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Care homes education: what can we learn?

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ABSTRACT

Medical care received by care home residents can be variable. Initiatives, such as matron-led community teams, ensure a timely response to alerts about unwell residents. But early recognition of deterioration is vital in accessing this help. The aim of this project was to design and deliver an education programme for carers. It was hypothesised that the implementation of a teaching programme may result in improved medical care for residents. By understanding the enablers and barriers to implementing teaching, we hoped to identify the components of a successful teaching programme. Four care homes in Enfield received training on topics such as deterioration recognition over a 1-year period. The project was evaluated at 3, 6 and 9 months. Each evaluation comprised: pre-and-post-teaching questionnaires, focus groups, analysis of percentages of staff trained, review of overall and potentially avoidable, hospital admission rates. A Plan–Do–Study–Act cycle structure was used. The programme was well-received by carers, who gave examples of application of learning. Modules about conditions frequently resulting in hospital admission, or concerning real cases, demonstrated the best pre-and-post lesson change scores. However, the reach of the programme was low, with attendance rates between 5% and 28%. Overall, the percentage of staff trained in deterioration recognition ranged from 35% (care home one) to 12% (care home three). Hospital admissions reduced from 37 hospital admissions to 20 over the duration of the project. Potentially avoidable admissions reduced from 16 to 5. Proving causality to the intervention was difficult. Factors facilitating delivery of training included a flexible approach, an activity-based curriculum, alignment of topics with real cases and embedding key messages in every tutorial. Barriers included: time pressures, shift work, low attendance rates, inequitable perception of the value of teaching and IT issues. Care home factors impacting on delivery included: stability of management and internal communication systems.
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PROBLEM

The Optimal study[1] reported that healthcare provision to care homes was 'reactive and inequitable'. The Health Foundation Report[2] found that many emergency hospital admissions from care homes may have been avoidable.

Several initiatives have been developed to help improve medical care in care homes. These include outreach services such as rapid response and care homes assessment teams (CHAT). However, these services only address part of the problem: ensuring a robust response once medical assistance is requested. Carer recognition of the early signs of deterioration, and an awareness of common medical problems, are vital in accessing holistic health needs assessments of decompensating frailty for residents.

There are 80 care homes in the borough of Enfield,[3] one of the highest number in London. In 2018–2019, there were 63 hospital admissions across the 41 care homes affiliated to Medicus Health Partners. Common reasons for admission included general deterioration, pneumonia and sepsis.

It is paramount to ensure that all care home residents receive excellent care. This aligns with the core values of the NHS[4] and falls within the remit of the enhanced health in care homes (EHCH) framework[5]; to provide care home residents with the same level of care as people living in their own homes.

Medicus Health Partners were awarded a contract to provide clinical care to 25 (later expanded to 41) care homes in Enfield in 2018. They recognised the requirement for a multidisciplinary approach to the provision of excellent medical care, and of the vital role of care staff in this. Thus, they collaborated with UCLPartners on this project.

The aim was to design and deliver an education programme in four care homes in Enfield in order to improve patient care over a 1-year period. The homes were a mix of residential and nursing, registered to Medicus Health Partners. They ranged from those with low hospital admission rates to those with a higher rate of secondary-care conveyance. Across the four care homes, there were a total of approximately 190 residents and 206 staff, although this fluctuated throughout the course of the project.

The intention was to explore the link between care home staff education and good medical care. It was hypothesised that the implementation of a teaching programme may result in better care. Reduction in

potentially avoidable hospital admissions was used as a surrogate marker for improved care.

By understanding the enablers as well as the barriers to implementing regular teaching, we also hoped to identify the components of a successful teaching programme.

BACKGROUND

Several recent studies have alluded to the variable quality of medical care in care homes. The Optimal study[1] reported that healthcare provision to care homes was 'reactive and inequitable'. The Health Foundation Report[2] found that many emergency hospital admissions from care homes may have been avoidable. Happ *et al*[6] evaluated advanced care plans (ACPs) and end-of-life (EOL) care in a care home, concluding that absent or inadequate ACPs were resulting in EOL patients being admitted to hospital. The Prosper study[7] assessed whether the rate of urinary tract infections (UTIs), pressure sores and falls improved after safety tools were introduced into care homes. Both falls and pressure sore rates fell when safety processes were implemented. Gott *et al*[8] looked at hospital admission in EOL patients, deducing that UTIs, confusion, reduced consciousness and stroke were common reasons for admission in EOL patients. Hence, the problem of variable or suboptimal care within care homes is well evidenced.

The link between improved medical care and investment in education is an exciting area of research. The EHCH[5] framework identified seven core elements to the provision of high-quality care to care homes. One of these was workforce development. The common competencies[9] stated that non-palliative care specialists working in social care often find themselves looking after people who are dying. Some trials looked specifically at the impact of implementing an education programme for carers in an attempt to improve early recognition of reversible causes of deterioration, thus improving quality of care. The PROSPER[7] programme run by UCLPartners in 2016 evaluated whether quality improvement (QI) methods could be introduced in care homes to improve safety for vulnerable residents at risk of admission to hospital or significant deterioration. Results showed that two-thirds of participating care homes made changes to their working practices and changed the way they thought about safety. The 'What's best for Lily?' project,[10] endorsed by UCLPartners, evaluated a 'train-the-trainer' approach to the delivery of EOL care education. This study concluded that EOL care training is required, and works well when implemented as an activity-based, discussion-orientated programme. However, the 'train-the-trainer' approach encountered challenges, for example, staff being inexperienced/underconfident in teaching, and a high staff turnover in the care sector resulting in loss of corporate knowledge.

The 'Skills for Health' Frailty Core Capabilities Framework[11] published in 2018 highlighted the importance of recognition of frailty as a long-term condition, and set out the skills, knowledge and behaviours healthcare staff need when providing care for people living with frailty.

This literature review, thus, validated the hypothesis that education may lead to improved care, and helped form the basis for the content of teaching programme.

MEASUREMENT

The project was evaluated at the 3, 6 and 9 month points. It was initially planned to run for 1 year, but was redesigned at the 9-month point due to the coronavirus pandemic. Each evaluation was composed of four facets.

First, pre-and-post-teaching lesson questionnaires were used to assess carers' self-perception of their knowledge. This gathered useful information about the learners' reaction the teaching, but had limited ability to assess impact of learning because the predictive validity of the questionnaires could not be assumed.

Second, focus groups with carers and managers were undertaken to identify examples of implementation of learning.

Third, an analysis of the number of staff trained was performed, to assess the reach of the programme. Overall percentages of staff trained in deterioration by the end of the project was also reviewed. This module was chosen as a marker because recognition of deterioration is a key topic, fundamental to providing good patient care.

Finally, hospital admission rates were analysed. These data were collected from EMIS primary care records, and cross-referenced with data provided by Enfield's CHAT. Each admission was reviewed by the author to decide whether it was potentially avoidable. Some admissions were also reviewed by the CHAT matron, and a consensus reached. 'Potentially avoidable' was defined as an admission that was either manageable utilising an alternative service or pathway, preventable in the first place, or in contravention to a pre-existing ACP. Primary care records and discharge summaries were accessed to assess the circumstances surrounding the deterioration, the staff involved in the escalation decision, the information acted on and the presence or absence of possible alternative pathways. It is acknowledged that such retrospective case analysis incorporates a degree of subjectivity. The rates of potentially avoidable admissions at the beginning and end of the teaching programme were compared for each care home. Proving causality between any intervention and hospital admission rates is difficult due to the presence of multiple confounding factors. Looking at potentially avoidable admissions helped minimise the variable of unequal sickness rates over time and between care homes, but the retrospective case analysis involved had the potential to introduce bias.

The project was a QI study across four care homes. The total population was approximately 190 residents and 206 staff. As such, this study was not designed to have the statistical power to prove effectiveness of intervention. Nor was it designed with control groups with which to

Figure 1 PDSA-cycle diagram and timeline. IT, information technology. PDSA, Plan–Do–Study–Act.

compare the study group, as matching for cofounding factors would have been extremely challenging. The multimethod evaluation was used in order to provide the most practical, comprehensive evaluation within these limitations.

A Plan–Do–Study–Act (PDSA) analysis was conducted after each evaluation to identify change ideas for the next cycle (figure 1).

Prior to the programme commencing, research staff conducted baseline data gathering in the form of focus-groups with carers, managers and support staff, to establish baseline knowledge and attitudes of carers. They found that attitudes to providing EOL care in the care home were inconsistent. Some saw it as appropriate, but often, the staff felt that hospital was more appropriate for the very sick. Care homes that admitted to hospital less

frequently demonstrated a greater willingness to care for the very sick.

The staff scored highly when it came to listing symptoms of deterioration. Knowledge regarding what constitutes sudden or gradual deterioration was variable. Lower-admitting care homes were better at recognising the difference between the two.

Hospital admission data for Enfield was analysed at the start of the project to identify topics for inclusion. Interviews with managers were conducted to discuss delivery and content for inclusion.

DESIGN

The modules were written in advance, evidence-based and activity-focused. Topics included: deterioration recognition, care of the dying, falls, UTIs and strokes.

The programme delivery was adaptable and reactive: events occurring within the care home such as complex cases, deaths and inappropriate admissions influenced teaching content. The care homes were consulted about what they wanted, and how they wanted to receive it. Some opted for frequent, short sessions. Others requested periodic, all-day training. A single trainer delivered the sessions, drawing on the expertise of other healthcare professionals where appropriate. The research team, comprising UCLPartners staff and Medicus Health Partners clinicians, were involved throughout, assisting with data collection, analysis and generating change ideas.

Ensuring engagement was an anticipated challenge, as care home staff have multiple calls on their time. To help overcome this, teaching sessions were scheduled in advance, with reminder phone calls and emails sent. At the end of each session, further training was organised to maintain momentum of the project.

STRATEGY

After each evaluation at the 3, 6 and 9-month points, change ideas were generated for the next cycle (figure 1). These changes included amendments to both the content and to the delivery of the programme.

At the end of the 0–3 months period (PDSA cycle 1), it was concluded that the teaching was highly valued, as learners consistently rated their knowledge to be better after the session than before it (figure 2). Good anecdotal examples of change of practice were also provided. However, the teaching programme only reached 12%–28% of the carers in the care homes.

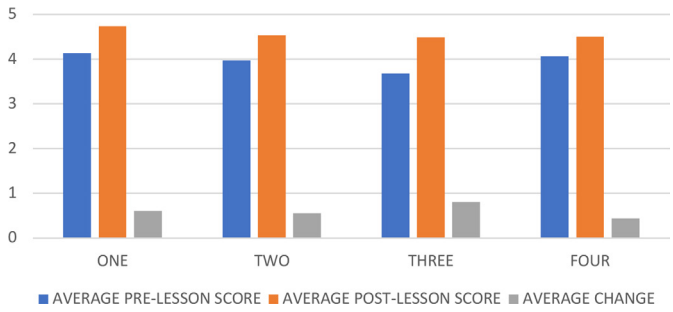

Figure 2 Graph to show average pre-and-post-teaching session questionnaire scores per care home.

Change ideas concerning alterations to the delivery of the programme were generated in an attempt to address this. Interventions for PDSA cycle 2 included: nominating a training monitor to promote teaching and utilisation of evening teaching sessions. Ensuring that key topics were delivered at each teaching session was thought to represent a more realistic approach to addressing low attendance rates. Permission was granted to use 'Is my Resident Well- 10 everyday questions to ask'.[12] Modules were adapted to incorporate key information on deterioration, with references to this toolkit, and case studies to support its implementation.

At the end of the second PDSA cycle, the teaching sessions continued to demonstrate positive pre-and-post session change scores. However, the reach of the programme had not improved. Potentially avoidable hospital admissions reduced in three of the care homes and remained unchanged in one. Potentially avoidable admissions were reviewed by the author to identify causal factors and the circumstances surrounding the escalation decision. Factors involved were: staff calling the wrong service so receiving inappropriate advice, patients admitted to accident and emergency (A+E) when a rapid-access outpatient service may have been more appropriate and the admission of an EOL patient for care that could have been provided in the home.

Change ideas implemented for the next PDSA cycle (PDSA cycle 3) included the development of a new teaching session about escalation of patients to the correct service. Any medical condition frequently resulting in admission was included in the programme if not already present. Cards with contact details for community support services were distributed at teaching sessions.

The project was originally designed to run for 1 year. However, due to the coronavirus pandemic, the face-to-face teaching was terminated at 9 months, and the final evaluation conducted early. The focus then shifted towards exploring ways to ensure the sustainability of the programme, seek accreditation for the programme and to develop alternative teaching delivery methods as holding face-to-face sessions became more difficult (PDSA cycle 4). While this change was as a consequence of COVID-19, it was hoped that the development of novel teaching methods might help boost attendance rates. Thus, the change ideas were focused on delivery modification. Interactive videos were recorded and sent to the care homes, but the uptake was poor. The delivery of live webinars was hindered by lack of WIFI/technology.

RESULTS

The programme was highly rated by carers, with all care homes showing a positive change between average pre-and-post-lesson questionnaire scores (figure 2). Only 1 out of 44 teaching sessions demonstrated a negative

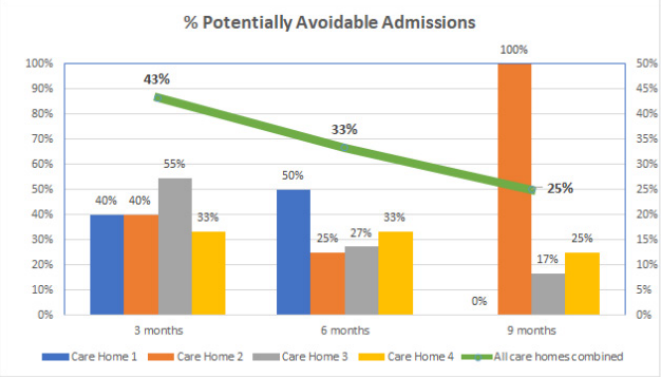

Figure 3 Graph to show change in percentage of hospital admissions deemed to be potentially avoidable across four care homes over time.

post-lesson change score. Modules about conditions frequently resulting in hospital admissions or relating to cases within the care home demonstrated the best post-lesson change scores. Good anecdotal evidence of improved care was gathered. Staff reported being more aware of the early signs of deterioration, of the importance of dehydration and nutrition, and of measures to reduce falls.

Hospital admissions reduced overall in all four care homes throughout the duration of the programme. There were 37 hospital admissions across the 4 care homes in the first 3-month period of the intervention (months 0–3), compared with 20 between months 7 and 9. This is a reduction of seventeen admissions. Hospital admission rates are affected by many variables, and proving causality with any intervention is challenging.

Measuring potentially avoidable admission rates removes fluctuating sickness levels as a variable, and helps avoid the potentially damaging intimation that all hospital admissions are 'bad'. However, error may be introduced through retrospective case review.

The total number of potentially avoidable admissions reduced from 16 (0–3 months) to 5 (7–9 months) across all four care homes, comprising 43% of all admissions in the 0–3 months period and 25% of all admissions in the 7–9 months period (figure 3). Three of the care homes showed a reduction in potentially avoidable hospital admissions over the course of the teaching programme. Two of these three care homes (care homes one and four) engaged well with training, taking a degree of ownership of the programme. These homes achieved the highest number of staff trained in deterioration recognition by the end of the programme, at 35% and 28%, respectively. They also received the most teaching sessions throughout the programme (14 and 13 lessons, respectively). The care home that showed an increase in the percentage of admissions deemed to be potentially avoidable (care home two) initially showed good engagement with teaching, but this reduced over time. This home achieved the second-lowest number of staff trained in deterioration (26%) and received the second-lowest number of teaching sessions overall (10). This care home showed persistently low attendance rates, with staff frequently being 'rounded up' on the day and certain groups (eg, night staff) not attending any sessions.

