Humber and North Yorkshire
Health and Care Partnership

Partners in Care

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Y&H Improvement Academy Patient Safety Collaborative

Recognising and Responding to Deterioration in individuals

Adult Social Care Nursing Team

The purpose of this session is to:

- Explore what is meant by the term's 'deterioration' and 'recognition’
- Introduce a simple tool to support own observations or 'gut feelings’ to guide appropriate decisions or responses to deterioration
- Demonstrate appropriate use of the prompt tool in practice, utilising effective teamwork and communication skills, to improve individual’s outcomes

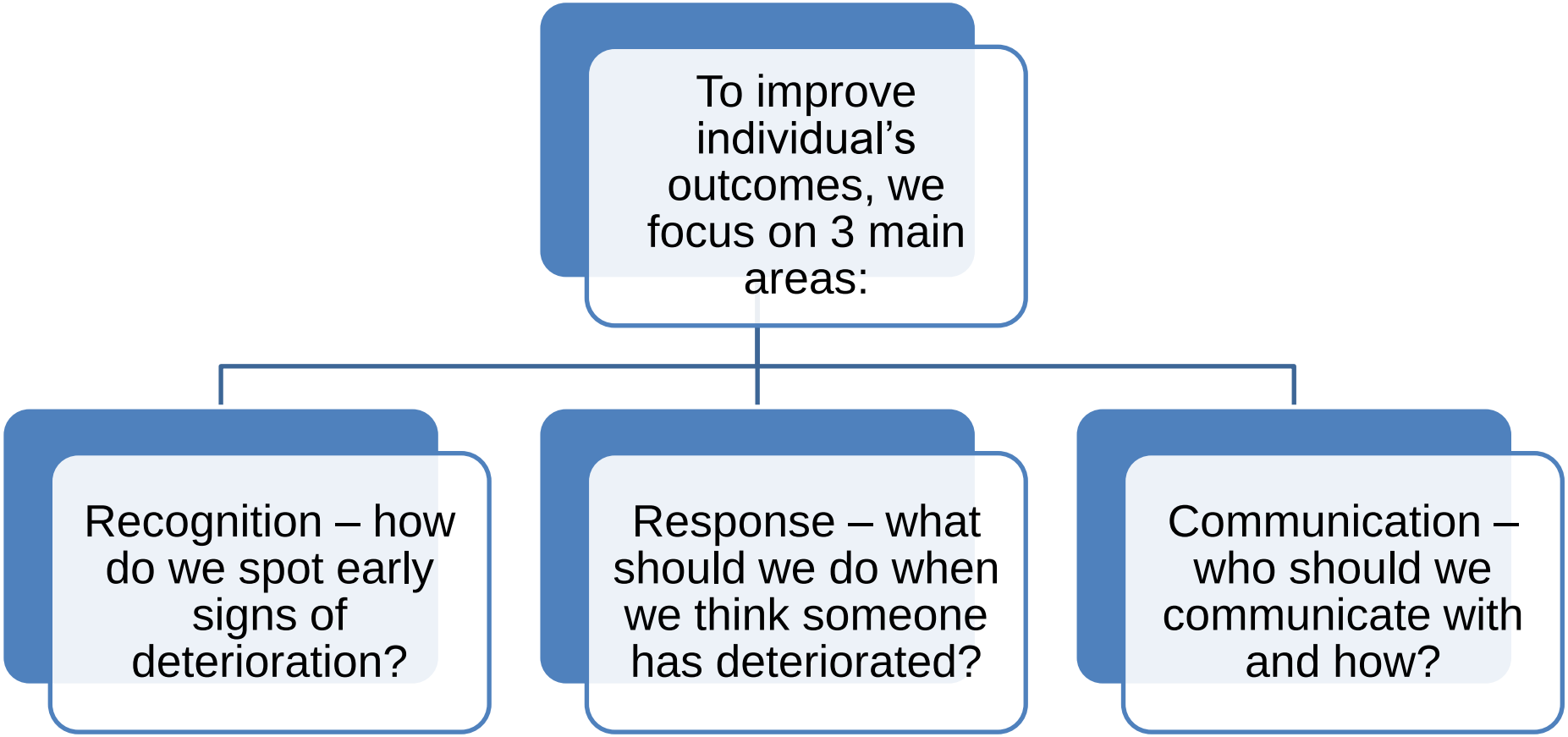
Outcomes of the session

- Learners will be able to identify what is meant by the term's 'deterioration' and 'recognition’
- Learners will understand how the use of a simple tool to support their own observations can guide decisions regarding appropriate response to improve individual outcomes
- Learners will be able to demonstrate appropriate use of the tool to support their decisions using appropriate and effective communication skills

