Care Homes and Domiciliary Care

NHS Vale of York Clinical Commissioning Group

Recognising and Responding to Deterioration in Residents and Clients with learning difficulties and/or Autism

Workbook

Disclaimer – This workbook is designed to be supported by the NHS Vale of York CCG Quality & Nursing Team. It can be used as a stand-alone resource, however careful judgement when implementing the training must be used by the manager of the care setting. This workbook and any parts contained therein including any of the tools must not be changed, amended, or reproduced. The workbook or any part including the tools cannot be sold or training delivered for monetary gain. The training is to be used in individual homes or care agencies and training must not be delivered to any others outside the organisation for which it has been intended. This workbook remains the property of the Vale of York CCG.

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Introduction

This workbook is a free resource that supports the process of recognising and responding to deterioration of individuals across care settings.

Individuals will deteriorate for a variety of health reasons and it is essential that these changes, however subtle be recognised and responded to promptly.

This workbook is broken down in sections:

1. **Understanding deterioration**
2. **Knowing your resident/ client**
3. **Recognising the signs of change and deterioration**
4. **Responding to deterioration**
5. **Clinical Observations**
6. **Pulse Oximetry**
7. **Communication**

Each section will have short tasks to be completed and will be indicated by

When reading & Understanding is needed

Thinking about or discussion

When reading & Understanding is needed

Finding out further information

The workbook will take approximately an hour to go through and can be completed by individuals, in pairs or teams. Some of this information will be an update and for others it will be new. The workbook is appropriate for use by all staff and all grades including senior experienced care staff and those new to role. In taking a whole home approach to recognition and responding to deterioration, teams can work and communicate within the care setting and with other health and social care services to benefit the residents and clients they care for.

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Part 1. What do we mean by deterioration?

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 deteriorationearlier we can prevent harm and hospital admissions

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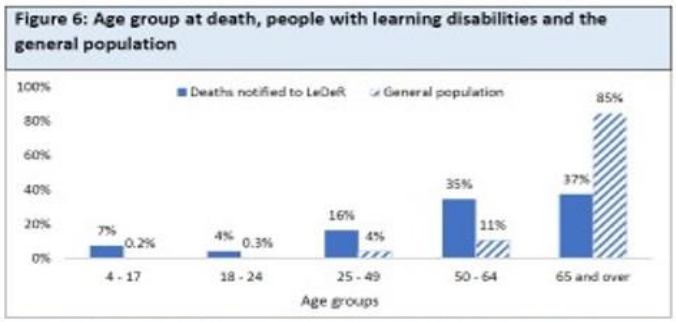
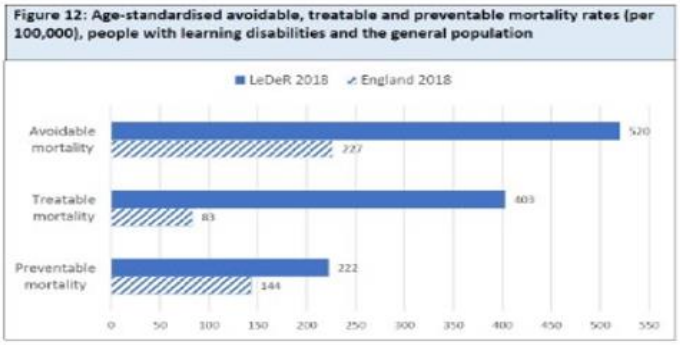
Why it's so important to spot deterioration in people with LD?





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.

Can Carers spot the signs of deterioration?

Studies suggest.... 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 both behavioural and functional status changes in clients

Think about any signs you might spot in a resident/client that may suggest they are deteriorating

Can you think of a situation with one of your clients/residents, where earlier recognition may have prevented more serious illness or a hospital admission?

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Part 2. Knowing your resident

Think about how long you have worked in the care setting and how many people you have looked after? – How well do you know your residents? Have you ever recognised when something was wrong with a client/resident? This is often called intuition or 'gut instinct'.

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

- 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.

You may need to find out what care plans / advanced care plans each of your residents or clients have and where they are kept

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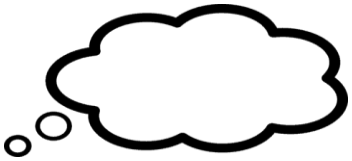
Part 3. Recognising the signs of Change and deterioration

Using a prompt tool can help us spot signs of deterioration it supports your 'Gut Instinct' or your first reaction to 'somethings not right with…' and it will help you explain to colleagues why you are worried so better care decisions can be made.



