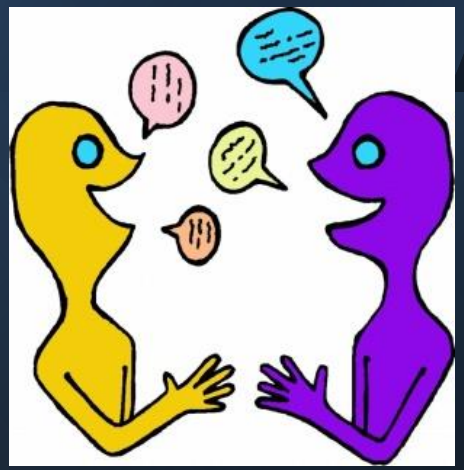
Recognising and Responding to Deterioration in residents with Learning disabilities and /or autism

Vale of York CCG

Y&H Improvement Academy Patient Safety Collaborative



- Ground rules

- By the end of the session
- Recognition
  - What that means
  - Use the structure of the tool to support your observations
  - using the prompt tool

- Responding
  - How to
  - Who to
  - essential information for communication
  - Stop and Watch and SBAR

What do we mean by Deterioration?

The term **Deterioration** can be defined as when a client moves from their normal clinical state to a worse clinical state. This increases their risk of morbidity, organ failure, hospital admission, further disability and even sometimes death.

To reduce the chances of this happening we focus on 3 main areas:

1. Recognition – how do we spot early signs of deterioration?

2. Response – what should do we do when we think someone has deteriorated?

3. Communication – Who should we communicate with and how?

By recognising deterioration earlier, we can prevent harm & hospital admissions

Why do we need to avoid unnecessary Hospital admissions?

- Often disruptive and upsetting for clients
- Significant demand on staff time and resources
- Average cost per visit to hospital £ 1603 (Improvement NHS Nov 18)
- By recognising deterioration earlier we can prevent harm and hospital admissions

Can carers spot the signs of deterioration?

Research suggests…
YES

One study in 2000 showed that carers spotted signs of illness by an average of 5 days before they were seen in the patients' observations.

The study found that carers were able to spot behavioural and functional status changes in clients

Why it's so important to spot deterioration in people with LD?

Figure 6: Age group at death, people with learning disabilities and the general population

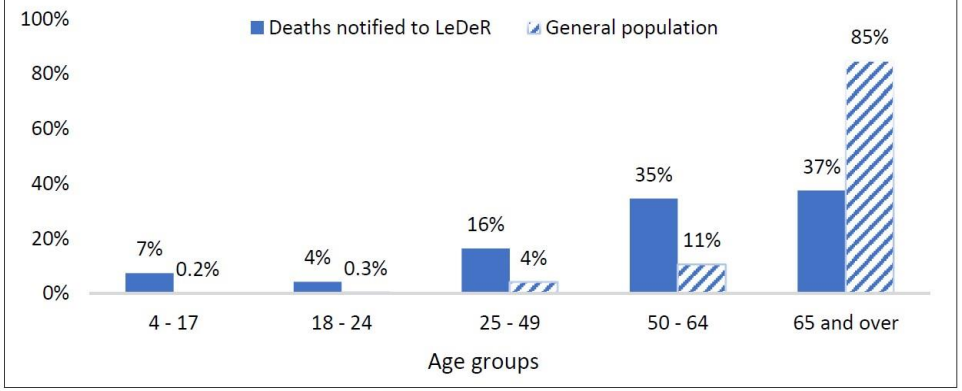
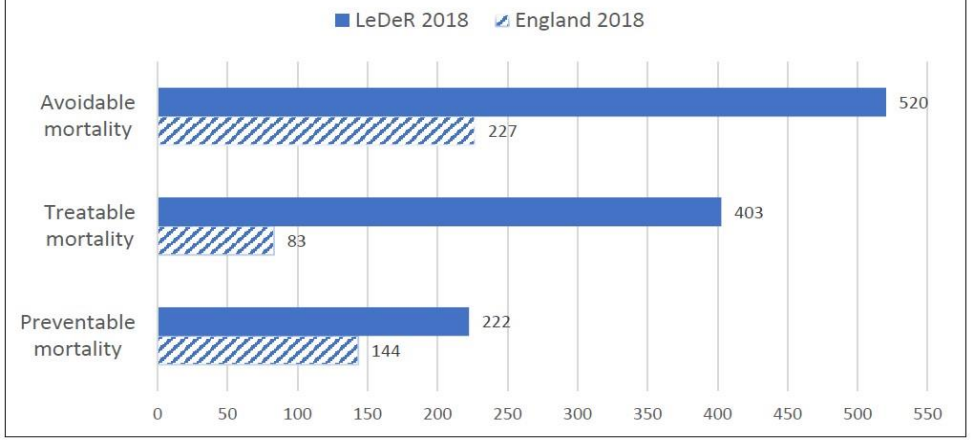


Figure 12: Age-standardised avoidable, treatable and preventable mortality rates (per 100,000), people with learning disabilities and the general population



In people with learning disabilities, males died on average 22 years earlier and females 27 years earlier than those in the general population

Treatable causes accounted for 403 per 100,000 deaths in people with learning disabilities, compared with 83 per 100,000 deaths in the general population.

Know the person you care for!

Understanding what is 'normal', is key to detecting changes.

On their own, some changes they may not look significant, however all play an important role in recognising deterioration.

Important signs can be spotted by everyone who comes into contact with the person

Be aware of clinical diagnostic overshadowing

- Good communication in the team is crucial for this, handover, accurate paperwork and up to date care plans all add value along with tools designed for this specific purpose e.g. 'This is me', Respect, advanced plans.