What do we mean by Deterioration?

The term **Deterioration** can be defined as when an individual 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.

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



Why do we need to avoid unnecessary Hospital admissions?

Exposure to avoidable harms such as deconditioning, infection, pressure ulcers

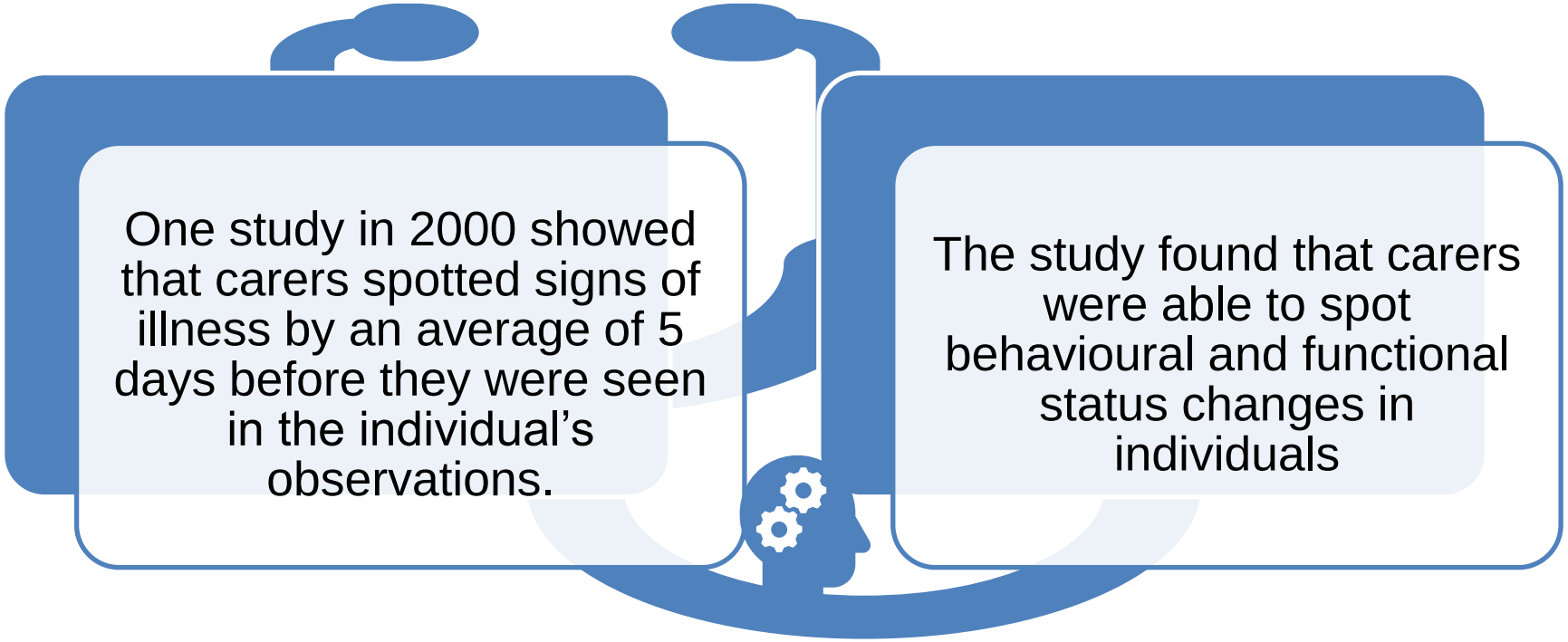
Often disruptive and upsetting for individuals

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 carer's spot the signs of early deterioration?