Care home three received the least the number of teaching sessions (9) and achieved 12% coverage of staff trained in deterioration recognition. This home faced other challenges throughout the course of the project, such as a change in management. This significantly affected engagement. However, the attending staff rated the sessions highly, and this home showed the best average pre-and-post session average change scores (figure 2). The number of potentially avoidable admissions in this home also decreased throughout the course of the project.

In all four care homes, poor attendance rates remained a challenge throughout (5%–28%), despite continued attempts to improve them. Overall, the percentage of staff trained in deterioration recognition ranged from 35% (care home one) to 12% (care home three).

Reasons suggested for low attendance rates are: shift work, staff required on duty, perceptions of value of teaching and time pressures. Attendance rates were better in homes with stable management, internal systems for organising training and in homes that placed a high value on teaching. Care homes with lower staff attendance rates were more likely to have unstable senior management, poor internal communication systems and place a lower value on teaching. The cessation of face-to-face teaching due to coronavirus at the 9-month point exacerbated this issue.

LESSONS AND LIMITATIONS

The teaching programme was interactive-quizzes, games and brainstorming were all 'low-tech' ways to engage learners. Case studies encouraged application of knowledge and demonstrated relevance. Tools such as 'Is my resident well- 10 questions to ask' and 'Significant care'[13] boosted learning, but required assistance with implementation. Analysing admissions to hospital, especially those deemed potentially avoidable allowed tailoring of the programme to the home's individual needs and ensured relevance.

To address low attendance rates, key concepts, for example, deterioration recognition were embedded within each teaching session, ensuring that these messages were disseminated at every lesson. The deterioration recognition module was run more than once in each home, due to its importance to resident care. Each module was 'stand-alone', as regular attendance could not be assumed. Nominating a teaching monitor and developing 'individualised learning plans' encouraged the care homes to take ownership of their learning. Evening sessions were a good way to offer flexible delivery, but were limited by availability of professionals time.

Reminder phone-calls and emails prior to the teaching helped keep the teaching in the fore. However, despite

these measures, maintaining attendance at teaching was an enduring challenge. In addition, high staff turnover within the social care sector posed further challenges in ensuring that all staff were trained.

Using webinars and podcasts presents an opportunity to provide training flexibly. However, methods to maintain momentum for teaching must be explored further if a self-directed learning model is to be implemented: with so many competing time-pressures, there is a risk that training could be side-lined. An investment in information technology (IT) is also required if remote learning is to be delivered at scale. Inadequate IT facilities is currently a barrier to successful utilisation of virtual meeting platforms.

Factors within the care home such as stability of management and communication systems impacted on delivery of the programme. Due to the public–private sector interface between health and social care, addressing these elements will require a multiagency approach.

Evaluation of the project was challenging. The multimethod evaluation provided the most practical evaluation solution, helping address the limitations of each single element. Admissions' data provided robust quantitative data, but its use was constrained by challenges in proving causality to the intervention. The project was not designed to have the statistical power to prove effectiveness of intervention. Nor was it designed with control groups with which to compare the study group, as matching for cofounding factors was too difficult.

Analysing potentially avoidable admissions allowed staff knowledge and decision making to be better evaluated. However, retrospective case analysis potentially introduced research bias. This was compounded by the variability in availability of hospital discharge summaries. Using reduction in potentially avoidable hospital admissions as a surrogate marker for improved care may be unreliable as it does not encapsulate all aspects of improved care. In particular, it may not reflect qualitative end-points such as better communication with residents, improved pain management and enhanced holistic care. 'Improved medical care' is a difficult entity to measure. In future, other quantitative end-points could also be assessed, such as UTIs, falls and pressure sore rates within the care home.

Good examples of changes to practice were collected, including some that resulted in admission avoidance. Review of individual cases of change to practice, and the resultant improved care, allowed the 'human' impact of the programme to be captured.

CONCLUSION

The project demonstrated, within the limitations of the evaluation approach, a link between education of staff and reduced potentially avoidable admissions. The two care homes (one and four) that received the most sessions, and achieved the highest overall rates of staff trained in deterioration recognition, showed a reduction in potentially avoidable admissions. The care home(two) that showed an increase in potentially avoidable admissions demonstrated suboptimal engagement. The final care home (three) rated the sessions highly, but received the fewest sessions. This home encountered difficulties with engagement due to a change in management midway through the project.

The project explored factors, both intrinsic to the programme and inherent to the care home that augmented successful delivery of training. These included a flexible delivery approach, an activity-based curriculum, alignment of topics with admission data and embedding key messages in each tutorial. The project also examined barriers to implementation, such as competing priorities on time, shift work, low attendance rate, inequitable perception of the value of teaching, internal communication systems within the care home and availability of IT support.

The project was funded for 1 year. However, it is sustainable as an on-going intervention. Educational material, in the form of a 13-module work book (online supplemental file 1), has already been compiled. A general practitioner or allied healthcare professional would be required to lead on the programme in the future, to update modules, to plan and orchestrate teaching sessions and maintain momentum for training. In light of COVID-19, the programme may evolve to incorporate new teaching methods, resulting in a higher dependence on technology. This may help improve the reach of the programme, as this remained an enduring challenge.

The financial cost of the programme was limited to the cost of the lead professional's and carer's time. One A+E attendance costs approximately £160.[14] A non-elective hospital stay is on average £1600, although there is a wide deviation around this average. Hence, if fifty admissions per year are saved, this programme is financially justified. The knowledge and skills gained by carers (and thus the cost saving from reduced admissions) may continue beyond the duration of the programme.

The human impact of earlier medical care, better EOL care and prevention of serious medical problems cannot be calculated. Nor can improved motivation and morale of care staff, and the postulated secondary effects of this such as increased staff retention, recruitment and reduced staff sickness rates.

This is an exciting area for future development. Opportunities for the future include: ensuring that teaching reaches all staff, maintaining momentum for teaching during the coronavirus pandemic, embedding clinical training into compulsory training packages, validating training modules so learners receive an accredited qualification and implementing at scale. The recent drive for improved provision for care homes lends credence to the need for further research. Discovering flexible and innovative ways to deliver teaching, assisting care homes with technology, and ensuring engagement with remote training would be useful themes for future QI projects.

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Contributors Conception or design of the project: Mike Roberts, AS, SJ, TG, AG, SFA, JJN, MS and KB. Acquisition, analysis or interpretation of data for the work: SFA. Drafting the work or revising it critically for important intellectual content: SFA, TG, AG, AS and SJ. Final approval of the version to be published- SFA, TG, AG, AS and SJ. Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved: SFA.

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Competing interests None declared.

Patient consent for publication Not required.

Ethics approval It was a quality improvement study. The recipients of the intervention were fully consenting care home staff. The intervention was an education programme and the educational material was in-line with accepted best evidence. No patients were put at any additional risk, and were likely to benefit through better care.

Provenance and peer review Not commissioned; externally peer reviewed.

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REFERENCES

1 Goodman C, Davies S, Gordon A. Optimal NHS service delivery to care homes: a realist evaluation of the features and mechanisms that support effective working for the continuing care of older people in residential settings. Southampton: health services and delivery research. *NIHR Journals Library* 2017.
2 Wolters A, Santos F, Lloyd T. Emergency admissions to hospital from care homes: how often and what for? improvements analytics unit Briefing the health Foundation, 2019. Available: https://www.health.org.uk/sites/default/files/upload/publications/2019/Emergency-admissions-from-care-homes-IAU-Q02.pdf [Accessed 24 May 2020].
3 Care quality commission. The independent regulator of health and social care in England. Available: https://www.cqc.org.uk/search/services/care-homes/enfield?location=&latitude=&longitude=&sort=default&la=&distance=15&mode=htm [Accessed 29 Jul 2020].
4 NHS Health Education England. The NHS constitutional values hub. Available: https://www.hee.nhs.uk/about/our-values/nhs-constitutional-values-hub-0 [Accessed 29 Jul 2020].
5 NHS England. The framework for enhanced health in care homes, 2016. Available: www.england.nhs.uk/vanguards [Accessed 24 May 2020].
6 Happ MB, Capezuti E, Strumpf NE, *et al*. Advance care planning and end-of-life care for hospitalized nursing home residents. *J Am Geriatr Soc* 2002;50:829–35.
7 UCLPartners, Essex County Council and The Evidence Centre. Improving resident safety in care homes-learning from the PROSPER programme in Essex, 2016. Available: https://www.livingwellessex.org/media/571025/prosper-final-evaluation-report.pdf [Accessed 24 May 2020].
8 Gott M, Gardiner C, Ingleton C, *et al*. What is the extent of potentially avoidable admissions amongst hospital inpatients with palliative care needs? *BMC Palliat Care* 2013;12:9.
9 Skills for care and Skills for health. *Common core principles and competences for social care and health workers working with people at the end of life*. 2nd edn. Leeds: Skills for Care and Skills for Health, 2014.
10 UCL Partners and Health Education England. End of life care (EOLC) programme -What's best for Lily, 2018. Available: https://uclpartners.com/work/whats-best-for-lily-end-of-life-training-for-care-home-staff/ [Accessed 24 May 2020].
11 Health Education England and NHS England. Skills for health. frailty core capabilities framework. Available: https://www.skillsforhealth.org.uk/services/item/607-frailty-core-capabilities-framework [Accessed 21 Nov 2020].
12 NWL CCG. Is my resident well? – 10 questions to ask. The "Is my resident well" booklet was produced by the North West London Collaboration of Clinical Commissioning Groups (CCGs) with the North West London health and care partnership with associated training materials. The associated training materials were produced by Dr Asha Katwa for the Harrow Planning And Caring Together project (HEE North London funded Partnership in Innovative Education Project) co-designed with St Luke's Hospice. These materials have been adapted by UCLPartners. Available: http://anyflip.com/vxeq/qxfd [Accessed Cited 25.05.2020].
13 Rodgers G. NEFLT and UCLPartners. significant care. Available: https://s31836.pcdn.co/wp-content/uploads/Significant-Care-Tool-V.21.04.20-high-resolution.pdf [Accessed 06 Jun 2020].
14 NHS Improvement. Reference costs are the average unit cost to the NHS of providing secondary healthcare to NHS patients, 2020. Available: https://improvement.nhs.uk/resources/reference-costs/ [Accessed 24 May 2020].

Enfield care homes education curriculum guide for trainers.

Enfield Care Homes Project.

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Module 1- DETERIORATION- part 1

Aims of session

1) Explore deterioration.
    a. What is deterioration?
    b. Why does recognising it matter?
    c. What is the difference between sudden and gradual?
    d. Why might this difference matter?
2) Explore signs and symptoms that may relate to sudden deterioration, and those that may relate to gradual.
3) Explore frailty

End-points of session

1) Learners understand that gradual deterioration happens over time and sudden tends to happen more quickly. Gradual deterioration often relates to the progression of a pre-existing condition. Sudden deterioration may be because of another medical problem such as infection, constipation, medication or an injury.
2) Learners can describe signs and symptoms that may relate to sudden deterioration and those that may relate to gradual deterioration.
3) Learners know how to escalate their concerns.
4) Learners recognise frailty as a medical condition.

Structure of session

1) Activity 1- gradual vs sudden deterioration- handout 1. (20 minutes)
    a. Get the learners to work through this handout, considering whether each symptom could represent sudden or gradual deterioration. Go through the answers as a group and use to prompt discussion
2) Question 1- *'why does distinguishing between the two matter?'* (15 minutes)
    a. Pose the above question to learners. Try and get them to consider that sudden deterioration may represent a new medical problem. Gradual deterioration may be due to a decline in their pre-existing condition-e.g. dementia or frailty.
    b. Causes of sudden deterioration may be treatable and reversible so it is important we know about them. Measures can be put into place to support residents who are deteriorating gradually- e.g. dietician review. If those residents are nearing end-of-life, it is important that we are aware of that too.
3) Activity 2- causes of sudden deterioration. (10 minutes)
    a. Think of a resident whom you cared for who deteriorated suddenly. Can you remember what the cause of this was? Brainstorm possible causes of sudden deterioration.
4) Activity 2- mapping changes in deteriorating patient-handout 2. (20 minutes)
    a. Work through the activity. Read each month out aloud and ask carers to plot their answer on a chart. Show charts at the end of session and invite carers to explain their charts. Also consider interventions that may help, e.g. dietician assessment etc.
5) Frailty

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a. In groups, brainstorm what you understand by the term 'frailty'.
    i. Frailty is reduced resilience/ increased vulnerability to deterioration as a result of relatively minor stresses.
b. Brainstorm- How might we recognise it?
    i. Confusion, falls, deterioration in mobility, incontinence, medication side effects, weight loss, slowing down, fatigue
c. Why is it important to recognise frailty?
    i. Group discussion- consider measures brainstormed in last exercise.
d. Consider how we might assess frailty.
    i. Rockwood frailty score- talk through.

RESOURCES:

Handout 1- 1 PER PARTICIPANT
Handout 2– 1 PER PARTICIPANT
Handout 3- 1 PER PARTCIPANT

REFERENCES:

UCL Partners and Health Education England. End of life care (EOLC) programme -What's best for Lily. 2018. [cited 24.05.2020]. Available from https://uclpartners.com/work/whats-best-for-lily-end-of-life-training-for-care-home-staff/

Is my resident well? – 10 questions to ask.
Available from: http://anyflip.com/vxeq/qxfd
The "Is my resident well" booklet was produced by the North West London Collaboration of Clinical Commissioning Groups (CCGs) with the North West London health and care partnership with associated training materials.
The associated training materials were produced by Dr Asha Katwa for the Harrow Planning And Caring Together project (HEE North London funded Partnership in Innovative Education Project) co-designed with St Luke's Hospice. These materials have been adapted by UCLPartners.

British Geriatrics Society. Introduction to frailty. 2014. [cited 18.11.2020]. Available from https://www.bgs.org.uk/resources/introduction-to-frailty

Health Education England and NHS England. Skills for Health. Frailty: A framework of core capabilities. [cited 21.11.2020]. Available from https://www.skillsforhealth.org.uk/services/item/607-frailty-core-capabilities-framework

Rockwood Clinical Frailty Scale. [cited 18.11.2020]. Available from https://www.bgs.org.uk/sites/default/files/content/attachment/2018-07-05/rockwood_cfs.pdf

Handout 1

UCLPartners
Academic Health Science Partnership

Handout for Activity 1: Gradual and sudden deterioration

Directions:
Below is a list of changes that may affect a resident **with dementia**.

Mark **S** if a change is sudden deterioration. Mark **G** if a change is gradual deterioration.