Remember all team members, families and visitors can spot differences in people . It is important everyone feels able to speak up and that they are listened to if they say they are worried or have noticed anything.

The Stop and Watch Tool

11 prompts to help spot signs of deterioration

Supports your 'Gut Instinct'

Questions based on clinical reasons

S	Seems different to usual
T	Talks or communicates less
O	Overall needs more help
P	Pain new or worsening; participating less in activities
A	Ate less
N	No bowel movement in 3 days; or diarrhoea
D	Drank less
W	Weight change
A	Agitated or more nervous than usual
T	Tired , weak , confused or drowsy
C	Change in skin colour or condition
H	Help with walking, transferring or toileting more than usual

Stop and Watch - Early Warning Tool

If you have identified a change while caring for or observing a resident, please tick the change and notify the person in charge with a copy of this tool.

Name of resident: …… …….. Date of Birth: ……/……/…… Room Number:……..

Date /time				Additional information
S Seems different to usual				
T Talks or communicates less				
O Overall needs more help				
P Pain new or worsening; participating less in activities				
A Ate less				
N No bowel movement in 3 days; or diarrhoea				
D Drank less				
W Weight change				
A Agitated or more nervous than usual				
T Tired , weak , confused or drowsy				
C Change in skin colour or condition				
H Help with walking, transferring or toileting more than usual				
Carer name				
Reported to (senior)				
Senior Action /call GP / 999/ 111 / DN etc Resident monitored or other action				
Outcome / transferred to hospital/ visited by GP/ DN or phone advice given				

CIRCLE IF APPLICABLE
In line with preferred place of treatment Y N
In line with preferred place of death Y N

PLEASE TURN OVER AND USE THE SBAR COMMUNICATION

S Seems different to usual

- However small the change, if **YOU** feel the client is different assess using Stop & Watch
- Often early signs of a problem show when a client is not ‘quite right’ or acting Out of Character – like a gut feeling.
- This may be changes in a clients daily routine, not joining in as much as usual.
- Are there any symptoms of Covid19

T Talks or communicates less

- Whatever the client's usual way of communicating, are they are doing this less often or less effectively?
- We focus on communication as this can be a sign a client is becoming more confused, depressed or tired.

O

Overall needs more help

Lower energy levels can point to infection or deterioration in the clients medical condition.

More dependent, asking for help, needing more staff to help transfers, needing more help for activities of daily living.

P

Pain, new or worsening/ participating less in activities

Not all clients can tell you they are in pain. You may need to observe for nonverbal clues.

Pain is often a symptom of something not being right e.g., pressure damage, bowel problems, angina.

Look for nonverbal cues; looking uncomfortable, fidgety, agitated or not wanting to move

Think about where the pain is – is it specific to one area or general aches and pains

Does the pain respond to pain relief

Use of a pain scale to assess

A Ate Less

You may notice the clients normal eating pattern has altered, eating less, avoiding certain foods.

Lack of appetite can be a sign of lots of medical conditions

Lack of nutrition can lead to malnutrition with its potentially serious consequences.

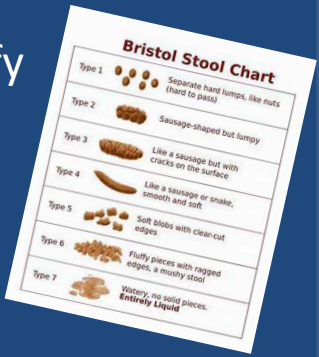
Many studies have found a direct relation between malnutrition and increased length of hospital stay, treatment costs, return to usual life.

Does the resident need help with feeding ?

N No bowel movement in days or diarrhoea

Monitoring of bowels is an important indicator of ill health. As well as frequency it is useful to also note the colour of stools:

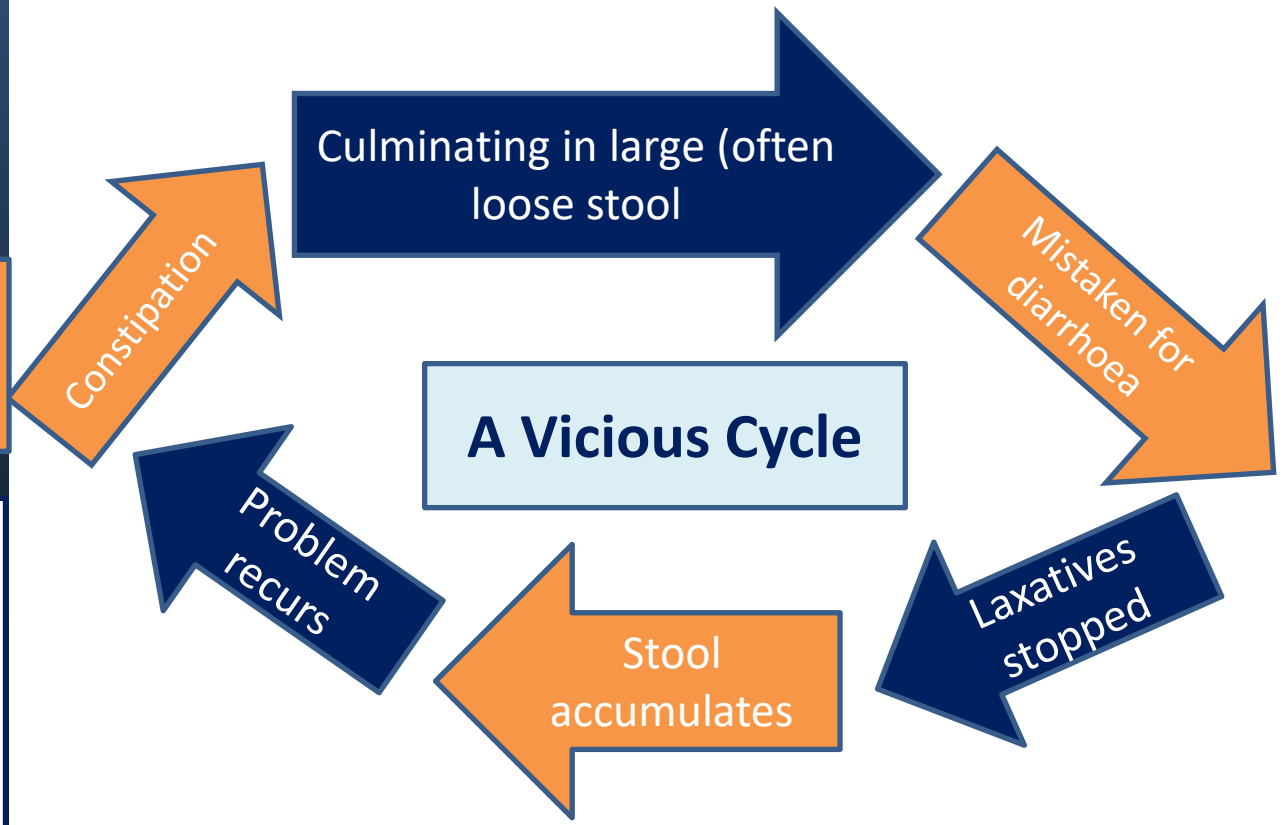
Black - Often a sign of internal bleeding
Red - Red signifies blood and bleeding
Pale - indicates an underlying problem in the liver, gallbladder, or pancreas; all of which contribute to the digestive system
Green - may also be caused by consuming leafy vegetables, iron supplements, or be due to an intestinal condition or infection.
Watery - Disturbances of the digestive tract, as seen with various bacterial and viral infections.
Use the Bristol stool scale or other to identify



Constipation

Can be difficult to identify and diagnose in a person with learning disabilities.

An estimated 10% of the general population suffer from constipation, whereas between 20 -50% of people with learning disabilities are affected.

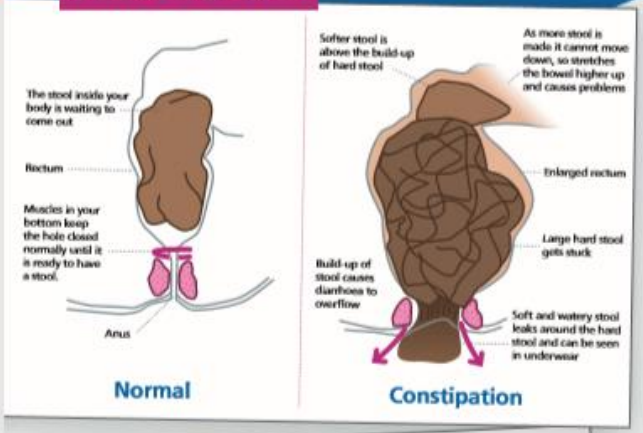


Over a period, the bowel becomes hugely distended, storing very large volumes of stool and the problem becomes very uncomfortable (and risky) for the sufferer. Deaths have occurred because of bowel ischaemia and bowel perforation.

Consider encouraging good bowel habits such as raising the feet onto a low stool ('squatty potty') which is known to help empty the bowel.

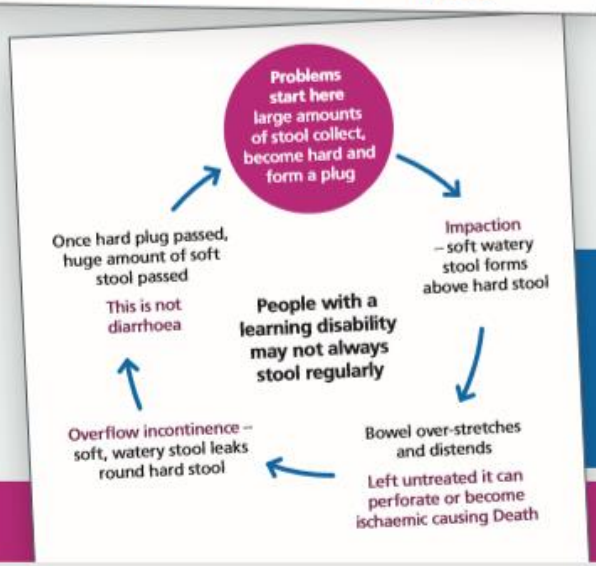
Poo matters

Information for health professionals



Normal

Constipation



Possible presentations of constipation

- Soiled underwear (leakage)
- Hard stool
- Infrequent stool
- Build up of lots of stool - three flush poo

Loose stool may be a symptom of impaction not diarrhoea. Think before stopping laxatives.

It is important to correctly identify constipation in people with a learning disability

Some people with a learning disability are more at risk of constipation than the general population, Reviews into the deaths of people with a learning disability have shown us that too many people are still dying from constipation.

Any changes in behaviour – think constipation

It may be the only way a person with a learning disability can communicate something is wrong. Look for physical causes, including constipation before diagnosing a mental health condition.

History

- Take a detailed history including frequency and consistency of stool.
- Ask about childhood constipation - a key risk factor for the development of megacolon/rectum*.