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

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

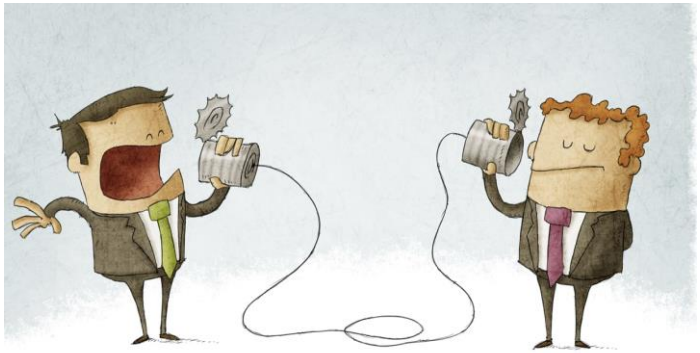
What do you think is the key to being able to spot these early signs?

Knowing the person, you care for!

- Understanding what is ‘normal’, is key to detecting changes.
- On their own, some changes may not look significant, however all play an important role in recognising deterioration
- Important signs can be spotted by everyone who is in contact with the individual

Good communication in the team is crucial:

- Verbal & written
- Handover
- Accurate paperwork
- Up to date person centered care/support plans all add value
- Tools designed for this specific purpose e.g. ‘This is me’, RESPECT, Advanced care plans.



Remember all team members, families and visitors can spot differences in people. It is important that everyone feels able to speak up, and that they are listened to if they are worried about an individual 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; 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

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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

PLEASE TURN OVER AND USE THE SBAR COMMUNICATION

Activity: Create a poster

Work in 3 groups to create a poster, highlighting what changes you might be looking for within each prompt and any potential clinical reasons for the changes seen

Group 1: STOP

S	Seems different to usual
T	Talks or communicates less
O	Overall needs more help
P	Pain new or worsening: participating less in activities

Group 2: AND

A	Ate less
N	No bowel movement in 3 days; diarrhoea
D	Drank less

Group 3: WATCH

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

P4-11 in workbook

S Seems different to usual

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

T Talks or communicates less

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

O Overall needs more help

- Is the individual More dependent, asking for help, needing more staff to help transfers, needing more help for activities of daily living
- Lower energy levels can point to infection or deterioration in the individual's medical condition

P Pain, new or worsening/ participating less in activities

Not all individuals 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.

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 individual's 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 individual need help with feeding?

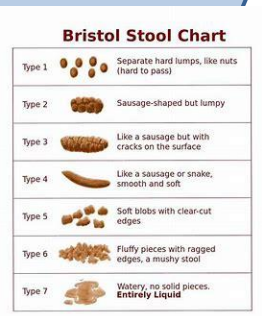
Do you know which individuals have food charts and why? Are they always completed accurately?

N

No bowel movements 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:

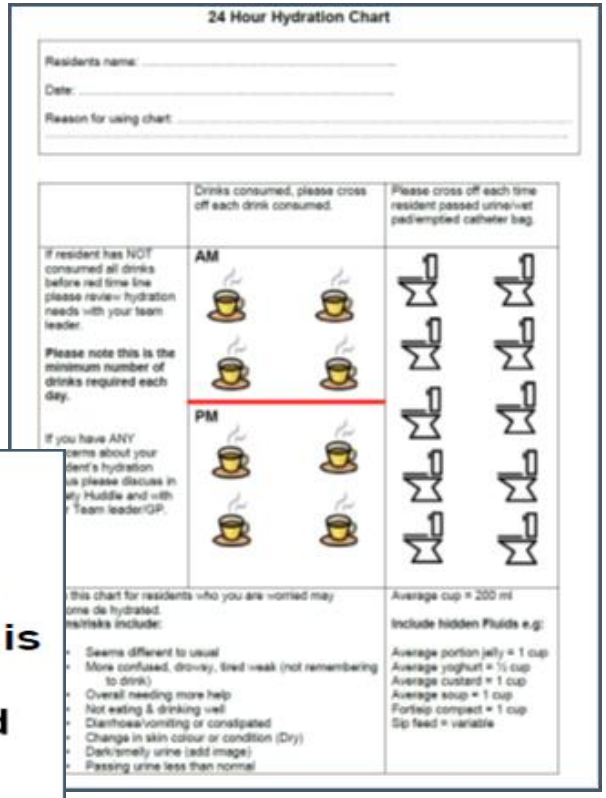
Black - Often a sign of internal bleeding
Red - Red signifies blood and bleeding
Pale - indicates an underlying problem in the liver, gallbladder, or pancreas; all of which contribute to the digestive system
Green - may also be caused by consuming leafy vegetables, iron supplements, or be due to an intestinal 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