Remember:
✓ **Gradual deterioration** happens over a long time.
✓ **Sudden deterioration** happens quickly; over a short period of time ✓ The key thing to ask yourself: **Is this a change from usual behaviour?**

A fall
Abrupt increase in confusion or agitation

Agitation
Changes in breathing – more breathless, coughing

Choking
Difficulty walking
Distressed/anxious (not usual behaviour)
Eating less
Fever
Forgets to eat, may need prompting

Gurgling/rattling noises
Incontinence
Increased confusion over time
Increased pain
Increasing difficulty with communication

Loss of appetite over a few days
Mood swings
Nausea and/or vomiting
Needs more help with activities of daily living

Recent weakness
Recently less engaged/more withdrawn

Restless
Skin breakdown
Swallowing difficulties
Unexpected behaviour changes

Unexpectedly sleeping more
Walks with purpose, getting lost in own environment

Withdrawing more

Handout 2

UCLPartners
Academic Health Science Partnership

Handout for Activity 2: Mapping changes in a resident's condition chart ● CASE EXAMPLE

Charlotte Leaf is a 91-year-old mother and grandmother. Her husband died about two years ago and she was living on her own before coming to the care home. She used to teach primary school years ago and sometimes talks about the children she taught. She enjoys talking with others, but can get overwhelmed easily when there is a lot happening in a room.

January: Charlotte enters the care home. She is very forgetful and often confused. She is pretty thin and frail but can walk. Charlotte had a recent hospitalisation due to a fall, and her family were worried to leave her at home alone so they moved her into the care home.

February: Charlotte is still adjusting to the care home. She is still very confused and frail, but she has put on a little bit of weight. She can walk but needs assistance and is a high risk for falls.

March: Charlotte is engaging more with activities but she needs increased support in her activities of daily living and is not walking much.

April: No major changes from previous month. Charlotte's weight has maintained but she is still frail.

May: Charlotte had an episode where she became very weak and does not want to get out of bed much. She prefers to be in bed but tolerates a chair some parts of the day. She engages in conversation, often repeating stories and questions over and over again, but seems to enjoy it. She gets tired and is taking more naps throughout the day.

June: She seemed to have improved a bit. She is staying up longer in her chair and has engaged more with others. She keeps taking naps throughout the day and continues to need lots of care with her activities of daily living.

July: Charlotte got a bad cold and then a chest infection. At first, she was in bed and sleeping most of the time, but she has been treated with oral antibiotics and improved.

August: Charlotte got another chest infection and was treated again. She is weaker than before and continues to spend most of her time in bed.

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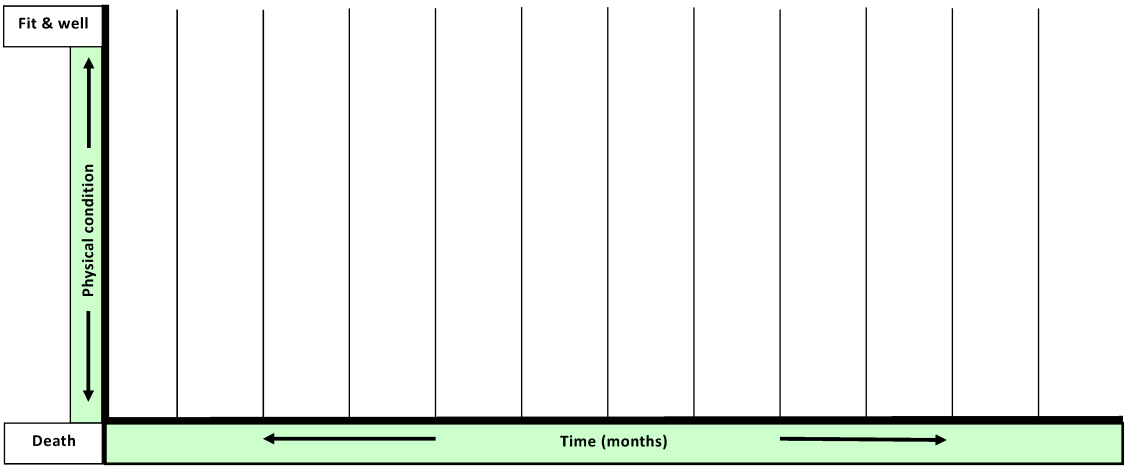
Handout for Activity 2: Mapping changes in a resident's condition chart

Monthly 'Mapping Change in Condition' chart (adapted from 'Foundations in Palliative Care': Macmillan Cancer Services, 2004)

Resident's name: _____ **Date chart commenced:** _____

Use this graph at your monthly multidisciplinary palliative care review meetings to plot change in the resident's condition.



Handout 3

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Module 1-DETERIORATION-Part 2- 'Is my resident well? 10 questions to ask'

Aims of session

1) To familiarise learners with the toolkit 'Is my resident well?' and to support its implementation
2) To consider what the soft signs of deterioration may mean
3) To help learners understand how, and to whom, to escalate the care of unwell residents

End-point of session

1) Learners understand why the signs featured in the toolkit are important
2) Learners are confident and competent in utilising the toolkit
3) Learners understand local escalation pathways
4) Learners are familiar with SBAR document for handover

Structure of session

1) Discuss booklet page-by-page. Discuss what each symptom may mean. (25 mins)
    a. *Why is breathlessness important? What conditions may cause breathlessness?*
    b. Repeat for each condition in booklet
    c. **Optional.** Is my resident well? Training videos by Hammersmith and Fulham CCG. These videos are very useful familiarisation resources. To be encouraged if the trainer is inexperienced in using 'Is my resident well?'
2) Activity 1- cases. Handout 1. (20 mins)
    a. Refer to 'Is my resident well?'
    b. Give the learners the opening line. Do not divulge the rest of the information until the carers ask.
    c. The carers then grade each sign depending on your response.
    d. *How should we help the resident?* Discuss escalation and practice using the SBAR tool. Handout 2.
    e. Local information- 'who to call when'. Handout 3.

RESOURCES:
Handout 1- 1 copy for trainer
Handout 2- 1 per participant
Handout 3- 1 per participant
'Is my resident well? 10 questions to ask.' Available from: http://anyflip.com/vxeq/qxfd
'Is my resident well? 10 Questions to ask.' Training videos by Hammersmith and Fulham CCG. Available from: https://www.youtube.com/watch?v=-TCMvXq7QTI

REFERENCES:
NWL CCG. Is my resident well? – 10 questions to ask.
Available from: http://anyflip.com/vxeq/qxfd

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‘Is my resident well? 10 Questions to ask.’ Training videos by Hammersmith and Fulham CCG. Available from: https://www.youtube.com/watch?v=-TCMvXq7QTI

SBAR tool. Originally produced by US Navy. Adapted by Dr M Leonard, Colorado, USA. Image from Doncaster and Bassetlaw NHS Hospital Trust handover policy. [Cited 17.06.2020]. Available from: https://www.dbth.nhs.uk/wp-content/uploads/2017/07/PAT-PA-31-v-3-Handover-Policy-Final.pdf

Handout 1.

1) Wilbur is one of your residents. You go in to get him up one morning and he isn't quite right.

Get residents to ask questions before divulging information.

PAIN- no signs of pain *(green)*
BOWELS- OPEN 2 DAYS AGO- TYPE 2 STOOL *(amber)*
URINE- DARK URINE- NUMBER 7 ON CHART *(amber)*
HYDRATION- DRINKING LESS, FEWER TRIPS TO TOILET *(amber)*
BREATHING- YES- BREATHING FASTER THAN USUAL BUT NOT GASPING *(amber)*
COUGHING- YES -COUGHING, LIPS BLUEISH *(red)*
SKIN- NO AREAS OF REDNESS *(green)*
MOOD- SLEEPING MORE, NOT PARTAKING IN ACTIVITIES AND STAYING IN BED *(amber)*
CONFUSION- MORE CONFUSED, RAMBLING FOR THE LAST WEEK *(amber)*

What 'colour' is Wilbur? What might be wrong with Wilbur? Who should we call? How do we format our handover?

2) 'Worried about Winnie.'

Winnie is 87. She has hasn't been herself over the last few days. You have noticed that she isn't leaving her room to do activities. She isn't eating as well as she used to. When you check her bowel chart, she hasn't had her bowels open for 2 days. She passed a type 2 stool. She is breathing normally, and no cough. *(amber for wellbeing and stool).*

What 'colour' is Winnie? What might be wrong with her? What should we do?

3) 'Worried about Wahid.'

Wahid is a bedbound patient. He needs turning regularly. When you turn him, you notice a big red mark over his lower back. The skin is broken. *(red for skin)*

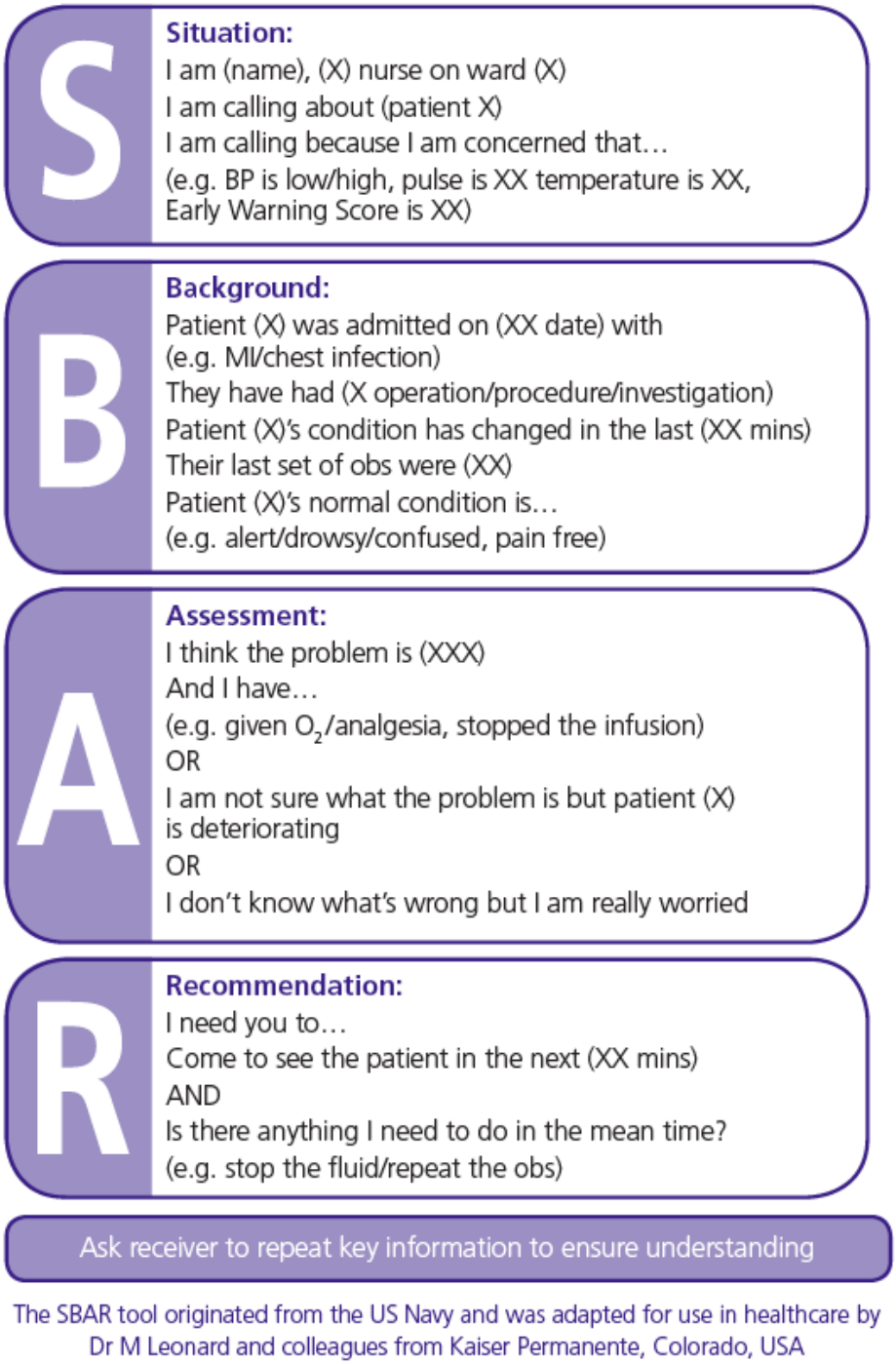
What 'colour' is Wahid? What might you do next?

4) 'Worried about Wendy.'

Wendy is 95 and is dying of breast cancer. Her breathing hasn't been quite right for several months but now it is even faster than usual. Her lips are blue and she is starting to gasp. She isn't conscious or rousable. Her records state that she is not for hospital or resuscitation. *(red for breathing and confusion)*

What 'colour' is Wendy? What would you do in this situation? *(Aim to get learners to consider that in some circumstances, escalation to hospital may not be in patient's best interests.)*

Handout 2


S
Situation:
I am (name), (X) nurse on ward (X)
I am calling about (patient X)
I am calling because I am concerned that…
(e.g. BP is low/high, pulse is XX temperature is XX, Early Warning Score is XX)
B
Background:
Patient (X) was admitted on (XX date) with (e.g. MI/chest infection)
They have had (X operation/procedure/investigation)
Patient (X)'s condition has changed in the last (XX mins)
Their last set of obs were (XX)
Patient (X)'s normal condition is…
(e.g. alert/drowsy/confused, pain free)
A
Assessment:
I think the problem is (XXX)
And I have…
(e.g. given O_2/analgesia, stopped the infusion)
OR
I am not sure what the problem is but patient (X) is deteriorating
OR
I don't know what's wrong but I am really worried
R
Recommendation:
I need you to…
Come to see the patient in the next (XX mins)
AND
Is there anything I need to do in the mean time?
(e.g. stop the fluid/repeat the obs)
Ask receiver to repeat key information to ensure understanding
The SBAR tool originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA

Handout 3 *(tailor to local services)*

Who to call when:

Usual GP- (weekdays 0800-1830)

Care Home Assessment Team- (weekdays 0900-2000)
(weekends 0800-2000)

Medicus -(evenings 1830-2000)
(weekends 0800-2000)

Rapid response-(0800-2000 every day)

111*6- (24/7)

Module 2. Advance Care Plans (ACPs) and Do Not Attempt Cardiopulmonary Resuscitation orders (DNACPRs).

Aim of lesson

1) To ensure learners understand what an advance care plan is and when we put them into place
2) To familiarise learners with different types advance care plans
3) To introduce the concept of capacity
4) To support learners in discussing 'DNACPR' with residents and relatives.

End-points of lesson

1) Learners recognise different types of advance care plans, and understand that these help guide escalation decisions
2) Learners are able to understand how assessment of capacity for decisions is conducted
3) Learners understand what resuscitation is and feel confident in discussing advantages and disadvantages with residents and families.

Structure of lesson

1) Discussion 1. Advance care plans.
    a. '*What is an advance care plan? When do we do them?*'- A plan made between residents, carers, doctors and families about what is best for the individual, and what should happen as their illness deteriorates.
    b. *What are the different types?*
        i. **Advanced care plan -**A plan made between residents, carers, **health-care professionals** and families about what is best for the individual, and what should happen as their illness deteriorates. Can be made if person lacks capacity.
        ii. **Advanced statement-** Made by the resident before losing capacity. General statement about what they want or what is important. E.g. place of care, religious beliefs
        iii. **Advanced decision to refuse treatment-** Made by resident before losing capacity. Relates to a specific treatment. Written, signed.
        iv. **Lasting power of attorney.** Can be for health or finance. Made by resident before losing capacity. Nominates someone to speak for them. Cannot 'demand' treatment. Official process- through office of public guardian.