Think about an occasion when a person you were caring for 'wasn't themselves' or 'gone of their legs' – what were your actions and who did you tell?

The STOP and WATCH tool consists of 11 prompts there are clinical reasons why each of these questions are in the tool and will help make sense of the changes in the resident / client.

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You do not need to be able to carry out clinical observations such as blood pressure or temperature to use the STOP and WATCH, however ***if you do*** you can add this information to your overall observations. The STOP and WATCH tool uses 'softer signs' that recognises and helps to make sense of your observation of a resident / client that is deteriorating.

The tool can be used for any client / resident regardless of age or condition, you may not use this every day or for every client or resident - ***but you will use this when a client is showing signs of deterioration.***

The following pages go through the prompts in more detail and while individually may appear insignificant together gives a better overall picture of the client / resident. You will need to read thoroughly and ensure you understand the significance of each prompt.

Seems Different to usual

However small the change; if **YOU** feel your 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 client's daily routine, not joining in as much as usual.

Are there any symptoms of COVID-19…? Make Sure you know what these are, and your information is up to date

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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.

Think how your clients/ residents usually communicate – they may not communicate verbally – what can change in communication tell us?

It could indicate pain, sadness, feeling unwell but not having the words or ability to describe it, a change in communication may be the first indicator that something is not quite right.

Overall needs more help

- More dependent, asking for help, needing more staff to help transfers, needing more help with activities of daily living.
- Lower energy levels can point to infection or deterioration in the client's medical condition.
- This may happen quickly or be a subtle less obvious change

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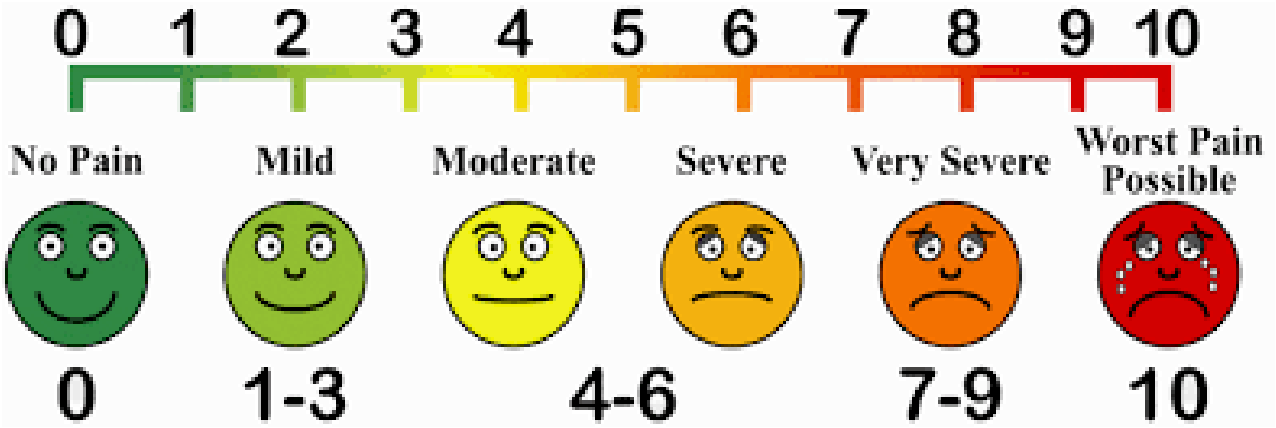
Pain, new or worsening; Participating less in activities

- Not all clients can tell you they are in pain. You may need to observe for non-verbal 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
- Is the pain worse or better on movement of being still?
- Use of a pain scale to assess level of pain is useful e.g., 1 being no pain, 10 being worse pain experienced
- Does the pain respond to pain relief?



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Ate less

Appetite can vary throughout life even from day to day and is a good indicator that something may be wrong. Some clients / residents may have Dementia or other memory problems that mean they may not accurately recall if they have eaten – you may use food diaries with some residents

Find out if any of your residents/ clients have these and why?

- You may notice the clients/ residents 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?
- Is there a problem with their mouth, teeth, or dentures?

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No bowel movement in 3 days; or diarrheoa

This is a guide – what is the 'normal' bowel pattern for your client / resident?