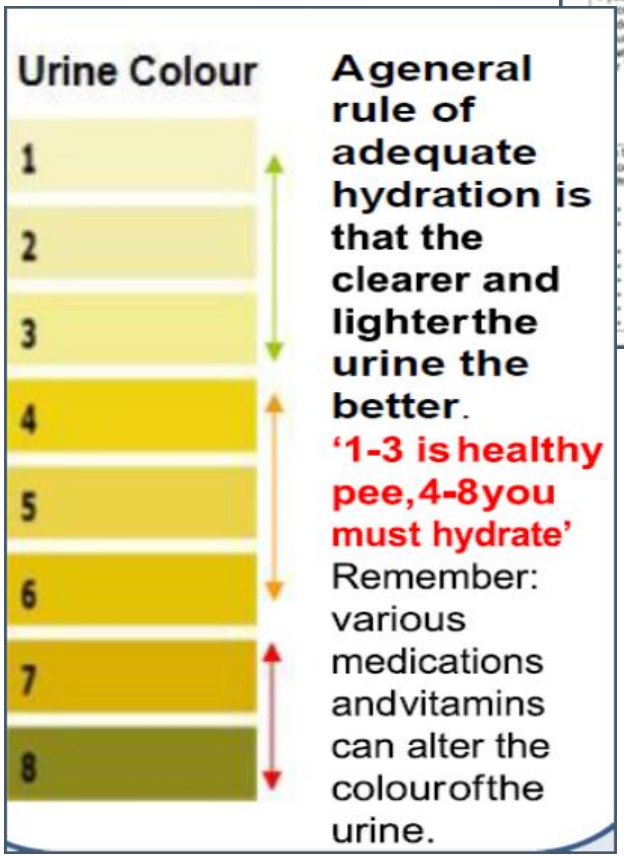


D Drank less

Hydration in all individuals is important

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





Page 7 in workbook

W Weight change

•You may notice the individual 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 individual fidgeting, trying to get out of their chair/bed, looking scared or anxious. The individual 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.

Page 8 in workbook

T Tired, weak, confused, drowsy

You may notice the individual appears to have less energy or 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).

https://youtu.be/BPfZgBmcQB8

	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** - 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	**METABOLC** - high or low blood sugar, diabetes, pancreatic problems