2) Activity 1. Advance Care Plan Quiz. Handout 1. *Shout out what you think.*

3) Discussion 2. What is capacity? *How do you go about assessing capacity?*
    a. Stage one: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain? This could include dementia, learning disabilities, mental illness, brain damage etc.
    b. Stage two: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to? A person is unable to make a decision if they cannot:

i. understand information about the decision to be made
ii. retain that information in their mind
iii. use or weigh that information as part of the decision making process
iv. communicate their decision

c. Capacity case studies. Handout 2.

4) Discussion. *Resuscitation- what is it?*
   a. Case study. Handout 3.
   b. Key points to discuss with relatives. Handout 4.

RESOURCES

Handout 1- 1 FOR TRAINER
Handout 2- 1 PER PARTICIPANT
Handout 3- 1 PER PARTICIPANT
Handout 4- 1 PER PARTICIPANT

REFERENCES

What's best for Lily. UCLPartners.

The National Council for Palliative Care, The University of Nottingham and NHS National End of Life Care Programme. Planning for your future care- a guide. 2016. [Cited 25.05.2020]. Available from: https://www.nhs.uk/livewell/endoflifecare/documents/planning_your_future_care%5B1%5D.pdf

Advanced Care Planning- key points. Palliative and End of Life Care in the East of England

Advanced Care Planning- a quick guide for registered managers of care homes and home care services. NICE, SCIE.

E Byway, S Oware. East and North Hertfordshire Clinical Commissioning Group. Palliative and End of Life Care Strategy. May 2017- March 2020. [Cited 25.05.2020]. Available from: https://www.enhertsccg.nhs.uk/sites/default/files/documents/Oct2017/ENHCCG-Palliative-and-End-of-Life-StrategyFINAL.pdf

Changing our NHS together. NHS East of England. NHS East of England Integrated Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy for adults. [Cited 25.05.2020.] Available from: https://heeoe.hee.nhs.uk/sites/default/files/dnacpr_policy_-_east_of_england_1.pdf

Resuscitation Council UK. Decisions about cardiopulmonary resuscitation- model information leaflet. [Cited 25.05.2020]. Available from: https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

Carers UK. Mental capacity in England and Wales. [Cited 25.05.2020]. Available from: https://www.carersuk.org/help-and-advice/practical-support/managing-someone-s-affairs/mental-capacity-in-england-and-wales

Handout 1- quiz

- Anyone can help with advance care planning-T
- Resident may wish to discuss wishes with carers, partner or relatives- T
- Include anything that is important to resident no matter how trivial it seems- T
- Patients are obliged to carry out advance care planning -F
- You should be sensitive- if person doesn't wish to engage- do not force them- T
- Always check records- they may already have one -T
- It can never be reviewed -F
- There are different types-T
- You have to have capacity to make any advance care plan- F
- If the resident wishes to refuse a specific treatment, consider making an advance decision to refuse treatment-T

Handout 2

Capacity Case studies.

Think about whether the following people have capacity to discuss advanced care plans. Discuss in your groups. *(you don't have to cover all of these)*

1) Albert is 97. He is slow to move around and often tired. His medical history includes high blood pressure and constipation. You decide to discuss advanced care planning with him.

   (no reason to question capacity from information given)

2) Mohammed is 72. He speaks Farsi as a first language and has very little English. He had a stroke five years ago that left him paralysed down one side, so he needs help with all his personal care. He uses a wheelchair to get around. He enjoys visits from his family, where he partakes in lively debates about world events in Farsi.

   (highlight the fact that every effort should be made to address things which may affect communication. For example, employ a translator, assistance with writing/communication)

3) Mary is 85 and has dementia. She often forgets what has happened that day. She accuses staff of not washing her. She is very particular about her clothes and often berates the staff for putting her in the wrong clothes. She also complains that the staff do not feed her, and forget her medicines. In fact, her notes state that she takes all of her meals well, and is having medicines 3 times per day.

   (may not have capacity for complex decisions. Aim to highlight that capacity is decision-specific- may have capacity for less-complex decisions)

4) Jeanette has been an environmental protestor all of her life. She used to live in a communal residence, grew all of her own food and attended protests against pollution. She now lives in your care home because she was having frequent falls. She tells you that if she becomes very unwell, she would refuse all medications, as well as hospital admission, because she doesn't agree with the pharmaceutical industry's environmental policy.

   (prompt discussion around people being entitled to make decisions that we may not agree with without having capacity questioned)

5) Elvin has dementia. In the mornings he is quite good. He can manage most of his personal care. He eats his food, jokes with staff, and partakes in activities. He is

chatty and likes to tell stories of his days as a postman. He likes living at the home and often tells the staff (who he calls his 'girls') that he never wants to leave. Evenings are trickier. He tends to get a bit agitated and confused in the evenings. Sometimes he wanders around the home, thinking he is on his postal round.

(discuss that capacity can fluctuate and attempts should be made to have discussions when the person is at their best)

Now consider the same cases. Would the individuals have capacity for smaller decisions- e.g. what to wear or what to eat?

Handout 3. DNACPR case-study

Mohammed, the son of one of your residents, approaches you to discuss resuscitation. Earlier today the G.P tried to have a conversation with him regarding resuscitation. The problem is, he found the conversation a little emotional and overwhelming. He is struggling to remember exactly what was said and would like you to explain things again before he sees the G.P next week.

What will you say to Mohammed?
How will you explain resuscitation?
Can you think of some advantages and disadvantages?
Where else might you signpost him to?

Handout 4- DNACPR- leaflet for patients

https://heeoe.hee.nhs.uk/sites/default/files/dnacpr_policy_-_east_of_england_1.pdf

This leaflet explains:

- What cardiopulmonary resuscitation (CPR) is
- How decisions about CPR are made
- How you can be involved in deciding

whether you receive CPR

This is a general leaflet for patients over
16 years. It may also be useful to relatives, friends and carers of patients. This leaflet may not answer all your questions about CPR, but it should help you think about the issues and choices available.

If you have any other questions, please talk to one of the health professionals caring for you.

1. What is CPR?

Cardiopulmonary arrest means that a person's heart and breathing has stopped. When this happens it is sometimes possible to restart their heart and breathing with an emergency treatment called CPR.

CPR can include:

- repeatedly pushing down very firmly on the chest
- using electric shocks to try to restart the heart
- 'mouth-to-mouth' breathing; and
- artificially inflating the lungs through a

mask over the nose and mouth or a tube inserted into the windpipe.

2. When is CPR used?

CPR is most often used in emergency situations, for example if you have a serious injury or suffer a heart attack. However, CPR is not always automatically used; this depends on the circumstances and the doctor's estimate of how likely it is to work.

If you are already very seriously ill and nearing the end of life, there may be no benefit in trying to revive you. In this case, CPR may not be attempted.

CPR will not be used if you have said in advance that you do not wish to receive
it. The information in this leaflet has been written to help you to decide whether or not you want to make this decision. It is important to remember that your relatives, friends or carers cannot make this decision for you.

3. Does CPR always work?

The chances of CPR restarting your heart and breathing will depend on:

- why your heart and breathing have stopped
- any illness or medical problems you have (or have had in the past)
- the overall condition of your health

When CPR is attempted in a hospital it
is successful in restarting the heart and breathing in about 4 out of 10 patients. However only about 2 out of 10 patients survive long enough to leave hospital.

The figures are much lower for patients with serious underlying conditions and for those not in hospital.

It is important to remember that these figures only give a general picture and not a definite prediction of what you personally can expect. Everybody is different and
your healthcare team will explain how CPR might affect you.

4. Can CPR ever be harmful?

The techniques used to start your heart and breathing sometimes cause side effects, for example, bruising, fractured ribs and punctured lungs. Attempts at CPR do not always restart the heart and breathing despite the best efforts of all concerned. Success depends on why your heart and breathing stopped, and on your general health. It also depends on how quickly your heart and breathing can be restarted.

People who are revived are often still very unwell and need more treatment, usually in a coronary care or intensive care unit. Some patients make a full recovery; some recover but have health problems. Some people never get back the level of physical or mental health they previously enjoyed.

Some have brain damage or go into a coma. People with many medical problems are less likely to make a full recovery.

5. Can I decide in advance that I DON'T want to have CPR if my heart or breathing stops?

If you know that you do not want CPR, you can inform your doctor, who will ensure that your decision is respected. You may also find it useful to make a living will (also known as an Advance Decision) to document your wishes. If you have a living will, you should let your healthcare team know about it so they can keep a copy of it in your healthcare records. You should also let the people close to you know so they are aware of your wishes.

For more information on Advance Decisions visit:

www.adrtnhs.co.uk

6. Can I decide in advance that I DO want to have CPR if my heart or breathing stops?

If you think you would like to have CPR, then it is a good idea to discuss this with your doctor and make sure that they know your views. However, CPR will only be given if the doctor believes it is clinically appropriate. This will depend

on your current state of health and other underlying medical problems. Your doctor can explain the chances of CPR being effective in your case.

If there is a chance that CPR could restart your heart and breathing but it is likely
to leave you severely ill or disabled, your opinion about whether these chances are worth taking are very important. Your doctor will listen to your opinions and, if you choose to involve them, the opinions of your family, carers and friends.

If you disagree with your doctors opinion about whether CPR is appropriate for you, you can ask for a second opinion. You can also seek mediation or counselling or use the formal complaints procedure.

7. If I make a decision about CPR can I change my mind later?

Patients who previously wished to receive CPR

You can change your mind at any time.
If you have changed your mind, you should inform a member of staff who will ensure a doctor is contacted to discuss the decision with you. Your doctor will make sure that your most recent decision is documented in your healthcare record. If you have changed your mind since making an Advance Decision, the staff caring for you will dispose of the old documentation.

Patients who previously wished not to receive CPR

If you have changed your mind, and now DO wish to receive CPR, you should discuss this with your doctor and document it
in writing. Also, see point 5 above: a patient's decision to receive CPR will only be carried out if the health team believes it is appropriate.

8. Do I have to make a decision about whether or not I want to receive CPR in the future?

You don't have to make a decision about CPR at all if you don't want to. Alternatively, you can think about it at a later stage if you feel you are not sure at the moment. Your family, close friends, carers or those who you feel know you best might be able to help you make a decision you are comfortable with.

If you have not made any decision about CPR, the doctor in charge of your care will decide whether or not CPR should be attempted, taking account of things you have said and their own judgement.

25 NHS East of England Integrated Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) - Policy for Adults

9. What if I am unable to decide for myself?

The law allows you to appoint someone
to make decisions for you. This can be a friend, relative, or anyone whom you trust. This person will be consulted if at a later date you lose the ability to make decisions for yourself.

This person is known as your Lasting Power of Attorney (LPA). To appoint an LPA, you should speak to an Independent Mental Capacity Advocate (IMCA) or another impartial person such as a solicitor who will be able to advice you on appointing a suitable LPA.

If you have not formally appointed an
LPA, the doctor in charge of your care will make a decision about what is best for you, taking into account the views of your family and friends. If there are people you do, or do not want to be asked about your care, you should let the healthcare team know.

10. If I or my doctor decide I shouldn't have CPR, will this have an effect on other treatment?

Your doctors and nurses will continue
to give you the best possible treatment and care. Your doctor will make sure that you, the healthcare team, and friends and family involved know and understand the

decision. A decision not to receive CPR refers only to resuscitation, and you will receive all other treatment that you need.

11. Who else can I talk to about this?

If you need to talk about this with someone outside of your family, friends or carers, to help you decide what you want, you may find it helpful to contact any of the following:

- Counsellors
- Independent Advocacy Services

• Patient Advice and Liaison Service (PALS) • Patient support services
• Spiritual carers, such as a chaplain.

If you feel you have not had the chance
to have a proper discussion with your
care team, or you are not happy with the discussions you have had, you can follow the formal complaints procedure.
Please do not hesitate to keep asking questions until you understand all that you wish to know.

26 NHS East of England Integrated Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) - Policy for Adults

MODULE 3- COMMUNICATION/ DIFFICULT CONVERSATIONS

Aim of lesson

1) To explore what constitutes good communication
2) To increase learner confidence surrounding having difficult conversations
3) To support good communication with relatives

End-points of lesson

1) Learners understand the principles behind good communication
2) Learners understand what might be involved in a conversation about serious illness
3) Learners have learned some phrases that they can use to support relatives

Structure of lesson

1) Discuss the following principles of good non-verbal communication. Ask the learners *'what do you think makes good non-verbal communication?'*
   a. Positioning: carer at eye level- sit or crouch next to patient, chairs face on, no physical barriers,
   b. Body language: eye contact, nodding, leaning forwards, physical touch if appropriate, minimise interruption
2) *What makes for good verbal communication?* slow speech, pauses, minimise interruption, check understanding, open questions, reflecting back, summarising, avoid jargon, small amounts of information at one time
3) Activity 1- role play. Handout 1
4) What are we trying to achieve with a serious illness conversation? Handout 2
5) Involving everyone in conversation- What's best for Lily video if possible (**optional)**
6) Communicating with relatives- Activity 2- p38 What's best for Lily Handout 3

Resources:

Handout 1- 1 for trainer
Handout 2- 1 per participant
Handout 3- 1 per participant
What's best for Lily video clip

References:

What's best for Lily UCLPartners.

Palliative and End of Life Care in East of England.

Ariadne labs. Serious illness conversation guide- Ariadne labs. [Cited 25.05.2020]. Available from: https://www.ariadnelabs.org/wp-content/uploads/sites/2/2017/05/SI-CG-2017-04-21_FINAL.pdf

Priorities for Care of the Dying Person
Principles of Good Communication- National End of Life Care Programme

Handout 1. Role play

1) Option 1- One person will role play the carer. The rest of the group will assist this individual. The carer is to talk to Ada. If you get stuck, at any time you may call 'Time Out.' The rest of the group must then offer suggestions to move the conversation forward.

2) Option 2- the trainer is the carer. A volunteer from the group plays Ada. They must be briefed before-hand. The trainer role plays two examples of communication. In one, they employ the principles of good communication. In the other, they do not. The group discusses the difference between the two performances.

Ada is 87. She is a much-loved resident in your home. She has mild dementia, occasionally gets a bit confused but is able to participate in activities in the home. She talks to everybody, likes to help do the teas and coffees, and often bosses around her carers.
Last week, the G.P and manager had a meeting with Ada. The cancer in her breast has come back, and has now spread to her brain. It is no longer curable, and it is expected that she will die of it within weeks to months.

You go into see Ada and she is in her room crying. When you ask her what is wrong, she says 'It's all this business with this cancer.'

What do you say next?

Handout 2

Discussion- principles of good communication in relation to difficult conversations.
What are we trying to achieve?

Understanding- what does patient understand about what is happening?
Preferences- how much would s/he like to know?
Goals- if your health situation worsens, what's important to you?
Fears- what are your biggest fears and worries?
Function- what abilities are so critical that you cannot imagine your life without them?
Trade-offs- if you were to become sicker, what are you prepared to go through to get more time?
Family- how much does your family know? How much do you want them to know?

Handout 3

Handout for Activity 3: Supporting a family member

Ms Jenny has been a resident for about 9 months. Her family live out of the area and do not come in very often. Recently Ms Jenny became ill and has not eaten much lately. She is receiving oral antibiotics for her chest, but mostly she just sleeps. Everyone in the care home thinks she is dying. Her daughter has come a few times this week, anxious and sometimes demanding. The daughter has just walked in and wants to talk. What can you say?

Draw an X through the quotes that are not helpful or are inappropriate to say.