Additional symptoms

- Abdominal pain, bloating, distension, loss of appetite, loss of weight.
- Rectal bleeding and pain when defaecating. Anal fissures are associated with chronic constipation.
- Beware when the wind stops - It can be a sign of significant obstruction.

Examination

Distended abdomen.

Rectal examination maybe misleading as the constipation often involves the colon and does not reach the rectum. Check for anal fistulae.

Abdominal radiology can confirm the diagnosis, but needs to be used judiciously.

Ask about pharmacological factors

- Prescribed drugs causing constipation include opiates, anti-psychotics, anti-depressants, anti-epileptics, antimuscarinics and antispasmodics.
- Are prescribed laxatives been taken regularly?
- Is the dose sufficient? Consider a stimulant alongside softeners/macrogols.

Lifestyle factors

Lack of exercise, diet low in fibre and fresh food, and low fluid intake predispose to constipation.

Make sure people with a learning disability or their family or carers know the symptoms of constipation

#TakeActionSaveLives

Get the diagnosis right - Get the treatment right

Get the diagnosis right - Get the treatment right

Key to prevention

Healthy diet **Plenty of fluids** **Regular exercise**

Good toilet habits

- Encourage regular habits.
- Suggest raising the feet onto a low stool as this relaxes the pubo-rectalis muscle and facilitates complete emptying of the rectum
- Advise on abdominal massage where appropriate.
- While privacy is important, don't allow this to put someone at risk – it is more important to be able to keep an accurate bowel chart.

Annual Health Checks

- Ask about constipation.
- Review the poo book or bowel chart.

Treatment

- Treatments for constipation will vary depending on assessment of cause.
- Prescribe regular laxatives if needed.
- Make sure water is taken with the osmotic laxative.
- Gradually titrate dose of laxative upwards, titrating to maximum tolerated dose before adding/switching laxatives.
- Check if you are prescribing drugs that cause constipation such as anti-depressants and anti-psychotics - you may need to prescribe regular laxatives to mitigate the side effects.

If in doubt, seek expert advice. This could be from the:

- community learning disability service.
- bladder and bowel service.
- specialist advice in hospital (involve the liaison nurses).

Why the risk?

In addition to lifestyle factors and medication, people with a learning disability are at higher risk of chronic constipation because of:

- **Underlying genetic disposition and brain injury**
  - May affect the neural-gut axis and function adversely resulting in poor muscle tone and bowel atony.
  - Higher risk of Hirshsprung's disease and Coeliac disease in people with Down's Syndrome.
- **Communication barriers**
  - Difficulties in communicating pain and other symptoms when they are not feeling well.
  - Not always understanding the information and instruction given by a healthcare professional.
- **Fear of unfamiliar environments**
  - Can stop a person with a learning disability from going to the toilet, eg while in hospital.

People at risk from constipation should have a bowel management and escalation plan which should not be stopped without good reason.

References:

Flynn M and Eley R. (2015) A serious case review: James. Available online at www.suffolkas.org/assets/Working-with-Adults/SARs/SCR-Case-James-091015.pdf

NICE guidance - cks.nice.org.uk/constipation (Revised June 2017)

Making reasonable adjustments for people with learning disabilities in the management of constipation. PHE August 2016 www.ndti.org.uk/uploads/files/Constipation_RA_report_final.pdf

Useful links

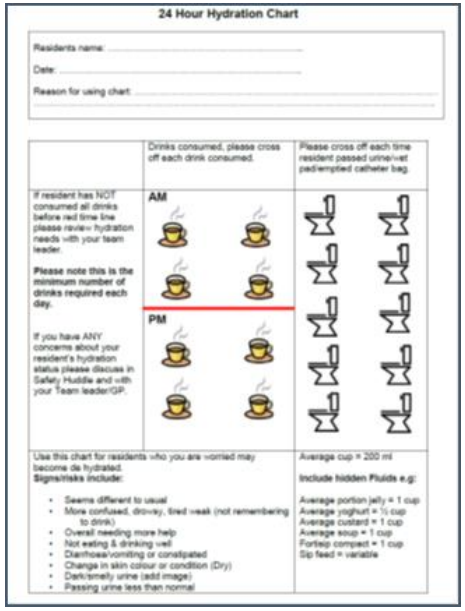
*Constipation in children - www.bbuk.org.uk/wp-content/uploads/2019/02/Paediatric-pathway.pdf
Dimensions video - youtu.be/1TlcefPXjgg
YouTube demonstrating the Squatty Potty www.youtube.com/watch?v=5P8L0r4JVpo
Bladder and Bowel UK https://www.bbuk.org.uk/

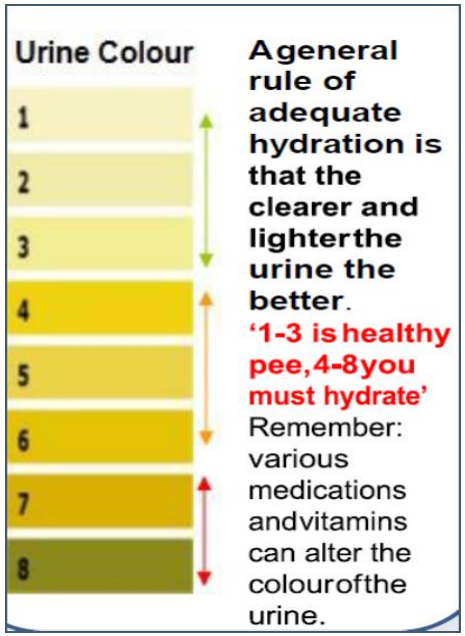
Let's talk about poo #TakeActionSaveLives

D Drank Less

Hydration in all residents is important

- Sometimes difficult to spot until the resident becomes dehydrated which can have serious health consequences.
- Key is monitoring, using a simple hydration chart. Also observe the colour of urine.
- Other signs of dehydration include dry skin, dry mouth/tongue, worsening / new confusion.