C Change in skin colour or condition

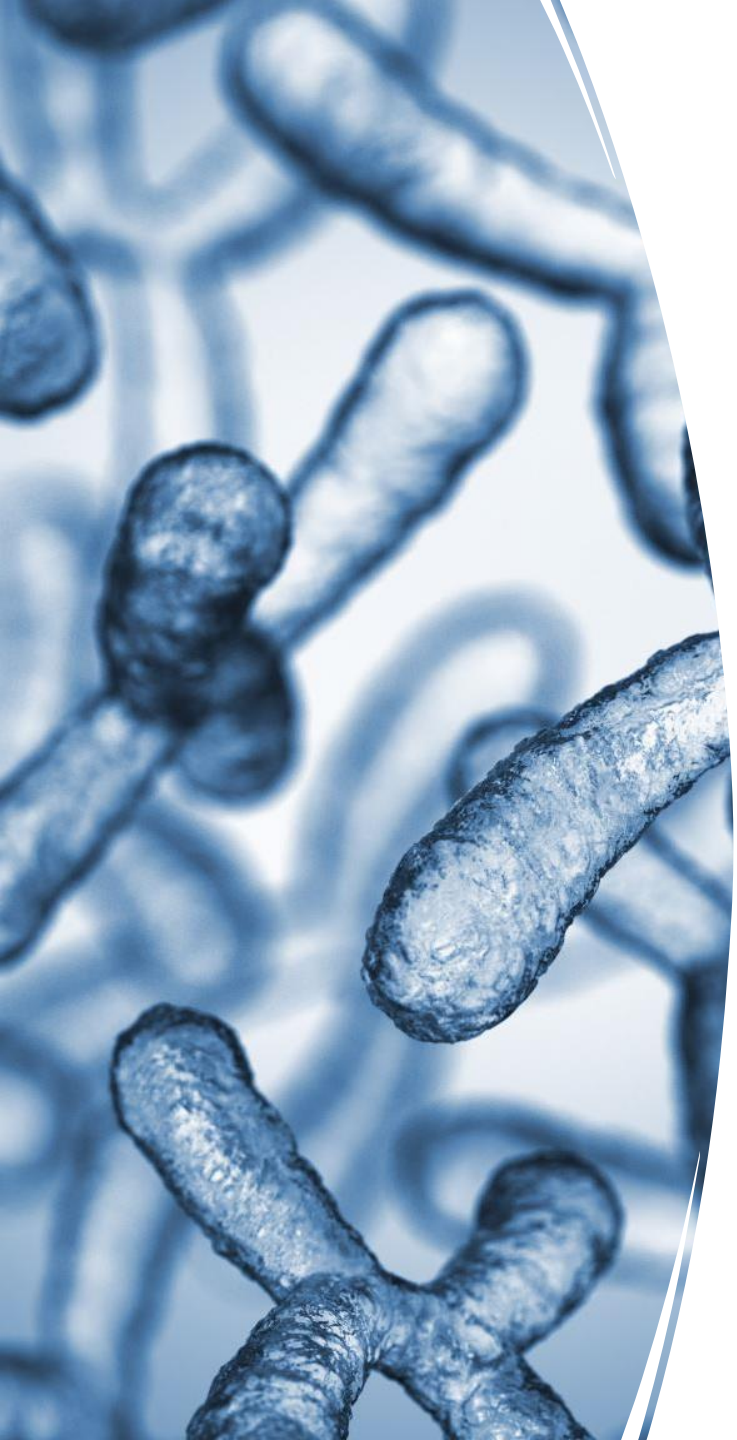
Increasingly dry skin is a sign of dehydration. Other changes may be increasing bronzing of the skin (problem with iron), a yellowing of the skin and whites of eyes (liver failure). Poor circulation or inadequate oxygen levels in blood can also cause your skin to turn bluish (Hypoxic).

- 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 individuals 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 that the individual 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.



Sepsis

What is 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.
- Approx. 48,000 people die of sepsis every year in the UK (more than bowel, breast & prostate cancer together)

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

More information can be found online
https://sepsistrust.org/

Other things you need to consider when a person is deteriorating

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

Slurred speech or confusion

Extreme shivering or muscle pain

Passing no urine (in previous 18 hours)

Severe breathlessness

It feels like you're going to die

Skin mottled or discoloured

If you or another adult develop any of these signs, it is important to seek urgent medical attention.
Call 111 or contact your GP if you are worried about an infection.

Sepsis stats

5

DEATHS AN HOUR

In the UK, five people lose their lives to this condition every hour.

48,000

DEATHS EACH YEAR

In the UK, there are 48,000 sepsis related deaths each year.

245,000

PEOPLE AFFECTED

In the UK, 245,000 are affected by sepsis each year.

11,000,000

DEATHS GLOBALLY

Sepsis is responsible for 11 million deaths globally each year.

If an individual 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 and handover to the team

Most importantly….**Tell someone**

Page 11 in workbook

The Important Bit…
Teamwork & Communication

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.