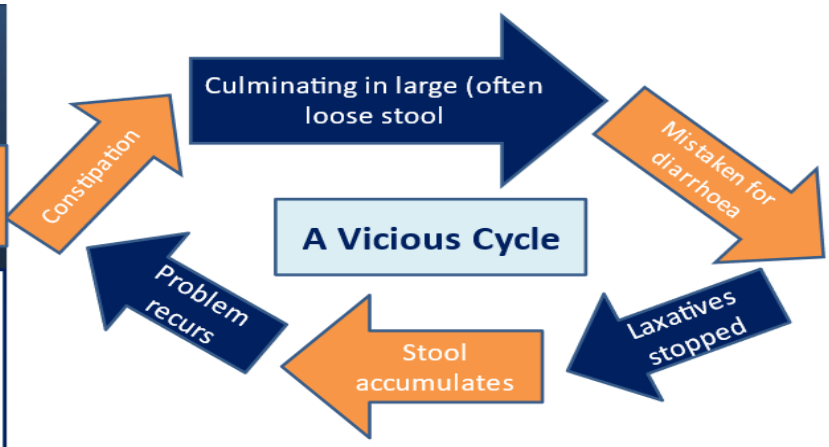
Monitoring of bowels is an important indicator of ill health. As well as frequency it is useful to also note the colour of stools:

- **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.
- **<u>Use the Bristol stool scale or other to identify, monitor and record bowel movement</u>**

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.

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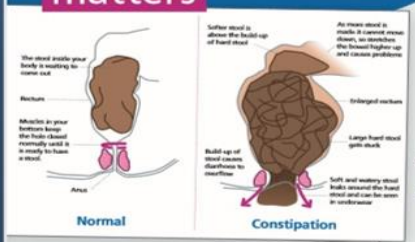
Poo matters

Information for health professionals



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.

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.

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).

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/1TIcefPXjqg
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

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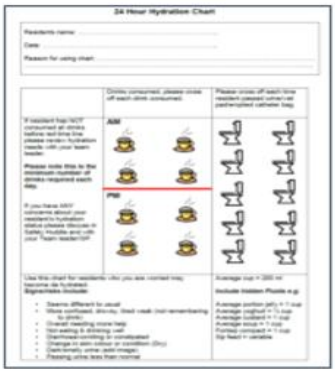
Drank Less

- 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.



- Has the resident/ client finished their drink - just because they were given a drink may not mean they drank it
- Some residents / clients may not want to drink because of making trips to the toilet – reassure them you are there to help them regardless of how many times they need to go to the toilet

Think of what can happen if someone is dehydrated, this can lead to urine infection, constipation, and confusion. If someone is confused due to dehydration this could also lead to a fall.

Find out more: www.reactto.co.uk

Find out what dehydration charts your organisation uses and familiarise yourself with them

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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

- Do you know what is 'normal for your resident/client?
- How do you monitor your clients/resident for any weight changes?

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Agitated or more nervous than usual

You may notice the client fidgeting, trying to get out of their chair/bed, looking scared or anxious. Client's 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.

Think about your experiences with your clients/residents…. What kind of things cause them to become more agitated or nervous than usual?

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Tired, weak, confused, drowsy

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.

Delirium may be difficult to spot in those with Dementia or learning difficulties – Remember **you** know your clients / residents

Prevent it, Suspect it, Stop it.

Delirium can be prevented and treated.
Remember the causes of delirium.

TIME AND SPACE

T - Toilet
I - Infection
M - Medication
E - Electrolytes

A - Anxiety/Depression
N - Nutrition/Hydration
D - Disorientation

S - Sleep
P - Pain
A - Alcohol/Drugs
C - Constipation
E - Environment

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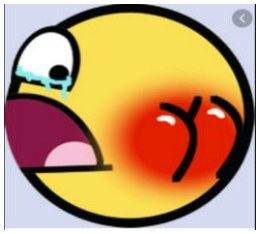
Change in skin colour or condition



- 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
- **If resident/ client becomes unwell and is not mobilising as usual or are confined to chair / bed / room - Think pressure areas**

Think about pressure area prevention - what do you know about preventing pressure areas?

