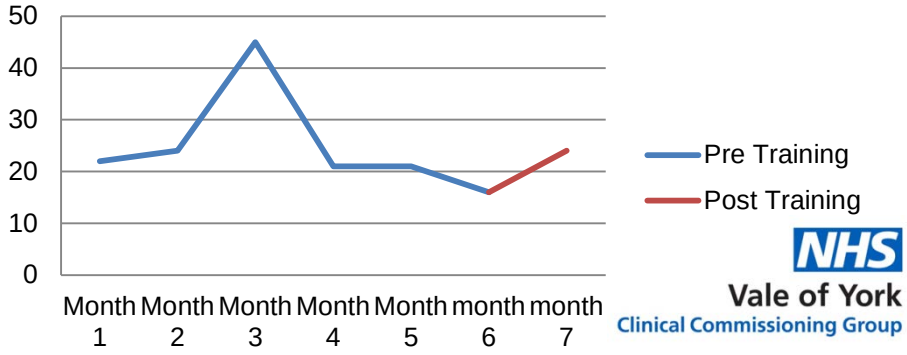
Number of Falls by Month - Care Home 2



Number of Falls by Month - Care Home 3



Number of Falls by Month- Care Home 4



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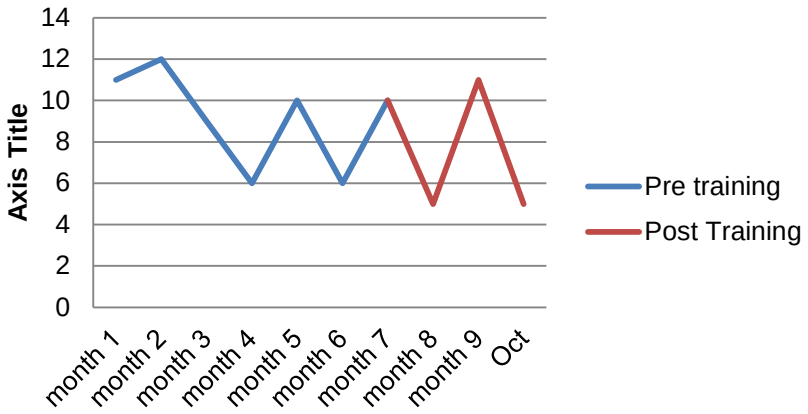
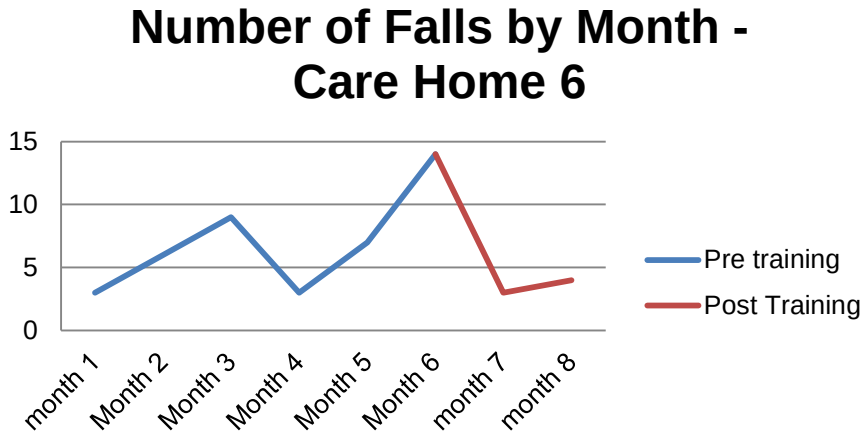
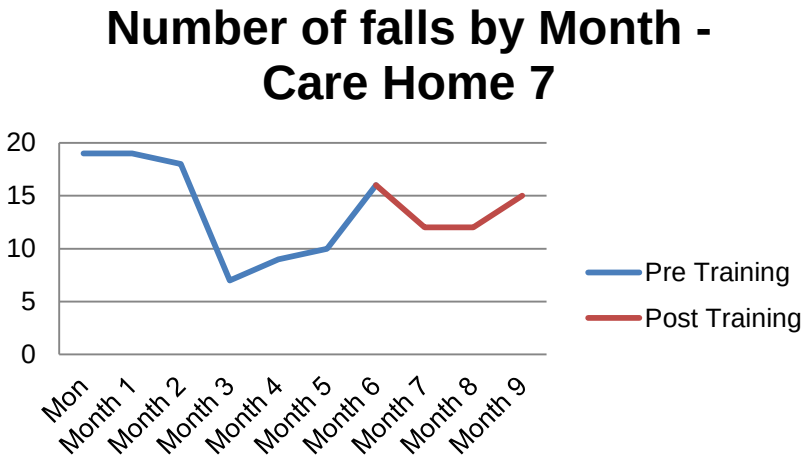
REACT TO FALLS PREVENTION