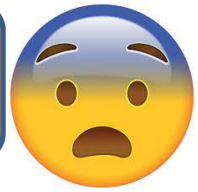
W Weight Change

- You may notice the client has lost or gained weight, either through weekly monitoring or you may notice other signs like loose or tightly fitting clothes, shoes or jewellery or a drawn face.

- Causes of weight loss include stress, decreased intake due to ageing or can be a result of other changes in the body such as depression, infections and cancers.

- Weight gain could be a sign of ill health such as heart or renal failure or increased appetite

A Agitated or more nervous than usual



- You may notice the client fidgeting, trying to get out of their chair/bed, looking scared or anxious. Clients may become more active and aggressive, or nervous, withdrawn and tearful.

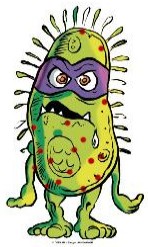
- This can be an important sign of a developing infection, pain, lack of oxygen or problems with medication.

T Tired, weak, confused, drowsy

You may notice the client appears to have less energy of has new or increased confusion. This could be a sign of delirium

Delirium is an acute confusional state compared to normal that is not progressive, but is reversible. It is often worse at night.

Delirium can mean the client has less energy (withdrawn, quiet, sleepy) or more energy (restless, agitated, aggressive).



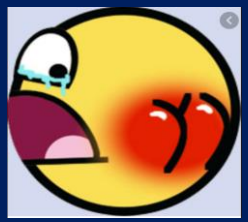
	Cause
D	DRUGS – new medications, medication side effects, interactions, withdrawal.
E	ELECTROLYTE DISTURBANCES – acute kidney disease, sodium or potassium imbalance
L	LOW OXYGEN - due to COPD, heart failure, heart attack, pulmonary embolism
I	INFECTION – UTI, chest infection, cellulitis
R	RETENTION – of urine or constipation
I	INJURY / PAIN / STRESS – fracture, head injury, pain from internal problem, lack of sleep / mental health problems
U	UNDER-HYDRATION / UNDER-NUTRITION – dehydration or malnutrition, weight loss
M	METABOLIC – high or low blood sugar, diabetes, pancreatic problems.

C Change in skin colour or condition

Increasingly dry skin is a sign of dehydration. Other changes may be increasing bronzing of the skin (problem with iron), a yellowing of the skin and whites of eyes (liver failure). Poor circulation or inadequate oxygen levels in blood can also cause your skin to turn bluish (Hypoxic).

•A rash that does not respond to treatment, and is accompanied by other symptoms — such as fever, joint pain and muscle aches — could be a sign of an internal problem or infection

•Think pressure areas & React 2 Red information
•If residents become unwell and are not mobilising as usual or are confined to chair / bed / room



H Help with walking, transferring or toileting more than usual

You may notice the client has "Gone off legs". This usually refers to older people who were previously mobile and active, having a sudden deterioration in their mobility.

It may be a sign of acute illness such as UTI, dehydration, malnutrition, chest infection.

Bacterial and Aspiration Pneumonia

- Often a direct result of swallowing difficulties (Aspiration Pneumonia)
- Higher risk in people with learning difficulties
- Accounted for 41% of notified deaths in people with LD in 1019/20

Ensure….

- Good posture when eating/feeding
- A positive & person centred eating experience
- Avoidance of distractions at meal times
- Annual Pneumococcal and Flu vaccines
- Good oral and dental care
- Regular review of medications, particularly anti-psychotic medications; prescribed to people prone to chest infection/at risk of aspiration

Refer to SALT or dietician for consistency/feeding advice

Sepsis can be especially hard to spot in:

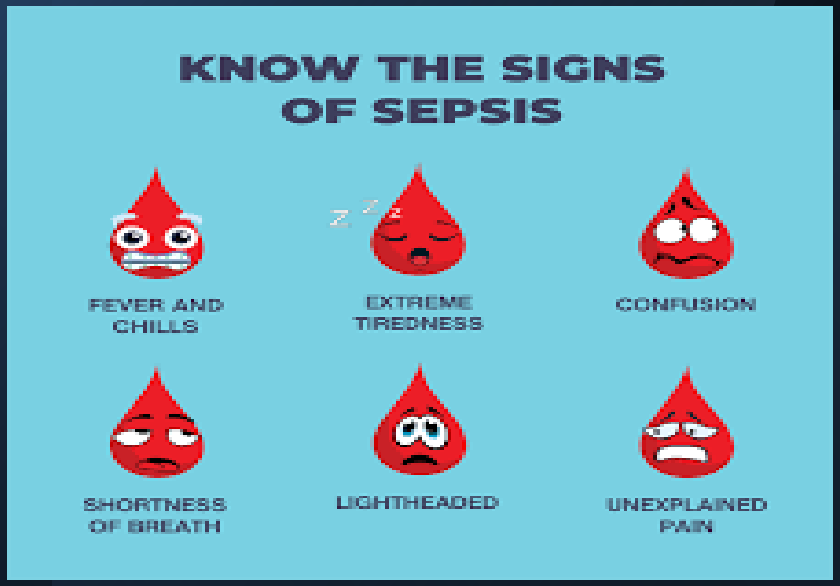
babies and young children

people with dementia

people with a learning disability

people who have difficulty communicating

SEPSIS



- Sepsis is a life-threatening reaction to an infection.
- It happens when your immune system overreacts to an infection and starts to damage your body's own tissues and organs.
- You cannot catch sepsis from another person.
- Sepsis is sometimes called septicaemia or blood poisoning.
- 50,000 people die of sepsis every year in the UK (more than bowel and breast cancer together)

Response

If you are concerned about anyone that you are caring for, the most important thing is to:

Tell Someone!