Have you had React 2 Red training? Refresh your memory or find out more about pressure area prevention: www.reactto.co.uk

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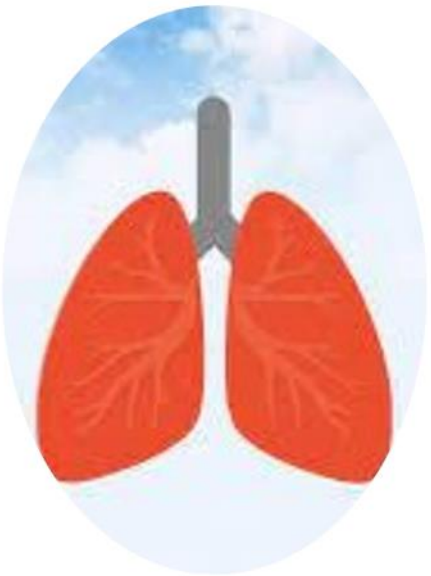
Help with walking, transferring, or toileting more than usual

- You may notice the client has “Gone off their legs”. This usually refers to 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/Pneumonia

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

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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

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The Important Bit!.....
Team Work & Communication

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An effective team is far more able to recognise when things are going wrong than any one individual.

A team that works together well is a safe team as they are more likely to know what is happening around them.

Teams work best when all members feel safe and have a voice.

Improving teamwork - Some top tips!

- Know your team by name (agency staff)
- Know a little bit about each other
- Focus on **all** caregivers (Admin, housekeepers, support roles, residents)
- Ensure everyone feels comfortable to ask questions & thank people for speaking up
- Acknowledge and recognise when things have gone well
- Learn from why things go wrong and **right** in your team

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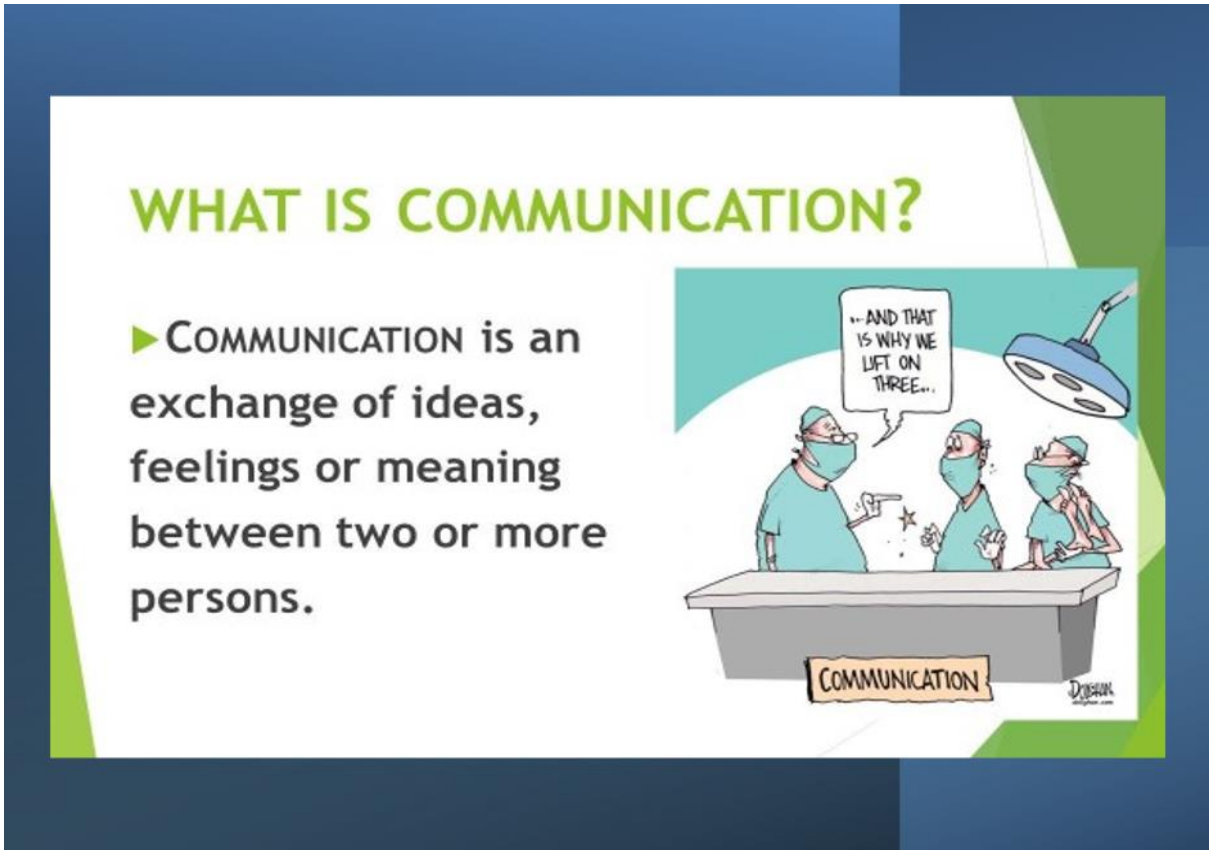