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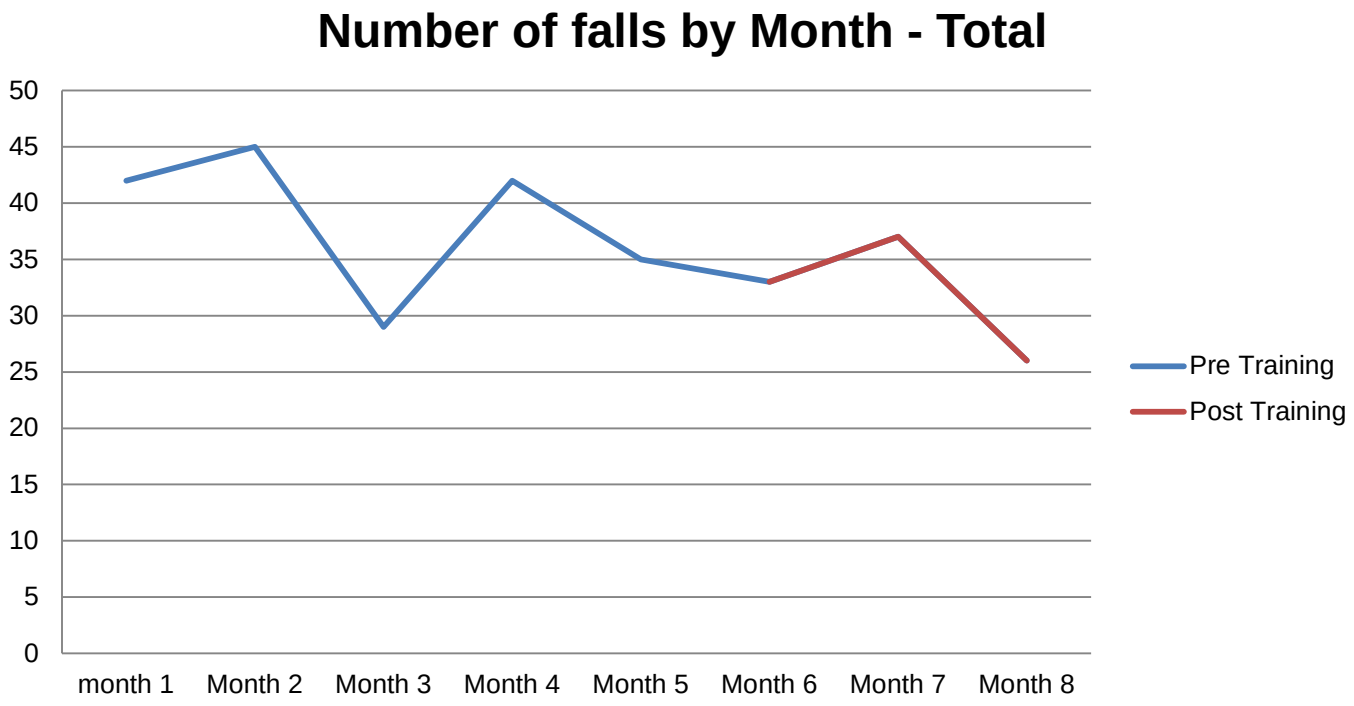

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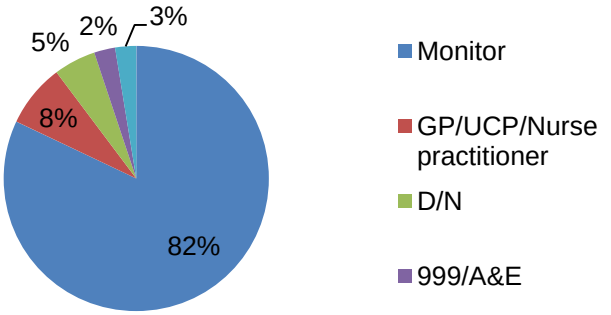
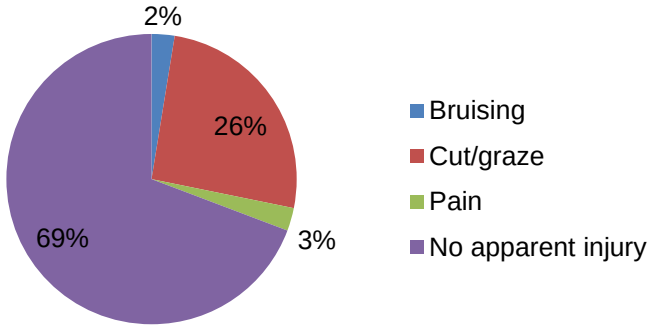
Data Collection