If a resident seems different to usual
Next steps….

Complete prompt tool → Talk to senior, Discuss action → Gather all info, Use SBAR for communication with other health & care services → Document handover to team

Vale of York Clinical Commissioning Group INTERACT Academy Part of the Yorkshire & Humber AHSN

Stop and Watch - Early Warning Tool *EXAMPLE OF USE*

If you have identified a change while caring for or observing a resident, please tick the change and notify the person in charge with a copy of this tool.

Name of resident: …Mrs A Resident…… …… Date of Birth: …1…/……1…/…31… Room Number:……365……

Date /time	2/2/19 9am	2/2/19 12am	2/2/19 2pm	Additional information
S Seems different to usual	√	√	√	9 am Not feeling well , 12 am still not well but Mrs A not sure why
T Talks or communicates less		√	√	12 am Very quite all morning
O Overall needs more help	√	√	√	9am needed help to wash & dress 12am needed help to go to toilet
P Pain new or worsening; participating less in activities		√	√	12am complaining of new pain all over body in muscles & joints
A Ate less	√	√	√	Only wanted toast 12 am only had soup at lunch had to be encouraged
N No bowel movement in 3 days; or diarrhoea				
D Drank less	√	√	√	Only taking small sips of tea and juice
W Weight change				
A Agitated or more nervous than usual		√	√	12 am not comfortable & fidgeting in seat & agitated & not settling
T Tired , weak , confused or drowsy	√	√	√	9am very tired, poor nights sleep 12 am still tired & not sure what time of day it is
C Change in skin colour or condition		√	√	Face looks tired & slightly grey in colour
H Help with walking, transferring or toileting more than usual	√	√	√	Needs help with getting out of bed & taking to toilet in morning & lunch
Carer name - describe the change you noticed	AB	EF	EF	9am General not well with aches & pains, not drinking or eating as much 12am Quite but more agitated at lunch time , feels tired 2pm Feeling much worse, seems confused, pale clammy skin, still in pain
Reported to (senior)	CD	CD	CD	Seen and agree with EF & AB to monitor 2pm agree changes continue with fluids and carers observe
Senior Action /call GP / 999/ 111 / DN etc Resident monitored or other action	9am – encourage fluids & small food take temp (normal) 12am – condition worse temp normal paracetamol given as MARs 2pm – condition worse temp raised still has pain although regular paracetamol given , GP Called & visit requested			
Outcome / transferred to hospital/ visited by GP/ DN or phone advice given	2pm GP called will visit today 5.30 pm Dr Gee visited antibiotics given, to push fluids , send urine specimen tomorrow			

CIRCLE IF APPLICABLE

In line with preferred place of treatment Y N

In line with preferred place of death Y N

PLEASE TURN OVER AND USE THE SBAR COMMUNICATION

- **Situation** – Who are you calling about? How long have you been concerned and why?
- **Background** – Important medical history (e.g. heart failure, diabetes). Do they have a DNACPR or Advanced Care Plan?
- **Assessment** – Identify changes from Stop and Watch tool. Observations if available.
- **Recommendation** – what would you like the responder to do? Are there any other actions you should take?

SBAR Communication Form

Clinical Commissioning Group INTERACT Part of the Yorkshire & Humber AHSN

EXAMPLE OF USE

Before calling for help
Evaluate the resident: Complete relevant: aspects of the SBAR form below
Review Record: Recent progress notes, medications, other orders
Have Relevant Information Available when Reporting
(i.e. medical record, advance directives such as DNACPR and other care limiting orders, allergies, medication list)

SITUATION - Date & Time 2/2/19 2pm

I am calling because I am worried about:……Mrs A resident ……Date of Birth: ……1…../…1…../……31….This started on today at 9am …../…./…./……
Since this started it has got Worse……Better…….Stayed the same……since this morning

BACKGROUND
Medical Condition (or this may be known by residents own GP) - GP knows resident & history of urine infections
Other medical history (e.g. Medical diagnosis of CHF,DM,COPD)
DNACPR Y/N Advanced care plan Y/N

ASSESSMENT
Identify the change/s from the stop and watch tool
Not feeling well since 9am this morning , has been very quite and not wanting to eat as usual, has also only drank small amounts, has needed more help generally in washing and dressing and mobilising, since 10 am complained of general aches and pains in muscles and joints, we have given paracetamol but this has not eased the pain temp taking was normal but at 2pm was raised to 38c. She is now feeling much worse and is more tired and confused than earlier in the day . we have been encouraging fluids.