Module 4- Care of Dying patient

Aim of lesson

1) To consider how we might know that a resident is dying
2) To increase learner confidence in caring for the dying
3) To discuss things that should be put in place for the dying residents
4) To raise awareness of carer grief reactions and reinforce importance of self-care

End-point of lesson

1) Learners are aware of symptoms that may signify end-of-life
2) Learners are more confident in caring for the dying, and are aware of what should be in place for the dying
3) Learners are exposed to tools to help them debrief after a death

Structure of lesion

1) Discussion 1- *How might we recognise that someone is dying?* Handout 1
2) Activity 1. *How might we know that someone is in pain?*
    a. Pain scales and utilising them- Abbey Pain scales. Handout 2.
    b. Ask carers to read each section aloud.
3) Activity 2. *What do you think makes a good death? What is it like to be dying?* Handout 3.
4) Activity 3. *How to care for someone who is dying.* Handout 4.
5) Activity 4. *What paperwork should we put in place if we suspect that someone is dying?*
    a. Brainstorm what might we put in place
        i. ACPS/DNARs/wishes/anticipatory meds
    b. Handout 5.
6) After death care
    a. Practical matters- Handout 6
    b. Activity 5. Taking care of you. *Brainstorm ways that you can look after yourself when you are grieving for a resident.*
    c. Activity 6. Death debrief. Handout 7.
        i. *Think of a resident who you looked after who died. This can either be a recent death, or one that happened a while ago. What went well about the death? What didn't go so well? What might you do differently in the future?*

Resources:

Handout 1- 1 for the trainer
Handout 2- 1 per participant
Handout 3- 1 for the trainer
Handout 4- 1 per participant
Handout 5- 1 per participant
Handout 6- 1 per participant.
Handout 7- 1 per participant.

References:

What's best for Lily? UCLPartners.

Bereavement advice centre. What to do when someone dies at home or in a care home. [Cited 25.05.2020]. Available from: https://www.bereavementadvice.org/topics/what-to-do-when-someone-dies/at-home-or-in-a-care-home/-

Dying Matters. Hospice UK. What to expect. [Cited 25.05.2020]. Available from: https://www.hospiceuk.org/what-we-offer/clinical-and-care-support/what-to-expect

Practical things to do after a death. Cancer Research UK. [Cited 25.05.2020]. Available from: https://www.cancerresearchuk.org/about-cancer/coping/dying-with-cancer/after-someone-dies/practical-things-to-do

An expected death at home. St Nicholas Hospice Care. [Cited 25.05.2020]. Available from: https://stnicholashospice.org.uk/support-and-information/getting-help/preparing-for-end-of-life/an-expected-death-at-home/

Providing care after death. Marie Curie. [Cited 25.05.2020]. Available from: https://www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone/final-days/care-after-death

Care of dying adults in the last days of life. NICE guideline 31. March 2015. [Cited 25.05.2020]. Available from: https://www.nice.org.uk/guidance/ng31/chapter/Implementation-getting-started

W Freeman. ABC Care Homes Education. Isabel Hospice. [cited 17.06.2020]. Available from: https://www.isabelhospice.org.uk/education-training/care-homes

Handout 1

What is dying?

- End of life
- Time-frame varies
- Usually days- weeks

How might we recognise that someone is dying?

There are a number of signs which may indicate that a person is dying, ranging from a loss of appetite, changes in breathing, restlessness or agitation, or drowsiness.

1) The person's appetite is likely to be very reduced.

   Eventually, the person will stop eating and drinking, and will not be able to swallow tablets.

- What can we do to help?
  - offer sips, provided they can still swallow.
  - offering a drink through a straw (or from a teaspoon or syringe)
  - moistening the mouth gauze wrapped around finger
  - placing ice chips in the mouth
  - applying lip balm.

2) The person's breathing may change

As a person's body becomes less active in the final stages of life, they need less oxygen, and their breathing may become shallower. There may be long pauses between their breaths.

Sometimes the person's breathing may also make a noise, commonly known as the "death rattle". This is likely to be because they are not able to re-absorb or swallow the normal fluids in their chest or throat, which can cause a rattling sound.

In the very last moments of life, the person's breathing pattern may change. Breaths may become much slower and quieter before they stop altogether.

- What can we do to help?
  - If the person is anxious, sitting with them so that they know you are there may help to reduce their anxiety.
  - A small fan and an open window can help
  - Change the person's position so that they are on their side if they are not too disturbed by being moved.

- The doctor or nurse may also suggest medication which may help to reduce the fluids in their chest or throat. This is not always needed, and it does not always make a difference.

3) The person may become much sleepier

The person is likely to spend more time sleeping, and will often be drowsy even when they are awake.

They may also drift in and out of consciousness. Some people become completely unconscious for a period of time before they die - this could be short, or as long as several days.

- Is there anything I can do to help?
  - Carry on speaking quietly and calmly to them.
  - Holding their hand
  - Reading to them
  - Playing their favourite music.

4) The person may become more restless or agitated

This may happen in the last few days of life, though the person may become more peaceful again before they die. Sometimes they may appear confused and may not recognise familiar faces. They may hallucinate, and see or hear people or things that are not actually there - for instance, they may see pets or people who have died. Agitation could also be caused by physical problems, like constipation or difficulty passing urine - ask the doctor or nurse caring for the person if you are concerned about this.

- Is there anything I can do to help?

Simply sitting with the person may often help to calm them down. Keeping things as normal as possible may help comfort the person. You can also talk to the doctor or nurse, as they can check if there is any treatable reason for this or may be able to offer medication to help settle the person's anxiety.

- You can help by:
  - Making sure that the person isn’t in pain
  - Making sure that they are not constipated
  - speaking clearly to the person;
  - telling/reminding them who you are (and being prepared to do so repeatedly);
  - keeping their surroundings calm with minimal changes in noise level;
  - trying not to correct them if they say something wrong, or insist on them getting things accurate, as this may be upsetting for you and for them.

5) The person's skin may feel cold and change colour

The person's hands, feet, ears and nose may feel cold to the touch (this is due to a reduced circulation). Occasionally, a person's hands or other body parts may swell a little.

Their skin may also become mottled and blue, or patchy and uneven in colour.

- Is there anything I can do to help?
    - Gentle massage may help - the nurses may show you how.
    - Keep the person at a comfortable temperature

6) The person may lose control of their bladder or bowels

This happens because the muscles in these areas relax and don't work as they did. The person may also have fewer bowel movements as they eat less, and their urine may get darker as they drink less.

- Is there anything I can do to help?:
    - Keep the person clean and comfortable
    - protect the bed.
    - Pads
    - Offer fluids but don’t force
    - Give laxatives if constipated and uncomfortable
    - You can also ask the nurse or doctor for equipment that may be able to help e.g. catheter (a long thin tube that can be put into a person's bladder to drain urine).

7) The person's eyes are closed

It is important to know that in these final stages, the person may close their eyes often. At some point, they may not open them again. Their eyes may often be half-open, which can be distressing to see.

- Is there anything I can do to help?
    - As they may still be able to hear you, take the opportunity to say the things that are important to you both.
    - Do not force their eyes open or closed
    - If the eyes become gungy, warm bathing may help

Handout 2

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Handout for Activity 5: Recognising pain

Addressograph

Abbey Pain Scale
For measurement of pain in patients who cannot verbalise.

Name and designation of person completing the scale: .....

Date: .....Time: .....

How to use scale: While observing the patient, score questions 1 to 6

Q1. Vocalisation Q1
eg. whimpering, groaning, crying
Absent 0 Mild 1 Moderate 2 Severe 3

Q2. Facial expression Q2
eg: looking tense, frowning grimacing, looking frightened
Absent 0 Mild 1 Moderate 2 Severe 3

Q3. Change in body language Q3
eg: fidgeting, rocking, guarding part of body, withdrawn
Absent 0 Mild 1 Moderate 2 Severe 3

Q4. Behavioural Change Q4
eg: increased confusion, refusing to eat, alteration in usual patterns
Absent 0 Mild 1 Moderate 2 Severe 3

Q5. Physiological change Q5
eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
Absent 0 Mild 1 Moderate 2 Severe 3

Q6. Physical changes Q6
eg: skin tears, pressure areas, arthritis, contractures, previous injuries.
Absent 0 Mild 1 Moderate 2 Severe 3

Add scores for 1 - 6 and record here → Total Pain Score

Now tick the box that matches the Total Pain Score →

0 - 2 No pain	3 - 7 Mild	8 - 13 Moderate	14 + Severe

Finally, tick the box which matches the type of pain →

Chronic	Acute	Acute on Chronic

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1996 - 2002
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Handout 3

What's it like to be dying?

Ask everyone to close their eyes, then read out the following paragraph slowly to the learners.

Pretend for a moment that you are the resident in this bed. Sometimes you are somewhat awake, but your eyes are so heavy and it takes too much energy to speak or move. There are times when you don't know what time of day it is or even quite where you are. Your lips and mouth feel extremely dry and you wish you had enough energy to take in some water and curl up on your favourite side. You know you are extremely unwell and may be dying. You can hear people come and go. You can hear when others speak, often talking about you as if you are not there. You don't recognise many of the voices. You feel hands on you at times, some gentle and reassuring but others rough, making you feel scared and worried. That's when you feel the most vulnerable.

Ask everyone to open their eyes. As the group the following questions to generate discussion.

What would be important to you at this time?
If you could speak to those caring for you, what would you tell them?
What would good care look like to you?

Handout 4

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Handout for Activity 7: Care in the last hours to days of life

Directions: Imagine you are caring for a resident who is **unresponsive** and in the last hours of life. Decide which tasks and activities you should and should not do. Put an 'X' through activities that you think should not be done.

Ask resident if she has pain

Ask the loved ones if there is anything you can do for them

Avoid the resident's room

Call the ambulance

Check on resident and their loved ones at least every 1-2 hours

Check pressure areas (ankles, hips, ears, elbows) every 2-4 hours

Clean mouth with a damp gauze wrapped around a gloved finger

Create a calming feel in the room

Don't ask the loved one if the resident looks comfortable

Focus on resident's comfort

Help feed resident lunch

Let all staff know the resident is dying

Listen for moaning or groaning

Look at facial expressions of frowning or grimacing

Make sure resident has clean and dry skin

Measure blood pressure every 4 hours

Moisten mouth regularly

No need to provide care if the resident is dying

Offer the loved one a cup a tea

Play soft music

Provide mouth care every 1-2 hours

Put cream on pressure areas

Remember the resident can hear you, even if unconscious

Reposition resident to maintain comfort

Show loved one how to provide care such brushing hair, mouth care, holding hands, talking to resident

Sit resident up

Spray disinfectant spray over the resident to help reduce odour

Tell resident what you are doing before you do it

Turn every 4 hours

Use a pink sponge to clean out resident's mouth

Use a warm flannel to wipe face

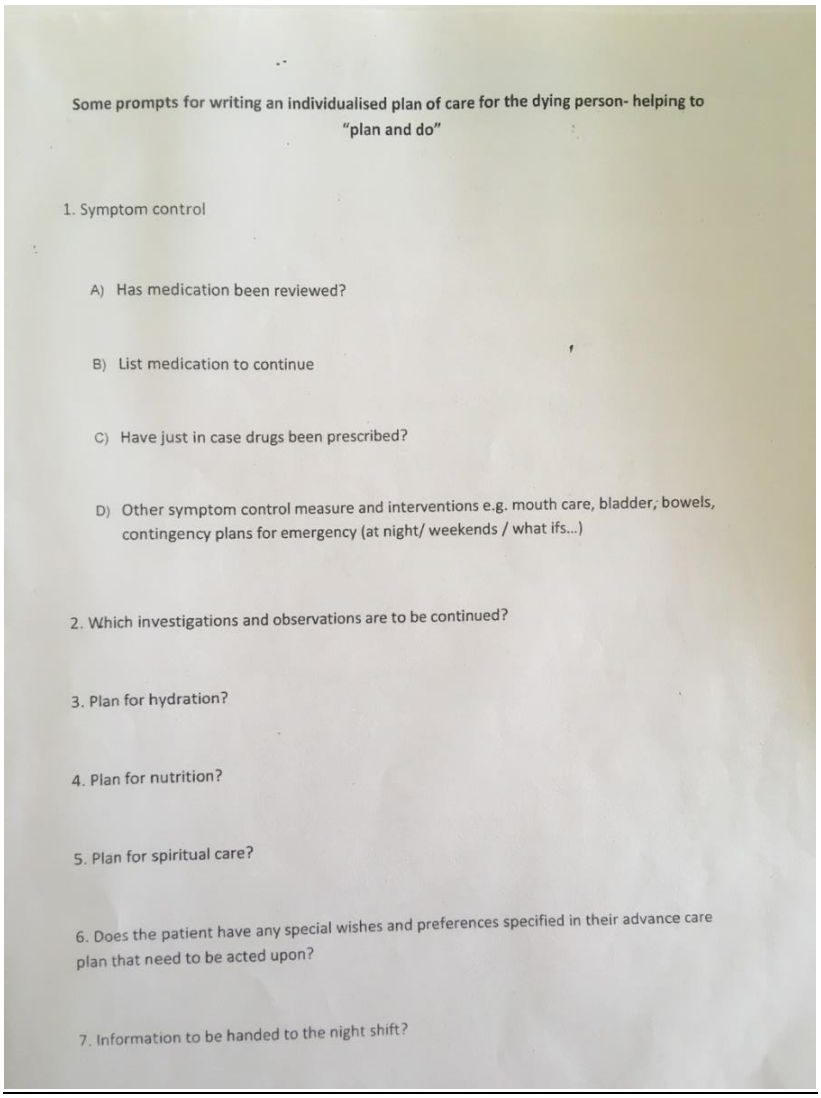
Use a wet cloth to clean out resident's mouth

Use hard toothbrush to clean teeth

Use lip balm to keep lips moist

Watch for incontinence of both bladder and bowels

Handout 5



Some prompts for writing an individualised plan of care for the dying person- helping to "plan and do"

1. Symptom control

   A) Has medication been reviewed?

   B) List medication to continue

   C) Have just in case drugs been prescribed?

   D) Other symptom control measure and interventions e.g. mouth care, bladder, bowels, contingency plans for emergency (at night/ weekends / what ifs...)

2. Which investigations and observations are to be continued?

3. Plan for hydration?

4. Plan for nutrition?

5. Plan for spiritual care?

6. Does the patient have any special wishes and preferences specified in their advance care plan that need to be acted upon?

7. Information to be handed to the night shift?

Handout 6

Practical matters

- Remain calm, the person is at peace and no longer feeling the effects of illness.
- When an expected death occurs at home there is no immediate rush to have the deceased person taken to the undertakers.
- The deceased person's death has to be verified either by the community nurse or a doctor before the deceased can be taken to the undertakers. Try to glance at a clock to make a note of the time, so you are able to inform the doctor or community nurse who visits to verify the death.
- The deceased person may be known to the community nurses and to St Nicholas Hospice Care. You may wish to contact either of these for further support and guidance at this time.
- **If the expected death has occurred during the hours of 9am–6pm, Monday – Friday**
    i. You will need to contact your GP surgery and explain to the receptionist as clearly as you can what has happened. They will pass this information to a GP or healthcare professional who will arrange to visit as soon as possible to verify the death.
- **Outside of surgery hours**
    ii. You will need to contact your GP or 111 to get the emergency contact number. Explain to the call handler that an expected death has occurred and that the deceased was a palliative care patient. The call handler will then ask a series of questions, i.e. the person's name, date of birth, address and contact telephone number so that they can call you back.
    iii. When the healthcare professional contacts you they will give you an estimated time of visit: do not be alarmed if they cannot come immediately as it may take a number of hours.
    iv. Whilst you are waiting for the healthcare professional to arrive, you may want to telephone family or friends to come and wait with you. You may also choose this time to be alone with the deceased.