Care Home 1 ed…

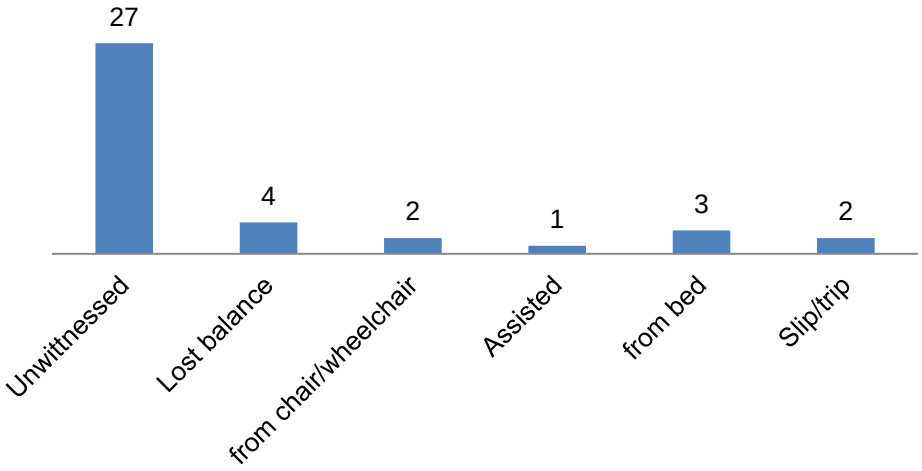
Actions following falls



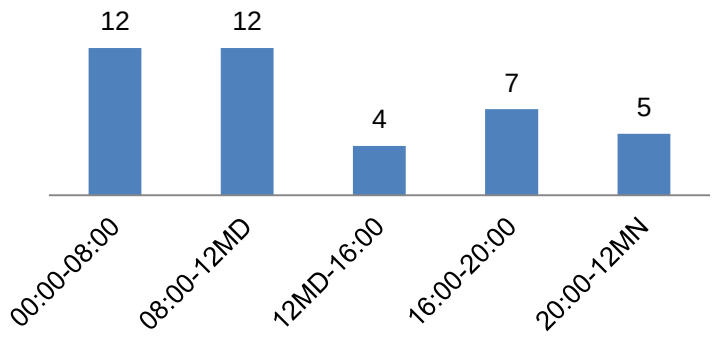
Injurys following Falls



Type of Fall



Time of falls



Stop The Pressure Day 2019

REACT TO FALLS PREVENTION

To be continued……

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VOY CCG, Care Homes & Domiciliary Care

Coming soon…….

- Identification of Deteriorating Residents
- Hospital Transfer Pathway
- ‘React to Falls’ Prevention
- Connecting Care Homes; digital programme
- DSPT- IG Toolkit

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Dispensing Creams Update

It has been brought to the attention of the CCG there have been some instances where topical preparations such as creams and ointments supplied via the District Nurse team do not have labels or directions meaning care staff do not have the information needed to apply them.

• The District Nursing (DN) teams obtain dressings and some topical preparations through a supplier called ONPOS to give to people directly instead of needing a prescription. This means supply of these items is quicker and more direct to support care for the person. However, this also means there is no dispensing label and the directions on how much to apply, where to apply the preparation and how often it should be applied need to be given in another way for care providers.Following on from this issue being raised, we have had conversations with the DN team leaders who have advised that care plans should be provided by the DNs and these should state how and where the preparation should be applied. The DN team leaders have been asked to remind all DNs to ensure they are leaving copies of care plans and if there are creams/ointments left to ensure the directions are clear.

• The details provided can be used by the care provider to prepare entries on the MAR chart and/or supplementary information for creams/ointments such as a TMAR. A blank supplementary information form is attached to this email which can be used if wished to record the information. A copy of the DNs care plan should be kept with the person's MAR chart or in their care records at the home. Staff can write the person's name on the packaging in order to identify it as belonging it to that person if necessary. The date of opening should be recorded on the packaging for creams or ointments with a short shelf life once opened.

• Going forward, if there are instances where DNs are not leaving care plans with directions, could these please be reported to jhussain1@nhs.net with as many specific details as possible, such as the person's details, the date of the visit, name of DN and name of care home. With these details we can feedback to the DN team leaders to improve the system as a whole

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Partners in Care… next time!