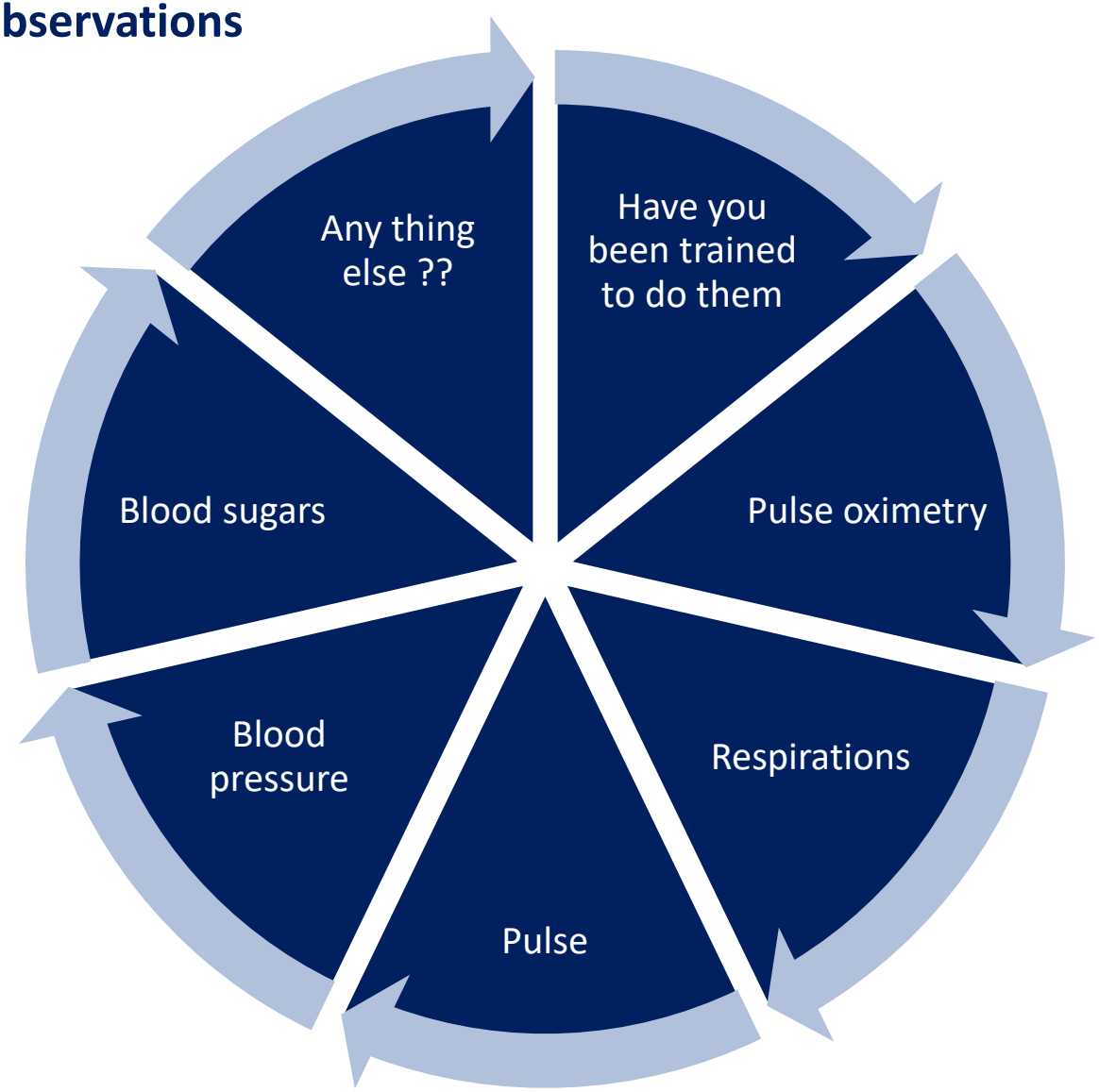
Consciousness: Alert?..... New Confusion? …Yes….. Responsive to voice? ……. Pain? …yes , general aches in muscles and joints …. Unconscious? …….

CIRCLE IF APPLICABLE		
In line with preferred place of treatment	Y	N
In line with preferred place of death	Y	N

RECOMMENDATION
Responding Service Notified: ……GP ……Date……2../….2…/..19…… Time(am/pm)……2pm ……
Actions you were advised to take : keep giving paracetamol and push fluids until Gp comes

THIS IS AN EXAMPLE OF USING THE SBAR WITH INFORMATION FORM THE STOP and WATCH ON PREVIOUS SLIDE

Observations



Follow instructions for use, maintenance and cleaning

NHS 111

- For advice and guidance if unsure
- For clinical advisor support
- To contact a GP
- For a medication query
- For general health information
- An expected death when no one can verify the person has died
- For UCP support

999 for urgent assistance

- If someone is choking
- If someone has stopped breathing and this is unexpected
- If someone is having a possible heart attack or stroke
- If someone has suffered a major injury / trauma

Joseph

- A care package was put into place two years ago when his wife died because he wasn't managing at home. His daughter visits once a week.
- He has a past medical history of bowel cancer and he had an operation in his 60's to remove part of his bowel, leaving him with a stoma which he can manage himself.
- He was diagnosed with prostate cancer 5 years ago, which has spread to his hip bone and can cause him some pain on walking. He walks with one stick, but can mobilise
- He is sometimes a little forgetful but does not have a diagnosis of dementia

He struggles with practical tasks such as washing, dressing and food preparation.

He can mobilise slowly with his stick.

He is normally an early riser and enjoys a large breakfast to start the day.

During the day he watches TV, reads the paper and socialises with staff and other residents. He likes to talk about his days in the navy.

He also likes to sit out in the garden on a sunny day and watch the birds.

He enjoys his life in the home and gets on well with all staff.

Monday

- Joseph gets up at his usual time but comments to carers that he feels a bit ‘groggy’ and that he didn’t sleep well.
- He sits in his chair and watches TV and doesn't chat to staff like he usually would.
- He dozes off a few times during the day, which isn’t like Joe but staff leave him to sleep because he has had a disturbed night’s sleep.
- He has not had much stoma output today, but he doesn’t mention this to carers.
- Joe does not mobilise as much as usual during the day.