Improving Communication

- Consider how does the team communicate with each other (face to face, via technology, paper records)
- Does the critical information always get shared especially when handing over to colleagues?
- Who is involved in discussions about resident's wellbeing?
- How do you know if the message was understood as intended?

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Having looked at the signs and possible causes of deterioration you now need to read the case study of Joseph (below). You may be caring for younger people than Joseph, you may be caring for people in supported living, in their own homes or in nursing care and this case study will give you in insight in recognising deterioration and how to respond. Remember the prompt tools you will be using can be used for any adult showing signs of deterioration and in any care setting

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.

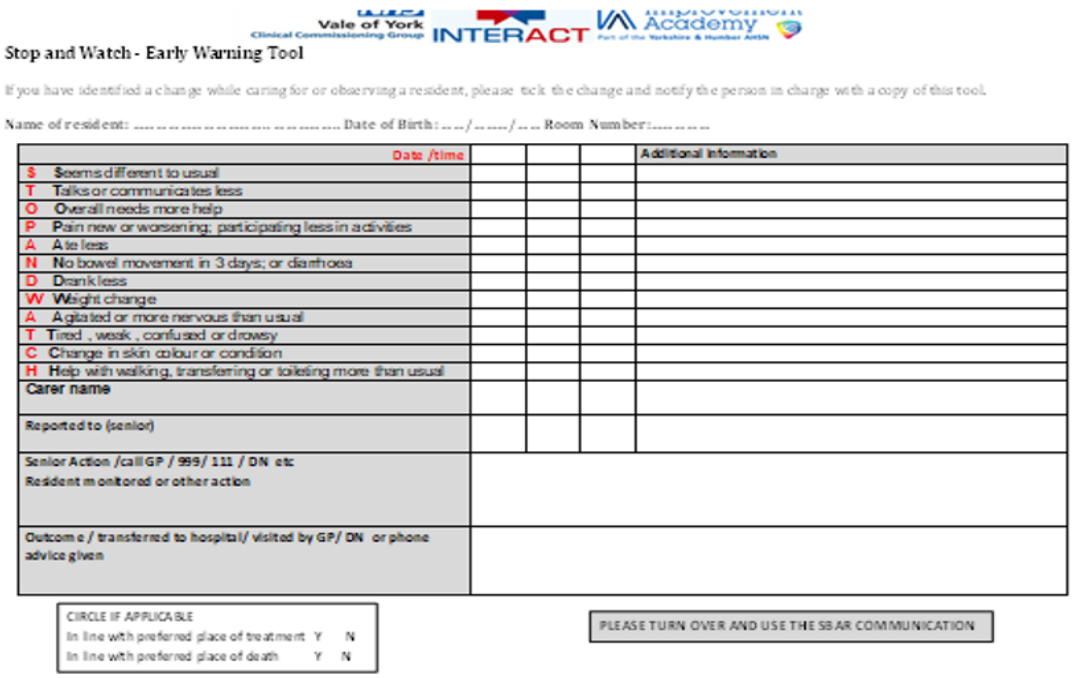
He also likes to sit out in the garden on a sunny day and watch the birds.

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

Now you know a little bit about Joseph, his medical history, likes and dislikes and daily routine. You should be able to understand how you can recognise when a resident or client such as Joeseph is not 'themself'

Part 4: Responding to deterioration

In order to respond to any changes, the STOP and WATCH prompt tool needs to be completed - at the back of the workbook you will find a blank copy of the tool which you can practice filling in as you chart Joseph's deterioration. This tool is to be used in addition to your existing documentation and not as a replacement. If you notice any change in your client/ resident grab a STOP and WATCH and complete it.



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

Look at how Joseph's health changes during the week and by using the STOP and WATCH prompt tool we can recognise deterioration and respond.

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.