SBAR communication form

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

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)

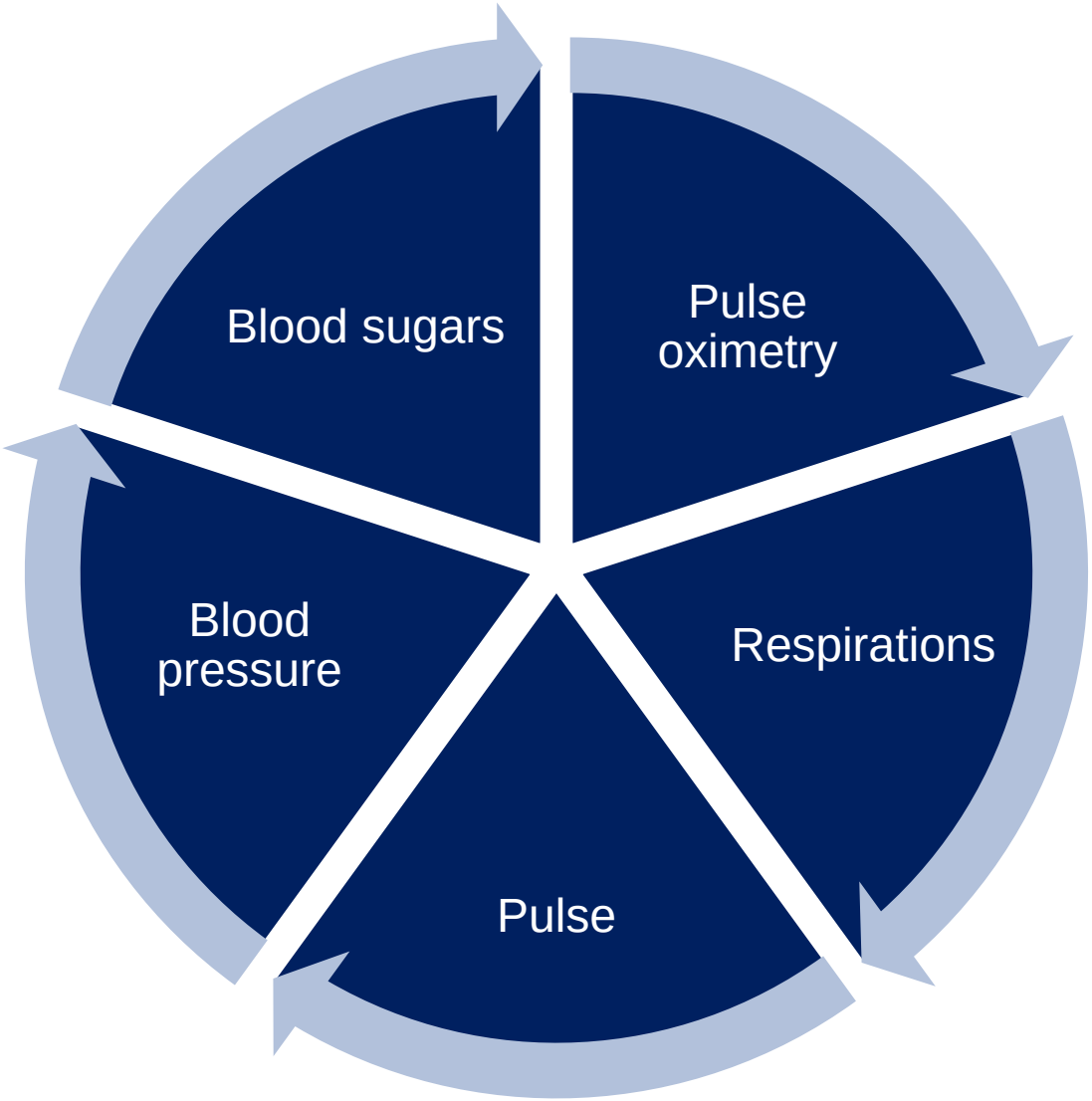
DNACPR Y / N Advanced care plan Y / N

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 :

Observations: Have you been trained to do them?



On the Wrist

Follow instructions for use, maintenance and cleaning

Which service should I call?

Do you use Immedicare?

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

999

- 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 or trauma

What do GPs look for?

Any injuries?

Are they conscious?

How are they behaving?

What does their breathing sound like?