Handout 7

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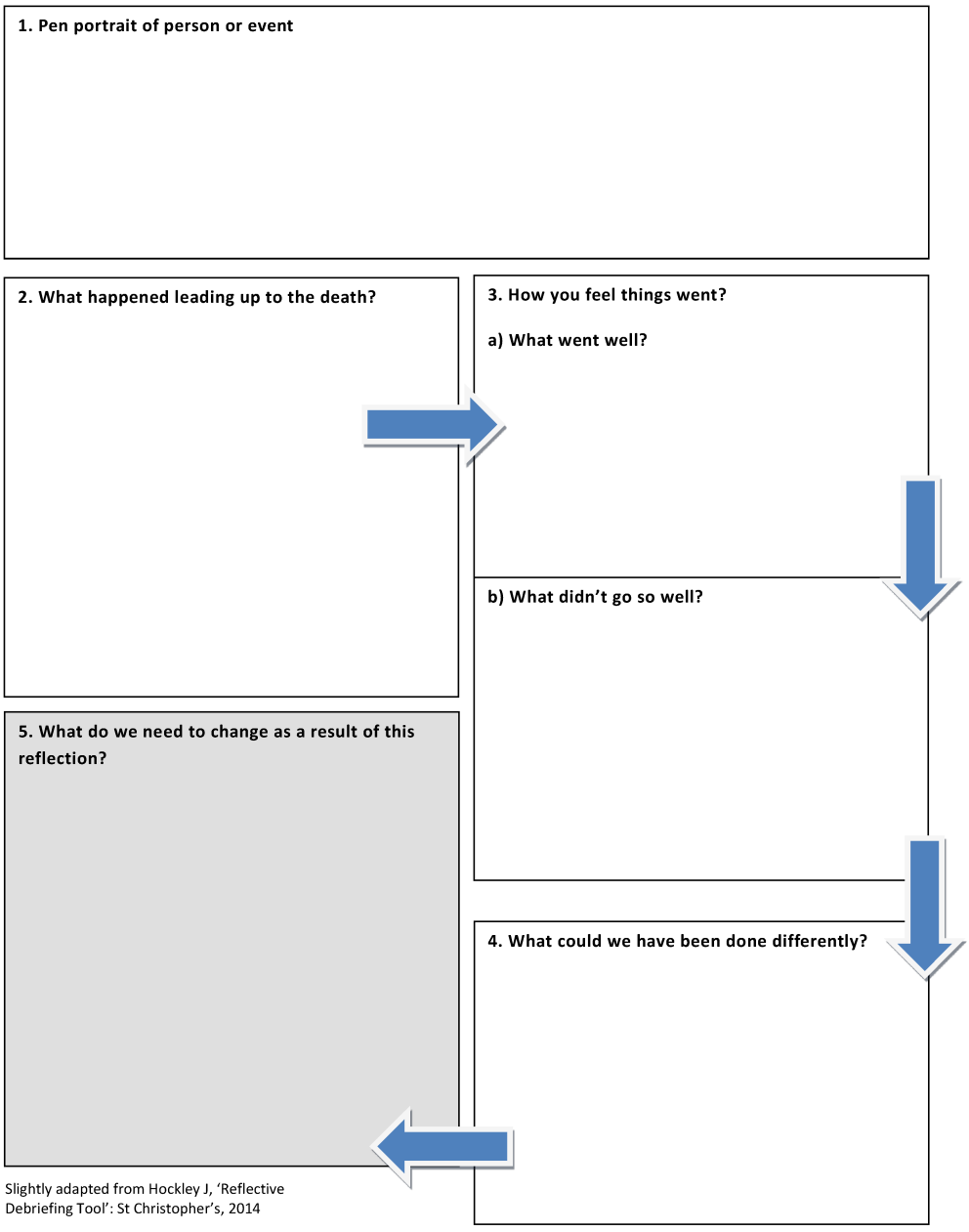
Handout for Activity 8: Reflective debrief after a death



Slightly adapted from Hockley J, 'Reflective Debriefing Tool': St Christopher's, 2014

Module 5- Urinary Tract Infection (UTI)

Aim of lesson

1) To think about prevalence of UTIs
2) To assist learners in understanding the signs and symptoms associated with a UTI
3) To consider simple ways to help prevent a UTI
4) To understand how a catheter may put someone at risk of a UTI

End-point of lesson

1) To understand prevalence and also be aware of asymptomatic bacteria
2) To recognise signs and symptoms of a UTI
3) To recognise when someone is very unwell
4) To understand risk factors and simple UTI prevention measures
5) To understand basic catheter care

Structure of the lesson.

- Discussion 1. *What is a UTI? Why do UTIs matter? How common are they?*
  - 23% all hospital infections nationally (SIGN guidelines)
  - 13.7% antibiotic prescriptions
  - Death figure
  - BUT 25% (NICE/SIGN) patients have bacteria in the urine without causing any symptoms

- Activity 1. Risk factors for UTIs. *Think of a resident in your care who developed UTI. Was there anything about them that put them at increased risk?*
  - *Consider:*
    Catheters, immobility, constipation, poor oral intake, DM, chemo/immunosuppressants, HIV, enlarged prostate, neuropathic bladder, frailty, stones, cancer

- Activity 2. Addressing risk factors. *Brainstorm in your groups how you may reduce the chance of someone getting a UTI-think of simple measures you can put into place.*
  - *Consider:*
    Fluids, bowels, catheter care, diet.
  - Discuss hydration chart in 'Is my resident well?' p8

- Activity 3. Signs and symptoms of UTI. *What might you notice if a resident has a UTI?*
  - Fever, loin pain, confusion, urgency, frequency, dysuria, blood in urine, abdominal pain, vomiting. Low BP, high pulse, febrile- consider upper urinary tract infection

- Activity 4. Using 'Is my resident well?' – *what might alert us to a resident who is very sick?*
  - *Consider:*
    Fast breathing, confusion, reduced urine output, dark urine, severe pain, sudden confusion, hallucinating, agitated, drowsy

- Activity 5. Using 'Is my resident well', work through the case study. Handout 1.
- Activity 6. Quiz. *To dip or not to dip.* Handout 2.

- Activity 7. Handout 3. *Talk through flow chart of management of patient with suspected UTI.*
- Activity 8. Handout 4. Catheter care. *Brainstorm problems and solutions.*

Resources:

Handout 1- 1 for the trainer
Handout 2- 1 for the trainer
Handout 3- 1 per participant
Handout 4- 1 for the trainer

References:

Urinary tract infections in adults. NICE guideline QS90. March 2015. [Cited 25.05.2020]. Available from: https://www.nice.org.uk/guidance/qs90/resources/urinary-tract-infections-in-adults-pdf-2098962322117

Management of suspected bacterial urinary tract infection in adults. SIGN guideline 88. 2012. [Cited 25.05.2020]. Available from: https://www.sign.ac.uk/sign-88-management-of-suspected-bacterial-urinary-tract-infection-in-adults

Catheter care. Bladder and bowel foundation. [Cited 25.05.2020]. https://www.bladderandbowel.org/bladder/catheter/

Urinary tract infection. NHS website. [Cited 25.05.2020]. https://www.nhs.uk/conditions/urinary-tract-infections-utis/

Gharbi, M et al. Antibiotic management of urinary tract infection in elderly patients in primary care and its association with bloodstream infections and all-cause mortality: population based cohort study**.** *BMJ* 2019; 364 doi. 27 February 2019. [Cited 25.05.2020]. Available from: https://doi.org/10.1136/bmj.l525

Beech, E. NHS Bath and North East Somerset CCG. To Dip or Not To Dip – a patient centred approach to improve the management of UTIs in the Care Home environment . February 2016. [Cited 25.05.2020]. Available from: http://test.bathandnortheastsomersetccg.nhs.uk/assets/uploads/2016/04/To-Dip-or-Not-to-Dip.pdf

Public Health England. PHE quick reference guide. Diagnosing urinary tract infections. 2018. [Cited 25.05.2020]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/708100/Draft_UTI_diagnostic_flowchart_review_for_consultation_17_May_2018.pdf

Handout 1

Wilma is 83. She has is slightly confused but usually can hold a conversation. She is mobile but quite unsteady on her feet. She uses a frame to walk. However, today, you are a bit worried about her. Use 'Is my resident well, 10 questions' to assess her. Ask questions about the symptom on each page and tell me whether she is red, amber or green.

a) Breathing- fine (green)
b) Coughing – no (green)
c) Bowels- type 2, yesterday (amber)
d) Hydration- fewer toilet trips. Seems a bit more confused- couldn't remember how to get dressed. (amber)
e) Urine colour- 7 on chart (amber)
f) Pain- nil (green)
g) Confusion- a bit more confused over 2 days (amber)
h) Well-being- not going into day room, didn't eat lunch (amber)
i) Skin-fine (green)

What will you do to help Wilma?

Handout 2

UTI dipstick quiz- T or F

- Urine dipsticks are the best way to diagnose a urine infection. F
- Urine dipsticks are always accurate. F
- Urine dipsticks should be undertaken routinely on every resident in the care-home. F
- Most catheterized patients will have some bacteria in their urine. T
- Clinical signs are more important than urine dipstick in diagnosing a UTI. T

Handout 3

Worried about a resident?

Features of other infection?

-cough, diarrhoea, red skin.

UTI UNLIKELY

Do they have any features of UTI?

- Fever, chills, loin pain, confusion (catheter)
- Urgency, dysuria, frequency, abdominal pain, blood (no catheter)
- New incontinence
- UTI LIKELY
- Do they have features of serious illness?
- High pulse, low BP, fever, drowsy/confused- urgent review

Armstrong SF, *et al. BMJ Open Qual* 2021; 10:e001153. doi: 10.1136/bmjoq-2020-001153

Handout 4

- My name is Doris. I am a relative of one of your residents, Derek. I wish to take my husband Derek on holiday for two weeks. He has a urinary catheter in situ (suprapubic, indwelling)

- Group 1- please advise Doris about how to care for this catheter.

    - Wash skin where catheter enters body twice per day with warm, soapy water
    - Wash hands with soap and water before touching catheter equipment
    - Wear gloves
    - Stay well-hydrated
    - Avoid constipation
    - Change bag or valve each week
    - Change catheter every 3 months – what documentation does home have?
    - Make sure the bag is below the level of the bladder!

- Group 2- please devise a list of problems Doris might face with Derek's catheter and advise solutions.

    Problems: Blocked catheter, bypassing catheter, leaking catheter, blood in catheter, discomfort.

    Solutions: reposition bag, empty bag, flush, consider UTI (call dr), change.

Module 6- Falls.

Falls module 9

Aims of lesson

1) To understand why falls are important
2) To explore factors that may contribute to a resident falling

End-point of lesson

- Learners are able to recognise risk factors for falls
- Learners are able to conduct a falls risk assessment
- Learners are able to conduct a post-fall debrief
- Learners are able to assess someone after they have fallen

Structure of lesson

- Activity 1. Quiz. Handout 1.
- Activity 2. Risk factors for falls. *Think of a resident that you knew well. In your groups, think of things about that person (risk factors) that put them at risk of falls*. Work through this activity then have a discussion with everyone in the room. Handout 2.
- Activity 3. *In your group, can you brainstorm ways to minimise ways that you might reduce someone's risk of falling?* Handout 2.
- Activity 4. Falls prevention. Is there a falls risk assessment tool in your home? Are you familiar with it? Is there a falls monitor? Discuss either the home's falls risk assessment or use Barnet/Chase farm. Handout 3.
- Activity 5. Safe transfer from a chair. Handout 4.
- Activity 6. Post- fall analysis activity. *What information is useful to collect when a resident has a fall?* Handout 5.
- Activity 7. *Assessment of a resident immediately after they fall*. Handout 6.
- Activity 8. Case study using 'Is my resident well?'. Handout 7.

Resources:

Handout 1- 1 for trainer
Handout 2- 1 for trainer
Handout 3- 1 per participant
Handout 4-1 for trainer
Handout 5-1 for trainer
Handout 6- 1 per participant
Handout 7- 1 for trainer

References:

World Health Organisation. Falls. January 2018. [Cited 25.05.20]. Available from: https://www.who.int/news-room/fact-sheets/detail/falls

Care Inspectorate and NHS Scotland. Managing Falls and Fractures in Care Homes for Older People – good practice resource. [Cited 25.05.2020]. Available from: Falls-and-fractures-new-resource-low-res.pdf

The Royal Free, Barnet and Chase Farm Hospital NHS trust. Falls Leaflet Information for Patients and Carers.

Domun N, Stork A. Medicus Health Partners. Falls policy 2019.

The Royal Free, Barnet and Chase Farm Hospital NHS trust. Therapy Falls Assessment Tool- Barnet and Chase Farm sites.

Hospice UK. Falls toolkit. [Cited 25.05.2020]. Available from: https://www.hospiceuk.org/what-we-offer/clinical-and-care-support/clinical-resources

NICE. Falls in older people. Nice guideline QS 86. [Cited 25.05.2020]. Available from: https://www.nice.org.uk/guidance/qs86/resources/falls-in-older-people-pdf-2098911933637

'Is my resident well- 10 questions to ask.' NWL CCG.

Bedfordshire Clinical Commissioning Group. A guide to safe transfers on and off chairs and beds. [Cited 17.06.2020]. Available from:www.bedfordshireccg.nhs.uk > page > downloadFile.

Handout 1

Falls quiz.

1) Definition of the word fall

'an unexpected event in which the participant comes to rest on the ground, floor, or lower level'

2) How many people over 65 experience one or more falls each year?

    a. one third of people over 65 experience one or more falls.

3) How many people over 80 living in the community experience a fall each year?

    a. Almost half

4) How much higher is the falls rate among care home residents (than non)?
    a. X 3

5) True or false. Injury caused by falls is the leading cause of accidental death for people over 75.

    a. True

6) True or false. A fall is a symptom not a diagnosis.

    a. True

7) What percentage of care home residents who fall suffer serious injury?

    a. 25% of older people who fall in care homes suffer serious injuries.

8) What percentage of care home hospital admissions are because of a fall?

    a. 40% of hospital admissions from care homes follow a fall.

9) List as many as possible physical consequences of a fall:

    a. Dehydration, pressure sore, infection, hypothermia, fracture, dislocation, renal failure, pneumonia, incontinence, disability, death, loss of muscle mass, immobility, head injury, soft tissue injury, urine infection, worsening nutrition

10) List as many possible psychological /emotional consequences of a fall:

    a. Loss of confidence, increased dependency, fear of falling, withdrawal, social isolation, loss of self-esteem, uselessness, anxiety and depression, loss of control, embarrassment, carer stress

11) True or False. A care home resident is most at risk of falling after they have been in the care home for a few months.
    a. False. High risk times- when new, after illness, after previous fall, upon readmission to home following hospital, upon change in meds, intercurrent illness

12) A fall and a collapse are the same thing.
    a. False. A fall can be from a simple trip. A collapse means that there was a brief blackout and there is more likely to be an underlying medical reason.

Handout 2

- Think of a resident that you knew well. In your groups, think of things about that person (risk factors) that put them at risk of falls, and why.