Think Is joseph different to usual? **Yes,** he is so complete the STOP & WATCH tool

Use the blank form at the back of the workbook and complete the changes you have observed on Monday

Tuesday

Joseph had another disturbed night with back pain. He is short-tempered with staff when they ask why he hasn't eaten all his breakfast.

He sits in his chair watching TV again. It is a lovely sunny day, but Joseph 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.

Joseph 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

Is Joseph worse or better on Tuesday? – how has his condition changed?

Complete the STOP and WATCH again on Tuesday and you will see clearly how Joseph is deteriorating.

Once you have completed the STOP and WATCH talk to the senior in charge with the information to help make a team decision about Joseph's care.

You can use the STOP and WATCH to inform your safety huddles, flash meetings and handovers.

On the next page is an example of how to complete the form for Joseph on Monday and Tuesday and the deterioration is clear.

How frequently you observe a client/ resident will depend on the individual and their care needs and how the deterioration is presenting. At the back of the workbook is another example of how to complete the tool when someone is deteriorating rapidly.

The most important thing to do when noticing a change in a resident or client is to:
.

TELL SOMEONE

If you think a resident may have deteriorated, grab a tool, and complete the Stop & Watch Assessment – even if it's just a gut feeling!
Spotting signs of deterioration and taking prompt action early really does make a difference.

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: ……Joe Black …… …… Date of Birth: …1…/……1…/…1938… Room Number:…675……

Date /time	1/1/20 9am	2/1/20 9am		Additional information
S Seems different to usual	Yes	yes		
T Talks or communicates less	yes	yes		
O Overall needs more help	no	yes		
P Pain new or worsening; participating less in activities	no	yes		
A Ate less	no	yes		1/2/20 But sleeping more
N No bowel movement in 3 days; or diarrhoea	Yes	yes		1/2/20 Stoma not working usually daily
D Drank less	No	yes		1/2/20 But sleeping more need to encourage fluids
W Weight change	no	no		
A Agitated or more nervous than usual	no	yes		
T Tired , weak , confused or drowsy	Yes	yes		1/2/20 Poor nights sleep
C Change in skin colour or condition	No	Yes		2/1/20 Pressure areas checked
H Help with walking, transferring or toileting more than usual	No	Yes		
Carer name	kf	kf		
Reported to (senior)	fk	fk		
Senior Action /call GP / 999/ 111 / DN etc **Resident monitored or other action**	1/1/20 Continue to observe, encourage fluids and mobility , observe PA, risk of falls, use SW aga 24 hours unless deterioration noted sooner 2/2/20 deteriorated – call GP for advice use SBAR to communicate			
Outcome / transferred to hospital/ visited by GP/ DN or phone	Important to document this			

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

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Joseph's condition continues to deteriorate

Read what happens next

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.

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How could this deterioration have been prevented? On what day would you have contacted the GP or other health services

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

Did you have any ideas what caused Joseph's deterioration? Would you have considered high calcium being the cause?

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Think how different this situation might be if Joe had to spend time in hospital in the current coronavirus

Other things you need to consider when a person is deteriorating

Consider Sepsis and seek immediate advice if these symptoms are accompanied by any of the following

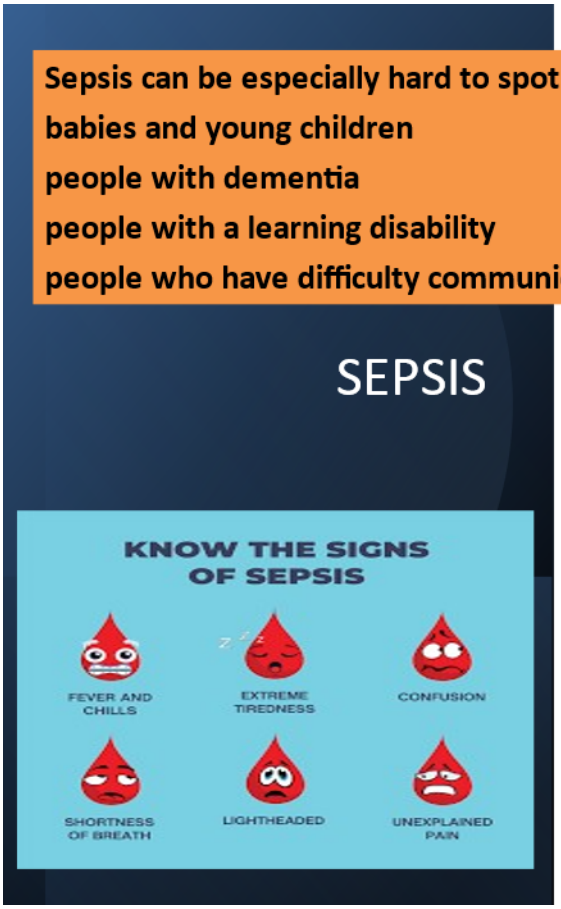
- New or increased confusion
- Recent hospital stay or injury (last 6 weeks)
- Breathing harder work than normal
- Not passed urine in the last 12-18 hours