How is their chest moving?

What does their skin look like?

Check their pulse

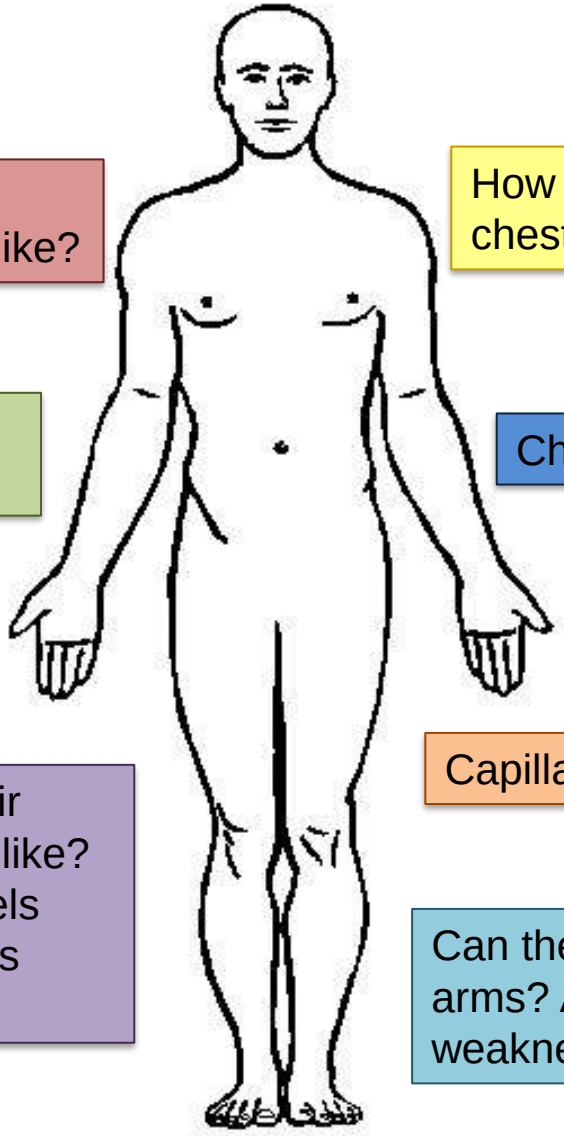
Gut instinct

What has changed?

Capillary refill

What does their abdomen look like? What are bowels and waterworks doing?

Can they move their legs and arms? Any one-sided weakness or facial changes?



Case study using the Stop and Watch tool and SBAR form

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 individuals. 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: Joseph **Date of Birth:** ...../...../..... **Room Number:**.....

Date /time	Mon			Additional information
S Seems different to usual	✓			
T Talks or communicates less	✓			Mon - Not chatting to staff as much
O Overall needs more help				
P Pain new or worsening; participating less in activities	✓			Mon - Mobilising less
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	✓			Mon - Tired – disturbed night
C Change in skin colour or condition				
H Help with walking, transferring or toileting more than usual				
Carer name	PQ			
Reported to (senior)	PQ			
Senior Action /call GP / 999/ 111 / DN etc Resident monitored or other action	Mon – continue to observe, encourage fluids & mobility. Observe PA, falls risk and use S&W again in 24hrs unless deterioration noted sooner			
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

Let's redo the Stop and Watch to see how his condition has changed

- 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 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.

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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: Joseph **Date of Birth:** ...../...../..... **Room Number:**.....

Date /time	Mon	Tues		Additional information
S Seems different to usual	✓	✓		
T Talks or communicates less	✓	✓		Mon - Not chatting to staff as much
O Overall needs more help		✓		Tues – Needed help with trousers
P Pain new or worsening; participating less in activities	✓	✓		Mon - Mobilising less Tues – back pain
A Ate less		✓		Tues – didn't eat all breakfast and didn't want cottage pie for tea
N No bowel movement in 3 days; or diarrhoea				
D Drank less		✓		Tues – declines cup of tea
W Weight change				
A Agitated or more nervous than usual		✓		Tues – Short tempered with staff
T Tired , weak , confused or drowsy	✓	✓		Mon - Tired – disturbed night Tues – Another disturbed night
C Change in skin colour or condition		✓		Tues – Dry mouth – sitting in chair all day, pressure areas checked
H Help with walking, transferring or toileting more than usual		✓		Tues – Unsteady and needed help with trousers
Carer name	PQ	PQ		
Reported to (senior)	PQ	PQ		
Senior Action /call GP / 999/ 111 / DN etc Resident monitored or other action	Mon – continue to observe, encourage fluids & mobility. Observe PA, falls risk and use S&W again in 24hrs unless deterioration noted sooner Tues – Deteriorated – call GP for advice use SBAR to communicate			
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