Stop and Watch - Early Warning Tool

If you have identified a change while caring for or observing a resident, please tick the change and notify the person in charge with a copy of this tool.

Name of resident: …… …….. Date of Birth: ……/……/…… Room Number:……..

Date /time				Additional information
S Seems different to usual				
T Talks or communicates less				
O Overall needs more help				
P Pain new or worsening; participating less in activities				
A Ate less				
N No bowel movement in 3 days; or diarrhoea				
D Drank less				
W Weight change				
A Agitated or more nervous than usual				
T Tired , weak , confused or drowsy				
C Change in skin colour or condition				
H Help with walking, transferring or toileting more than usual				
Carer name				
Reported to (senior)				
Senior Action /call GP / 999/ 111 / DN etc Resident monitored or other action				
Outcome / transferred to hospital/ visited by GP/ DN or phone advice given				

CIRCLE IF APPLICABLE
In line with preferred place of treatment Y N
In line with preferred place of death Y N

PLEASE TURN OVER AND USE THE SBAR COMMUNICATION

Tuesday

- Joseph had another disturbed night with back pain. He is short-tempered with staff when they ask why he hasn't eaten all of his breakfast.
- He sits in his chair watching TV again. It is a lovely sunny day but Joe shows no interest in sitting in the garden today.
- When walking to the toilet staff notices he seemed a little unsteady on his feet and needed help with his trousers.
- When offered a cup of tea he declines, asking for juice because his mouth is dry.
- Joe finds that he doesn't really fancy the cottage pie for evening meal. He usually looks forward to this on a Tuesday. He has some soup instead.

lets redo the Stop and Watch to see how his condition has changed

Wednesday

- Joe is really not feeling himself today. He is tired and doesn't have the energy to eat or drink much.
- He decides to mention his low stoma output to carers, and when they ask about his waterworks he realises it has been darker and more smelly than usual.
- Carers dip his urine which is all clear.
- Joe asks for extra paracetamol during the day and before bed for his backache. Embarrassingly, he forgets the name of several carers and domestic staff during the day. He goes to bed early.

Thursday

- Joe's daughter Maggie is visiting today. He always looks forward to the weekly visits, but today he seems to have forgotten, because the carers have to remind him this morning.
- He is eating and drinking less, and Maggie notices that his mouth and skin seem dry and his clothes appear loser than normal
- He falls asleep during her visit, which is troubling for Maggie. She talks to carers.
- Carers inform her of Joe's sluggish bowels and say they think it is because of the increase in pain medication at night. They reassure Maggie that they are giving him laxatives and keeping an eye on things.

Friday

- This morning, carers find Joseph in the bathroom in a mess. His stoma has started working and is passing loose watery stool.
- He has obviously tried to change the bag, but has not managed this and has soiled his clothes and the bathroom. He seems muddled and upset as to what he should be doing.
- Carers let him rest in his chair today and bring food to him at meal times. He picks at his food and leaves drinks unfinished.
- He is put to bed early because he is falling asleep in his chair throughout the day.

Saturday morning

- Joe has significantly deteriorated overnight. He mobilised to the bathroom during the night without his stick and fell for the first time. Luckily, he does not seem to have significantly injured himself, and denies hitting his head. Staff helped him back to bed. He seemed disorientated and unsteady on his feet.
- Carers note that his skin is dry and he appears pale.
- This morning, Joe was unable to get out of bed. He has had an accident and wet himself overnight. He is complaining of back and tummy ache. He is confused, asking for his wife Barbara.

Saturday afternoon
Clear, accurate information is crucial to help clinical decisions be made

Carer / Nurse / senior - calls GP or other responder for advice about Joe:

Situation – **I am calling about one of our clients , Joseph. He is 81. He started to be unwell on Monday and has since deteriorated**

Background – **He has a past medical history of bowel cancer and prostate cancer which has spread to his bones. He does have a DNACPR / does Joe have an advanced care plan in place and preferred place of care / treatment?.**

Assessment –Joe is more tired and confused than normal, and the pain is new. He is not eating and drinking much. He seems dehydrated. He has a stoma and has been constipated. He can usually get out of bed on his own but can't today and he fell last night for the first time.

Recommendation – I think Joe needs to be seen urgently by a doctor. He may even need to go to hospital. Is there anything else I need to be doing at this stage?

Saturday evening

Joe is taken by ambulance to hospital

He is transferred to an elderly medical ward where he is found to have high calcium. This has probably been caused by his prostate cancer affecting his bones.

High calcium causes dehydration, constipation, confusion and bony aches. It can be fatal if not treated quickly.

THINK WHAT WOULD HAPPEN IF JOE NEED HOSPITALISATION DURING THE CURRENT SITUATION !

THIS COULD HAVE BEEN AVOIDED AND SAVED JOE DISTRESS AND SAVED A HOSPITAL BED

Joseph had a prolonged hospital stay because of the severity of his symptoms. He was very dehydrated and he also needed lots of laxatives to get his bowels working again.

Joe's hospital stay may have been shorter if a GP Team had seen Joe earlier to assess and diagnose the problem.

On day 6, he developed a chest infection which set his recovery back another few days.

Community treatment may have prevented a hospital admission altogether.

Two weeks later

THINK HOW DIFFERENT THIS MIGHT BE IF JOE HAD TO SPEND TIME IN HOSPITAL RIGHT NOW

Thank you,
Any questions?