find out more from the sepsis trust or the NHS

Links can be found at the back of the workbook

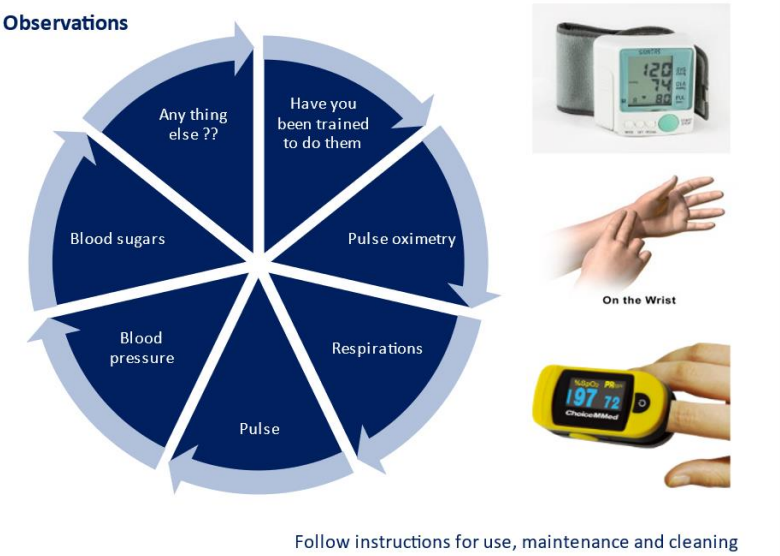
•Feels cold to the touch

•Skin, joints, or wounds swollen, red or pus visible



- 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)

Part 5: Clinical Observations



Follow instructions for use, maintenance and cleaning

You or other team members may be trained to carry out clinical observations including blood pressure, pulse, respiration, temperature, blood sugar monitoring and oximetry. These should only be carried out if you have been trained and assessed as competent. There is an accompanying workbook for these skills and how to access this is at the end of this workbook.

Part 6: Pulse Oximeters

All homes will have a pulse oximeter and here is a link demonstrating how to use

https://www.youtube.com/watch?v=QabKghrtXps

As with all equipment you need to follow the manufacturer's instructions for use, maintenance, and cleaning, for example - after each patient the pulse oximeter should be cleaned externally with an alcohol wipe.

Initially, we would suggest that you use the pulse oximeter when you need to speak to a health care professional about a resident. This information, plus other observations will help to guide the need for further assessment.

If you do carry out these clinical observations, you need to add this information to the STOP and WATCH assessment and SBAR communication form as this crucial information will help decide treatment and care for the resident

It is not recommended that you perform routine pulse oximeter checks, but only as a way of assessing someone you are concerned about already and want to call for help.

Most fit adults have a value over 95%, but for some of your residents a value as low as 90% may be ‘normal’ for them.

Part 7: Communication

Accurate and timely communication with your colleagues is vitally important when a client/ resident is deteriorating. To help communicate with others outside your teams including GPs, YAS, DNs etc the SBAR communication tool can be used.

Practice completing an SBAR on a blank tool at the back of the workbook

Below is an example of how it could be used for Joe. Blank copies and examples on how to complete can be found at the back of this workbook.

Carer calls GP or other responder for advice about Joe:

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Situation – I am calling about one of our clients/ residents, 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

Assessment –Use the assessment from the STOP and WATCH to relay how joe was on Monday and how he has since deteriorated to his current state, is there any symptoms of coronavirus? Include any temperature / blood pressure, respiration rates if you have them. Also say what you have been doing for Joe, e.g. increase fluids giving if pain relief and if it has been effective

Recommendation – remember you know Joe best and what you feel should be done, ask 'is there anything else we can be doing' (while waiting for GP / YAS visit)

Remember - gather all information together before you make that call

Find out where the information is stored.