- Sharing of information and discussion
- Please cascade information to colleagues who you think should be included
- What agenda items would you like including?

Feedback to sarah.fiori@nhs.net

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Anything to talk about?

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Good Practice and Sharing of Learning

Share your news and let's celebrate!!

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Good Practice and Sharing of Learning

- *The CCG's React to Red Programme was Highly Commended in the Patient Safety Category of the Health Service Journal Awards, and was also nominated in the Care for Older People' category of the Nursing Times Awards.*

Good Practice and Sharing of Learning

- *Congratulations to Alison Redhead, Manager of Minster Grange who was a finalist in the York Press Community Pride Awards. Alison was nominated in the Health Service Hero category for being an exemplary example of a caring, committed and passionate nursing home manager who is dedicated to ensuring that the service provided is of the highest standard.*

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Good Practice and Sharing of Learning

- *Congratulations to Apple Tree Care Home who have completed Stop and Watch training, and are now are successfully using the tool effectively to recognise and respond to deterioration in residents. Deputy Manager Sharon Clemitt received a certificate to recognise the work their staff have undertaken to embed Stop and Watch tool in the home.*

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Good Practice and Sharing of Learning

- *Julian Sturdy MP and Lord Mayor Janet Looker were just two of visitors who joined Home Instead Senior Care, to celebrate 10 years of them providing care and support to the older people of York.*

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Good Practice and Sharing of Learning

- *Amarna House hosted a " Make a Difference Day" where staff and residents were able to give back to all the people who make a difference to them. This included manicures and face packs for district nurses, and afternoon tea for the Friends of Amarna House volunteers from Manor House School. Actress Sherrie Hewson was on hand to host the day and provide entertainment.*

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Good Practice and Sharing of Learning

- ***Staff at Lotus Home Care York have been working to spread a little happiness by hiding over 100 crocheted flowers in community locations including libraries, bus stops and GP surgeries.***

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Good Practice and Sharing of Learning

- ***Somerset House Care Home marked BBC Music Day with a music workshop for staff and choir session for residents.***

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Good Practice and Sharing of Learning

- *Rosevale hosted a charity fun day in aid of York Tourette Support Group and took a brilliant £1050 from raffles, cake sales and a bouncy castle among other attractions for visitors, staff and residents.*

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Good Practice and Sharing of Learning

- ***Well done to Osborne House who have raised a fantastic £705.50 through a memory walk in aid of Alzheimer's Society***

Alzheimer's Society
United Against Dementia

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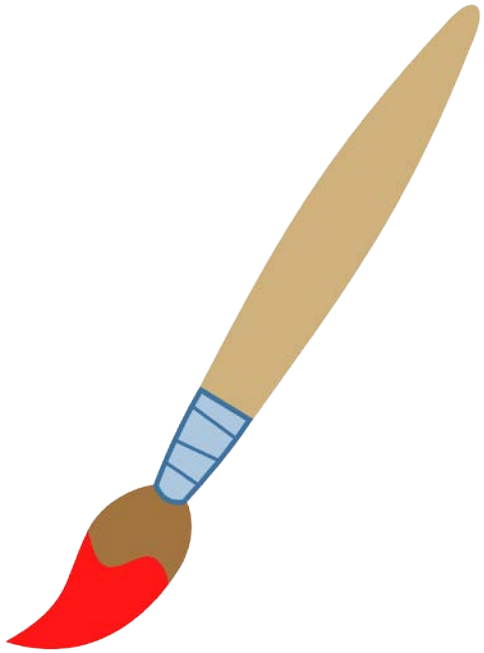
Good Practice and Sharing of Learning

- ***South Park Care Home have had mural painted by the Army Wives Choir that is designed to help bring the outside in and improve wellbeing.***



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Good Practice and Sharing of Learning

- ***Meadow Lodge Home Care Services held a "jabathon" in partnership with a local pharmacy, with 32 staff being vaccinated.***

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Good Practice and Sharing of Learning

Congratulations to all our providers who have been recognised as good by CQC this autumn:

- *Age Concern York in Safe Hands*
- *Abbeyfield House*
- *MENCAP York Domiciliary Care*
- *Bluebird Care York*
- *Apple Tree Care Home*
- *Carentan House*
- *The William Wilberforce*
- *Westwood Care Home*
- *Isabella Court*
- *Oak Trees Care Home*
- *Firth House Care Home*

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See you next time!

Next meeting: Wednesday 29 January 2019 Venue: York Sports Centre, Rawcliffe. York

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