Encourage the group to consider:

1) Frailty
2) Poor mobility
3) Altered gait- due to OA, stroke, Parkinson's
4) Reduced muscle mass
5) Numb feet
6) Dementia
7) Poor eyesight
8) Poor hearing
9) Intercurrent illness
10) Medical problems-esp.
    a. Dementia
    b. Parkinson's
    c. Infection
    d. Constipation
    e. Depression
    f. Chronic disease
    g. Arthritis
    h. Blood pressure
    i. Thin bones
    j. Diabetes
    k. Neuropathy
    l. Poor foot care
    m. Stroke/paralysis
11) Medicines
    a. list
12) Poorly-fitting clothes/shoes
13) Delirium
14) Newly joined care-home- unfamiliar environment
15) Poor nutrition
16) Poor hydration
17) Poor footcare
18) Alcohol
19) Fear of falling
20) Poorly-controlled BP- discuss postural hypotension

- What simple measures can you do to reduce falls risk in all patients?

1) Individualised falls risk assessment asap
2) Encourage good intake- food and fluids
3) Encourage regular medication reviews
4) Encourage safe transfers- push up, get up slowly

5) Encourage regular exercise e.g. falls prevention programme
6) Reg eye checks, clean glasses, glasses not lost
7) Hearing aid checks and batteries
8) Walking aid- correct one (? Decorate), within reach, in good state of repair
9) Identify intercurrent illness early-infection, constipation
10) Regular foot checks
11) Environment- good lighting, signs, appropriate toilet seats, grab rails, no clutter
12) Assistance with toileting
13) Post -falls analysis
14) Refer to physio/ OT for fall prevention
15) Treat pain early
16) Identify patients misusing alcohol
17) Check there is a call bell to hand, the resident can use it and the importance of getting assistance
18) Check their chair is suitable
19) Safe walking is discussed
20) Their bed is the right height
21) Their regularly used items are within easy reach
22) Their footwear and clothing fits well
23) They are not left unaided on commodes, toilets, in baths or showers if they have a cognitive impairment or poor mobility and you know that they tend not to ask for assistance

- Who can we refer to for help?

1) Medical team- esp. if recurrent or there was a collapse
2) Falls team
3) Falls prevention programme/OT/physio
4) Optician/audiologist
5) Dietician
6) Alcohol team
7) Lifeline/careline recurrent falls
8) Podiatrist

Handout 3

Falls risk assessment tool.

Barnet and Chase Farm Hospital.

Risk Factor	Yes	No	Subjective/Objective Assessments	Ac
1. History of Falls Has the patient had 1 or more falls in the last year?	☐	☐	**If fall caused by blackout → Automatic referral to falls clinic (unless already under investigation)** No…….. in 1 month No……in 12 months Type: LOC / Dizziness / Pain / Weakness / Loss of Balance / Other ……	Fa Inf
2. Confidence Does the patient have a fear of falling?	☐	☐	1 ----------10 No Fear Extreme Fear	Lif Co
3. Coping Strategies Does the patient have difficulty/unable to get up or get help after a fall?	☐	☐	Pendant Alarm ……. Telecare …… Family/Carer support ……	Fa Co Lif Te
4. Cognition Does the patient have any cognitive impairment?	☐	☐	Cognitive Screen: Intact ☐ Impaired ☐	Fu So
5. Alcohol Intake	☐	☐	Alcohol intake: ……units per …….	Alc
6. Nutrition Observed self-reported loss of weight or low fluid intake? Any difficulties with eating?	☐ ☐	☐ ☐	> or < than ½ Stone in 6 months (unintentional) …… No. of glasses of H2O per day: …….	Lia SA Ad
7. Footwear/ Foot Care Is there any pain, foot condition or foot wear that may be affecting mobility?	☐	☐	Sensation: intact ☐ impaired ☐ Nails: Last cut: ……..	Lia Su Inf
8. Vision Does the patient report / have any problems with their vision?	☐	☐	Eye test in last 1 year: Y/N Glasses: Y/N Varifocals: Y/N	Ad
9. Continence Does the patient have problems with continence, frequency or urgency?	☐	☐	Day Night Urine: Continent / Incontinent Continent / Incontinent Bowels: Continent / Incontinent Continent / Incontinent Urgency ☐ Night frequency: ……	Lia Lia OT
Name:	**PT/OT TSW**		**Date:** **Time:** **Signature:**	

Patient Sticker

Roya

Therapy Falls Assessment Tool

Risk Factor	Yes	No	Subjective/Objective Assessments
10. Environmental Hazards Are there any hazards in the home environment?	☐	☐	OT home visit: Y/N Collateral Hx: Y/N • Consider Clutter/Rugs/Poor lighting etc:
Name:	**PT/OT TSW**		**Date:** **Time:** **Signature:**
11. Power / ROM Any observed / reported weakness or difficulty moving limbs?	☐	☐	Power / ROM U/L's: Restricted / Unrestricted L/L's: Restricted / Unrestricted
12. Postural Hypotension Does the patient feel dizzy on standing / sitting up?	☐	☐	Lying/sitting BP…… Standing BP…….. (Drop of systolic 20mm Hg or diastolic 10mm Hg) Teach strategies to stabilise self after changing positions before walking
13. Balance Are there any observed or reported problems with the patients balance? Is the patient unsteady or need external support?	☐	☐	TUSS: Steady / unsteady Time: …… Reach out of BOS: Steady / Unsteady Supported / Unsupported Aids Used: ……
14. Transfers	☐	☐	Sit ←→ Stand: Bed: …… Chair: ……

Is there difficulty moving between surfaces or standing up from different furniture?			Toilet: ……..
15. Gait Is the patient unsteady, or do they shuffle, stagger, take uneven steps or hold onto furniture?	☐	☐	Gait Description: TUAG: …….. <10 secs – normal Time: …… <20 secs – Mob I no aids <30 secs – Requires walking aid <40 secs – High risk of falls
Falls Leaflets given to patient with relevant areas highlighted ☐			**Comments:**
Referred for community falls follow-up: Yes ☐ No ☐			
Name: **PT/OT TSW/ADT**		**Date:**	**Time:** **Signature:**

Handout 4

Safe transfer activity.

My name is Elsbeth and I am one of your residents. I had a fall last week when I went to get out of my chair. I wasn't badly hurt- I just tumbled to the ground. But you- my carers- are worried that it could happen again. You are my main carer and have been tasked with teaching me how to transfer safely.

1) Watch what I am doing, then talk me through how to transfer more safely.
2) Ideas for safe transfer:
    a. Getting up from a chair bend forward as they start to rise from the chair, use their hands to push up from the arms of the chair and once they have their balance, they should reach for their walking aid.
    b. They should get up slowly
    c. Slide bottom all the way to the front edge of your chair.
    d. Now that you're at the edge of the chair, sit up straight.
    e. With your knees bent, pull your feet back under the front edge of your chair underneath you.
    f. Place your feet flat on the floor, shoulder width apart.
    g. If you have armrests on your chair, place your hands near the front of the armrests. If you don't have armrests, place your hands beside your thighs at the front edge of your chair or on the tops of your thighs.
    h. Lean forward from the hips, keeping the back straight. **'Nose over toes'**
    i. As you are leaning forward, press your heels into the floor as you push yourself up with your legs
    j. Get up slowly
    k. Wait for a few seconds to check not dizzy and to achieve balance
    l. Another easy tip to help you stand up from a seated position is to consider the type of chair you sit in. Switching from a soft squishy chair to a strong, firm, armchair will give you more support as you stand up
    m. Ideally your chair should have armrests
    n. If you use a walking frame, place it in front of the chair about an arm's distance away. Do not use the walking aid to pull yourself up.
    o. Shuffle your bottom to the front of the seat. Place your feet back near the base of the chair, feet slightly apart and one foot slightly in front of the other.
    p. When using a walking frame, transfer one hand from the chair to the frame first, then the other.
    q. Steady yourself before you move away

What do you think of my chair?

Seat height: Can patient's feet touch the floor?
• Seat depth: How does this compare to patient height/femur length? Can patient's feet touch the floor? What is the position of the patient's pelvis (anterior vs. posterior tilt)?
• Seat width: Is patient slumping to one side?
• Elevating legs: May be indicated medically or for comfort. May also pose a fall hazard

Handout 5

Post-fall debrief.

What information is useful to collect after someone has had a fall?

Doris is 78. She has very early dementia, but is able to hold a conversation and interact with staff.

She came to your care home 3 weeks ago after a hospital admission for pneumonia. Since being here, she has had two falls in one week. She has a bit of bruise on her forehead, but is walking normally, doesn't seem in pain, and is back to her usual self so you don't think that she is badly injured.

However, you are worried that she may hurt herself in the future if she were to fall again.

You decide to conduct a post-falls analysis.

How will you go about this?

1) When were the falls?
    a. Both occurred at approximately 4pm

2) What was Doris doing when she fell?
    a. She was walking to the toilet.

3) What does Doris remember about the fall?
    a. She remembers feeling a bit giddy and then found herself on the floor.

4) How did Doris feel just before she fell? Collapse/fall
    a. She felt giddy.

5) Did she black out?
    a. If she did, it wasn't for long.

6) What happened straight after the fall?
    a. Doris shouted for help, and the carers came to pick her up.

7) Were the falls witnessed?
    a. No

8) Does she walk with a frame or a stick?
    a. Yes but she wasn't using it
    b. Probe- because she can't find it

9) Had there been any changes to her health those days?
    a. Not that she was aware of.

10) Any changes to health over the last few weeks?
    a. Recent UTIs. Still needs to pee more than usual so getting up to the loo more.

11) Any changes to eating and drinking?
    a. Not drinking as going to the loo all the time is a nuisance.
    b. Not eating lunch as prefers main meal in evening. Very hungry by 4pm.

12) Shoes fitting
    a. Fine

13) Visual / hearing
    a. Fine generally although hard to see in that dark corridor

14) Confusion.
    a. I've got all me marbles! But I find all these white corridors a bit confusing. Hard to get to the toilet.

15) Any change to medications?
    a. No

16) Do her feet hurt when she walks?
    a. A bit

Any suggestions for a tailored falls prevention programme?

1) Dehydration
    a. Keep fluids near her
    b. Encourage
    c. Jelly
2) Provide high calorie snacks
3) Extra check at half past three
4) Check UTI gone
5) Medication review
6) Lying/standing BP
7) Replace light bulb
8) Find stick/OT assessment
9) Signpost/assistance toilet
10) Careline
11) Gait check
12) Foot check
13) Medical review to exclude other causes of blackout

Handout 6

Actions to be taken immediately after a fall.

No 020 3773 4174

Yes

ANY CONCERNS?

Handout 7

Case review using 'Is my resident well?'

Edmund had a fall this morning. You didn't witness it yourself but the night staff said that they had gone in to his room first thing in the morning and found him on the floor. He was breathing ok, there was no major bleeding and he didn't look to have broken a bone. They were able to get him up off the floor and put him in bed. The night staff used the immediate falls assessment tool and thought that he was an 'amber'. They have asked you to keep a close eye on him today to decide what to do.
You have noticed that he seems reluctant to mobilise. He usually walks slowly with a stick but now is preferring to stay in bed. When you help him to the toilet he is grimacing and limping on his left leg.

Use 'Is my resident well?' to assess Edmund.

Pain- grimacing when he walks. This is a new pain. *(red)*
Well-being- not getting out of bed, not going to the day-room. *(amber)*
Breathing- normal *(green)*
Cough- no cough *(green)*
Bowels- open yesterday, type 3 *(green)*
Urine- going normally, type 3 *(green)*
Hydration- seems to be drinking as usual, no headaches or confusion *(green)*
Confusion- not confused *(green)*
Skin- his knee is swollen and red, but the skin isn't broken. *(red)*

Edmund warrants a same-day assessment. This may be in the form of a G.P visit, CHAT review or rapid response.

MODULE 7- CARE OF THE DEMENTIA PATIENT

Aim of the lesson

- To make carers aware of the different types of dementia
- To discuss signs and symptoms of dementia
- To consider the additional needs of residents with dementia
- To raise awareness of how we can support our dementia residents
- To promote strategies to assist with managing challenging behaviour

End-point of the lesson

- Learners can identify someone who is showing signs of dementia
- Learners are aware of how having dementia may infer additional medical needs
- Learners are aware of how they can support their dementia residents
- Learners have a toolkit for managing challenging behaviour in dementia residents

Structure of the lesson

1) Discussion 1. *What is dementia? What different types of dementia are you aware of?*
    a. Types of dementia
        i. Alzheimer's
        ii. Vascular
        iii. Frontotemporal
        iv. Lewy-body

2) Discussion 2. *What are the signs and symptoms of dementia? Spend a few minutes brainstorming in groups*.
    - poor concentration
    - difficulty recognising people or objects
    - poor organisation skills
    - confusion
    - disorientation
    - slow, muddled or repetitive speech
    - withdrawal from family and friends
    - problems with decision making, problem solving, planning and sequencing tasks
    - withdrawn
    - mood changes
    - eating less
    - incontinence
    - moving less
    - personality change
    - aggression
    - wandering and getting lost
    - difficulty remembering recent events while having a good memory for past events

3) Discussion 3. *Looking after residents with dementia can be very rewarding. But sometimes, people with dementia have additional needs that we need to be aware of. What extra challenges can looking after someone with dementia raise?*

i. Need extra help ADLs
ii. May be resistant to help
iii. May not remember carers
iv. Families may be upset by changes
v. Families may be more involved and there may be an increased need to communicate with them
vi. The resident may not be able to report changes to health so we may have to be extra vigilant
vii. The resident may be combative or aggressive
viii. The resident may be inconsistent in their likes and dislikes
ix. The resident is likely to decline and this is difficult

4) Activity 1. *People with dementia are individuals and communication must always be tailored to the individual resident. However, consider each statement and decide if it is true or false.* Communication Ways to communicate-true of false quiz. Handout 1.

5) Discussion 4. *Can you think of any techniques to help manage challenging behaviour?* Handout 2.

6) Activity 2. *People with dementia are sometimes at higher risk of other medical problems.* Work through the true or false quiz as a group. Handout 3.

7) Activity 3. *Sensory activities are useful ways to engage residents with dementia. Thinks of each of the five senses. For each one, brainstorm activities which you could undertake with your residents:*

a. Sight- photos, postcards
b. Smell- herb garden, guess the smell
c. Hearing- music quiz
d. Touch- guess the everyday object
e. Taste- mocktail tasting, guess the cordial, guess the flavour cake

Resources:
Handout 1- 1 for the trainer
Handout 2- 1 per participant
Handout 3- 1 for the trainer

References:

Alzheimers.org.uk. What is dementia? [Cited 25.05.2020]. Available: https://www.alzheimers.org.uk/about-dementia/types-dementia/what-dementia

NHS website. Dementia guide. [Cited 25.05.2020]. https://www.nhs.uk/conditions/dementia/

Alzheimer's net. How Sensory Stimulation Can Help Alzheimer's. March 2017. [Cited 25.05.2020]. Available from: https://www.alzheimers.net/2014-01-23/sensory-stimulation-alzheimers-patients/

Golden carers. Sensory stimulation for dementia care. [Cited 25.05.2020]. Available from: https://www.goldencarers.com/sensory-stimulation-for-dementia-care/4184/

Krishnamoorthy A, Anderson D. Progress in neurology and psychiatry. Managing challenging behaviour in older adults with dementia. [Cited 25.05.2020]. Available from: https://onlinelibrary.wiley.com/doi/epdf/10.1002/pnp.199

NICE. Dementia: assessment, management and support for people living with dementia and their carers. NICE guideline [NG97] Published date: June 2018. [Cited 25.05.2020].