SBAR Communication Form

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: Joseph ..... Date of Birth: ...../...../..... This started on Monday
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

He has a past medical history of bowel cancer and prostate cancer which has spread to his bones. He does have a DNACPR and an advanced care plan in place and would prefer to be treated in hospital.

ASSESSMENT
Identify the change/s from the stop and watch tool

Joe is more tired than normal and has no interest. He has new back pain which is keeping him awake at night, and he is short tempered. He is not eating and drinking much and seems dehydrated. He has a stoma. He is needing more help from staff and not mobilising very well and seems a little unsteady on his feet.

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

I would like Joseph to be seen by a GP today please

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

Wednesday

- Joe is 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
- 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 must remind him this morning
- He is eating and drinking less, and Maggie notices that his mouth and skin seem dry, and his clothes appear looser 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 mealtimes. 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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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: Joseph **Date of Birth:** ...../...../..... **Room Number:**.....

Date /time	Mon	Tues	Sat	Additional information
S Seems different to usual	✓	✓	✓	Significant deterioration overnight
T Talks or communicates less	✓	✓	✓	Mon - Not chatting to staff as much
O Overall needs more help		✓	✓	Tues – Needed help with trousers
P Pain new or worsening; participating less in activities	✓	✓	✓	Mon - Mobilising less Tues – back pain
A Ate less		✓	✓	Tues – didn't eat all breakfast and didn't want cottage pie for tea
N No bowel movement in 3 days; or diarrhoea			✓	Wed – low stoma output, Sat - watery stool
D Drank less		✓	✓	Tues – declines cup of tea
W Weight change			✓	Thurs – clothes appear looser
A Agitated or more nervous than usual		✓	✓	Tues – Short tempered with staff
T Tired , weak , confused or drowsy	✓	✓	✓	Mon - Tired – disturbed night Tues – Another disturbed night Wed – forgetful, sat - disorientated
C Change in skin colour or condition		✓	✓	Tues – Dry mouth – sitting in chair all day, pressure areas checked Sat – skin dry & pale
H Help with walking, transferring or toileting more than usual		✓	✓	Tues – Unsteady and needed help with trousers Sat - fell
Carer name	PQ	PQ	PQ	
Reported to (senior)	PQ	PQ	PQ	
Senior Action /call GP / 999/ 111 / DN etc Resident monitored or other action	Mon – continue to observe, encourage fluids & mobility. Observe PA, falls risk and use S&W again in 24hrs unless deterioration noted sooner Tues – Deteriorated – call GP for advice use SBAR to communicate111			
Outcome / transferred to hospital/ visited by GP/ DN or phone advice given	999 call and taken to hospital			

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

SBAR Communication Form

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

Joseph

Monday

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

He has a past medical history of bowel cancer and prostate cancer which has spread to his bones. He does have a DNACPR and an advanced care plan in place and would prefer to be treated in hospital.

ASSESSMENT
Identify the change/s from the stop and watch tool

Joe is more tired and confused than normal, he has been complaining of back pain and today tummy ache. He is not eating and drinking much and appears to have lost weight. He seems dehydrated. He has a stoma and has been constipated but had loose watery stools on Friday. He can usually get out of bed on his own but can't today and he fell last night for the first time.

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

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?

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

Advised to call 999 for ambulance

Any ideas about what may have caused Joseph's deterioration?

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.

What might have been different if Joseph's deterioration had been recognised earlier?

Two weeks later

- 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

Thank you,
any questions?