Do you know if your residents/ clients have an advanced care plan in place and preferred place of care / treatment? Knowing this information in advance will help decisions be made.

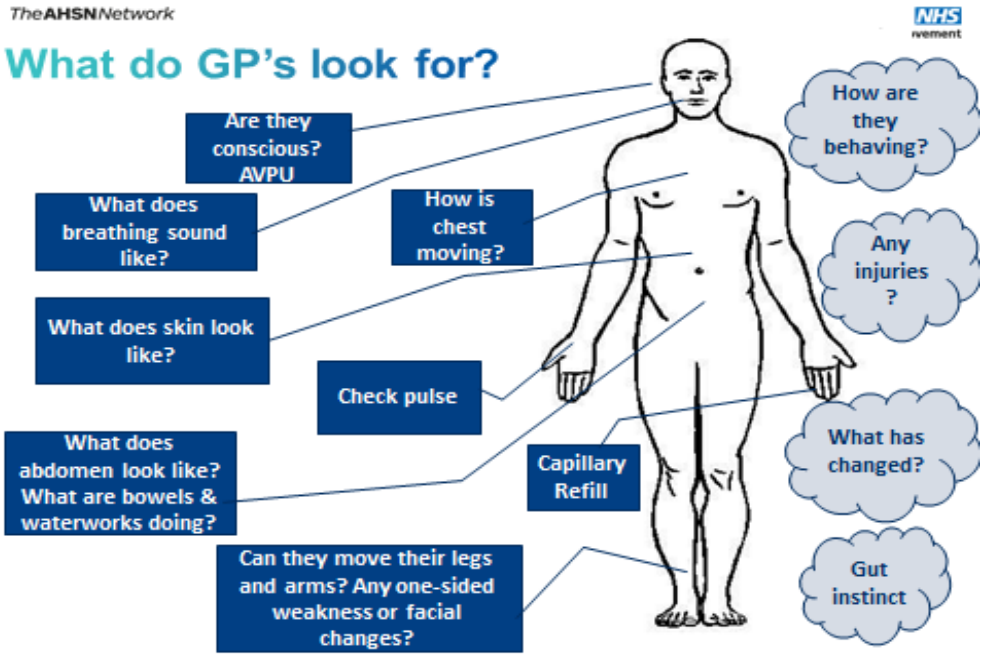
Which service should I call? Make sure you know

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



Summary

Now you have completed the workbook you should know the following - tick the box when you can answer yes and if there are any areas that you are unclear about, revisit the section and discuss with your manager or trainer.

I understand what deterioration means	
I understand why recognising deterioration is important	
I understand how to use the STOP and WATCH tool to pass information on to colleagues about a client/ resident who is deteriorating	
I understand how to use the SBAR communication tool	
I understand where and when I need to access emergency help	
I understand how to find information about a client/ resident in my organisation	
I understand how to find other information and resources about Sepsis and Covid19	
Do I know where the blank and completed STOP and WATCH & SBAR tools will be kept	

Stop and Watch - Early Warning Tool

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EXAMPLE

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 /phone advice	2pm GP called will visit today / 5.30 pm Dr Gee visited antibiotics given, push fluids , urine spec sent			

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)

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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 quiet 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? …….

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

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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

USE THE SBAR COMMUNICATION TOOL

Care Homes and Domiciliary Care

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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

I am calling because I am worried about……Date of Birth: ……. /……../…….This started on ...../…./…./……
Since this started it has got Worse……Better……. Stayed the same……

BACKGROUND

Medical Condition (or this may be known by residents own GP)
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

Consciousness: Alert?..... New Confusion? …….. Responsive to voice? ……. Pain? ……. Unconscious? …….

RECOMMENDATION

Responding Service Notified: ……Date……../……../..…… Time(am/pm) …….
Actions you were advised to take:

References

Reference: Boockvar K1, Brodie HD, Lachs M, J Am Geriatr Soc. 2000 Sep;48(9):1086-91. Nursing assistants detect behaviour changes in nursing home residents that precede acute illness: development and validation of an illness warning instrument.

Links

https://www.gov.uk/coronavirus

For more information and advice on the workbook, documents and training please see:

https://www.valeofyorkccg.nhs.uk/about-us/partners-in-care-1/partners-in-care/training/

and for contact details see https://www.valeofyorkccg.nhs.uk/about-us/partners-in-care-1/care-home-and-domiciliary-care-staff-area1/meet-the-team/