Handout 1

Communication strategies to assist with residents with dementia- true or false quiz

- speak clearly and slowly-T
- if the person doesn't understand, shout louder- F
- try to keep sentences short- T
- do not 'back-to-back' questions- T
- make eye contact with the person -T
- give them time -T
- leave the person out of the conversation as they won't understand-F
- let them speak for themselves during discussions about their welfare or health issues -T *(but may need to involve NOK too)*
- do not to patronise them- T
- make fun of what they say so they won't say it again- F
- acknowledge what they have said, even they say seems out of context – show that you've heard them and encourage them to say more about their answer -T
- go with the direction that the conversation takes you -T
- give them simple choices – avoid creating complicated choices or options for them -T
- use other ways to communicate – such as rephrasing questions -T
- be patient and remain calm -T
- keep your tone of voice positive and friendly -T
- talk to them at a respectful distance to avoid intimidating them- T
- being at the same level or lower than them -T
- pat or hold the person's hand while talking to them to help reassure them- T
- try not to interrupt them -T
- stop what you're doing so you can give the person your full attention while they speak -T
- minimise distractions – e.g. television or the radio -T
- repeat what you heard back to the person-T
- show active listening- shaking your head, turning away or murmuring are alternative ways of saying no or expressing disapproval -T
- Only speak to their relatives- F
- Do not encourage the person to talk about the past in case it upsets them- F

Handout 2.

Helping with challenging behaviour

- Make changes to the room or environment, such as checking the area is well lit, and covering or removing mirrors and patterned carpets or wallpaper that may be confusing the person.
- Talk to them about fears and ask what's frightening them.
- Acknowledge that it must be frightening.
- Reassure that you are there.
- Check for noises that the person could confuse with someone speaking, such as the TV.
- Make sure the person has had recent hearing and sight tests.
- Try not to leave objects that could be used as weapons around pt.
- Look for patterns or triggers to violent outbursts.
- Consider medical causes for outbursts-
    - Pain
    - Infection
    - Constipation
    - Delirium
    - Have resident reviewed by GP
- Have two members of staff present if the person is prone to violence
- If the behaviour becomes really unmanageable and the person is a risk to themselves or others, call the GP or chat team for a referral to mental health.
- De-escalation:
    - Be calm and neutral even if you don't feel it
    - Say useful things. 'I want to help you."
        ◦ "Please tell me more so I better understand
    - how to help you."
    - Use a low monotonous tone of voice (our normal tendency is to have a high-pitched, tight voice when scared).
    - Do not try to yell over a screaming person. Wait until he/she takes a breath, then talk. Speak calmly at an average volume.
    - Avoid the Danger Zone - within one arm length
        - ◦ Safety Zone – Outside of person's reach
        - ◦ Zone of Influence – Within Safety Zone, but still close enough to communicate effectively
        - ◦ Use Natural Barriers
    - Speak to person at their height. Acknowledge what they have said.
    - Position yourself nearest the door
- Ask the CHAT team for a mental health review.
- Drugs should always be a last resort.

Handout 3

Additional medical needs.

- People with dementia are more prone to anxiety, depression and psychosis. T
- People with dementia should not be offered a meal if they do not say that they are hungry. F
- People with dementia have the same falls rate as people without. F
- People with dementia are more prone to dental problems. T
- People with dementia are more likely to experience delirium if they suffer a medical problem. T
- People with dementia do not feel pain. F
- The abbey pain scale is a good tool to assess pain in dementia residents. T
- Constipation is a common problem with dementia residents. T
- Dementia is a life-limiting illness- T
- Agitation, aggression and confusion may indicate a new medical problem in dementia patients. T

Module 8- Oral Health

Aim of lesson

- To raise awareness of dental problems in residents
- To assist carers in recognising dental problems
- To promote prevention strategies such as good oral hygiene
- To discuss local pathways for accessing dental help

End-point of lesson

- Learners are aware of the dental problems that can exist in residents
- Learners know how to check for them
- Learners are more confident in providing basic mouthcare
- Learners know how to escalate dental concerns

Structure of lesson

- Activity 1. *'Scale of the problem'- introductory quiz.* Handout 1.
- Discussion 1. *Think of a resident that you cared for who had poor oral health. What were their risk factors? Brainstorm in groups.* Handout 2.
- Activity 2. How to conduct an oral assessment. Talk through the oral health assessment. Handout 3.
- Activity 3. Picture quiz. *Match the picture to the dental problem.* Handout 4.
- Activity 4. General tips for good mouth care. Case studies. Handout 5.
- Discussion 2. Escalation to doctors and dentists locally. *How do you access dental help for your residents?*

Resources:

Handout 1- 1 for trainer
Handout 2- 1 per learner
Handout 3- 1 per learner
Handout 4- 1 per learner
Handout 5- 1 per learner

References:

NICE Guidelines. Oral health for adults in care homes. NICE guideline [NG48] Published date: 05 July 2016. [Cited 25.05.2020]. Available from: https://www.nice.org.uk/Media/Default/Oral%20health%20toolkit/Oral_health_assessment_tool.pdf

Health Education England. Mouth care matters. January 2020. [Cited 18.12.2019]. Available from: http://www.mouthcarematters.hee.nhs.uk/wp-content/uploads/2016/10/MCM-GUIDE-2016_100pp_OCT-16_v121.pdf

NHS Scotland, Care Inspectorate, Healthier Scotland. Caring for smiles- guide for care homes. [Cited 18.12.2019]. Available from: http://www.knowledge.scot.nhs.uk/media/7460397/caringforsmilescarehomes2013.pdf

Public Health England (PHE). (2014) Delivering better oral health: an evidence-based toolkit for prevention. Third Edition. Available at: https://www.gov.uk/government/ uploads/system/uploads/attachment_data/file/367563/ DBOHv32014OCTMainDocument_3.pdf

Pictures from:
pictures from

1) https://en.wikipedia.org/wiki/Oral_candidiasis
2) https://www.sciencephoto.com/media/762210/view/teeth-covered-with-plaque-and-tartar
3) https://www.google.co.uk/search?q=oral+cancer&sxsrf=ALeKk01Fcpmt8U0QXEnK4XIaFNfDoC74eQ:1592426961266&source=lnms&tbm=isch&sa=X&ved=2ahUKEwj0_uza3InqAhWEZxUIHebFAUMQ_AUoAXoECA4QAw&biw=783&bih=537
4) https://www.google.co.uk/search?q=tartar&tbm=isch&ved=2ahUKEwjypovc3InqAhWC2OAKHXTkD9gQ2-cCegQIABAA&oq=tartar&gs_lcp=CgNpbWcQARgAMgQIIxAnMgQIABBDMgUIABCxAzICCAAyAggAMgIIADICCAAyAggAMgIIADICCAA6BwgAELEDEEM6BQgAEIMBUMD1B1j-gQhgyY0IaABwAHgAgAE9iAHKApIBATaYAQCgAQGqAQtnd3Mtd2l6LWltZw&sclient=img&ei=04HqXrLxM4Kxgwf0yL_ADQ&bih=537&biw=783
5) https://www.dentalproductsreport.com/dental/article/have-scientists-finally-solved-tooth-decay

Handout 1

Scale of the problem. Introductory quiz.

- How many adults living in care homes have tooth decay?
    a. Over half (NICE)

- T or F. Poor oral hygiene is linked to aspiration pneumonia.
    b. True (mouth care matters)

- T or F. A greater proportion of older people have dentures than ever before.
    c. False.

- T or F. Poor oral care puts the resident at risk of heart disease and stroke.
    d. True (infective endocarditis, stroke- mouth care matters)

- T or F. Residents with dementia are more likely to experience problems with their teeth.
    e. True

- Poor dental care is a risk factor for malnutrition.
    f. True

Handout 2

Risk factors for poor oral health:

Brainstorm:

1) Dementia
2) Learning difficulties
3) Stroke
4) Oxygen patient
5) Palliative care
6) Polypharmacy
7) Depression
8) Alcohol overuse
9) Poor manual ability to brush
    a. OA
    b. Parkinson's disease
    c. Stroke
10) Immune problems
    a. Diabetes
    b. Cancer
    c. HIV
    d. meds
    e. Dry mouth
    f. RA
    g. CF
    h. Radiotherapy
    i. Meds
11) Medications
    a. Immunosuppressants
    b. Chemo
    c. Antidepressants
    d. Anticholinergics
    e. Steroids
    f. Inhalers
    g. PPIs
12) Malnutrition
13) PEG fed
14) Anaesthetics

Handout 3

Oral health assessment tool

Resident: Completed by: Date:

Scores – You can circle individual words as well as giving a score in each category
(* if 1 or 2 scored for any category please organise for a dentist to examine the resident)
0 = healthy 1 = changes* 2 = unhealthy*

Lips:

Smooth, pink, moist	0
Dry, chapped, or red at corners	1
Swelling or lump, white, red or ulcerated patch; bleeding or ulcerated at corners	2

Dental pain:

No behavioural, verbal, or physical signs of dental pain	0
There are verbal and/or behavioural signs of pain such as pulling at face, chewing lips, not eating, aggression	1
There are physical pain signs (swelling of cheek or gum, broken teeth, ulcers), as well as verbal and/or behavioural signs (pulling at face, not eating, aggression)	2

Natural teeth Yes/No:

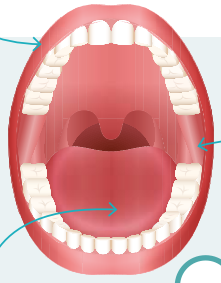
No decayed or broken teeth or roots	0
1–3 decayed or broken teeth or roots or very worn down teeth	1
4+ decayed or broken teeth or roots, or very worn down teeth, or less than 4 teeth	2

Oral cleanliness:

Clean and no food particles or tartar in mouth or dentures	0
Food particles, tartar or plaque in 1–2 areas of the mouth or on small area of dentures or halitosis (bad breath)	1
Food particles, tartar or plaque in most areas of the mouth or on most of dentures or severe halitosis (bad breath)	2

Dentures Yes/No:

No broken areas or teeth, dentures regularly worn, and named	0
1 broken area or tooth or dentures only worn for 1–2 hours daily, or dentures not named, or loose	1
More than 1 broken area or tooth, denture missing or not worn, loose and needs denture adhesive, or not named	2



Tongue:

Normal, moist roughness, pink	0
Patchy, fissured, red, coated	1
Patch that is red and/or white, ulcerated, swollen	2

Saliva:

Moist tissues, watery and free flowing saliva	0
Dry, sticky tissues, little saliva present, resident thinks they have a dry mouth	1
Tissues parched and red, little or no saliva present, saliva is thick, resident thinks they have a dry mouth	2

Gums and tissues:

Pink, moist, smooth, no bleeding	0
Dry, shiny, rough, red, swollen, 1 ulcer or sore spot under dentures	1
Swollen, bleeding, ulcers, white/red patches, generalised redness under dentures	2

- ☐ Organise for resident to have a dental examination by a dentist
- ☐ Resident and/or family or guardian refuses dental treatment
- ☐ Complete oral hygiene care plan and start oral hygiene care interventions for resident
- ☐ Review this resident's oral health again on date:

TOTAL:

SCORE: 16

With kind permission of the Australian Institute of Health and Welfare (AIHW). Source: AIHW Caring for oral health in Australian residential care (2009).
Modified from Kayser-Jones et al. (1995) by Chalmers (2004).

Handout 4

Activity- dental problems

- Find pictorial examples of each of the following and ask learners to match the disease to the picture

1= tartar
2= thrush
3= cancer
4= gingivitis (gum disease)
5= dental caries

- Or, ask carers whether they have seen any of the above.
    - What did it look like?
    - What symptoms did the resident have?

- Or, if a demonstration set of dentures and a toothbrush can be procured, have the learners conduct a demonstration of good toothbrushing.

Handout 5

Case studies. Tips for good mouthcare.

Consider the case and brainstorm in your groups.

1) Bill is going on holiday for 2 weeks with their family. The family ask for toothbrushing tips. What will you say?
    a. Brush twice per day with fluoride toothpaste
    b. Soft toothbrush
    c. Limit sugary drinks and snacks
    d. Use same force as if writing name with non-dominant hand.
    e. Brush for two minutes
    f. Spit, don't rinse.
    g. Brush using a circular motion with the bristles of the brush directed 45o towards the gum line.
    h. ENCOURAGE LEARNERS TO DO DEMO!

2) Ray has dementia and doesn't like having his teeth brushed. His family want to take him away for two weeks. Any tips that may help them?
    a. Develop a routine, providing mouth care at the same time each day
    b. Taking time and being kind and patient
    c. Asking a carer/family member who is more familiar
    d. Use short sentences and simple instructions and use reminders and prompts - sometimes placing a toothbrush in front of a patient will be a sufficient reminder
    e. Use the handle of a second toothbrush to improve access to the whole mouth
    f. Distraction with singing or by giving the patient something to hold in their hands
    g. A three-headed toothbrush if co-operation and access to the mouth is limited
    h. Hand-over-hand technique (carer's hand over the patient's hand), guiding the patient to brush their teeth
    i. A non-foaming toothpaste (SLS free) may be useful as it may be more tolerable
    j. Some patients with dementia may be very resistant to mouth care, it is important to stop and record that the patient is not compliant and try again at a different time or day.

3) Lucille has dentures. How will you advise the family to care for them?
    a. Rinse after meals
    b. Clean with soft toothbrush and dental paste or non-perfumed soap
    c. Take them out and soak overnight, either in denture solution or plain water

Module 9- Stroke

Aim of lesson

- To help learners to understand why stroke matters
- To help learners understand why strokes can cause a range of symptoms
- To help learners identify and manage stroke risk factors
- To improve confidence in management of an acute stroke
- To assist learners in supporting residents who have previoulsy had a stroke

End-point of lesson

- Learners can recognise that their resident is having a stroke and know how to deal with the problem in a timely manner
- Learners can put stroke-prevention measures in place
- Learners know how to support people who have been affected by a stroke

Structure of lesson

1) Activity 1. Introductory quiz. Handout 1.

2) Discussion 1. Functions of brain. Handout 2.

3) Discussion 2. Types of stroke. Handout 2.

4) Activity 2. *Think back to the picture of the functions of the brain. If part of the brain loses its blood supply, what signs and symptoms might you see straight away? What might you do?* Handout 3.

5) Activity 3. *Do you know any risk factors for a stroke? Can you think of any measures your home could introduce to reduce the resident's stroke risk?* Handout 3.

6) Discussion 3. *Think back to a resident who you looked after who had had a stroke. What long-term symptoms were they left with? Who might you involve to help?* Handout 3.

7) Activity 4. Case studies. *Work through the case studies in your groups.* Handout 4.

Resources:

Handout 1- 1 for the trainer
Handout 2- 1 for the trainer
Handout 3- 1 per participant
Handout4- 1 per participant

References:

NICE guidelines. Stroke and transient ischaemic attack in over 16s: diagnosis and initial management. NICE guideline [NG128] Published date: 01 May 2019. [Cited 25.05.2020]. Available from:

https://www.nice.org.uk/guidance/ng128/chapter/Recommendations#thrombectomy-for-people-with-acute-ischaemic-stroke

NHS website. Stroke. [Cited 25.05.2020]. Available from: https://www.nhs.uk/conditions/stroke/

Stroke.org.uk. What is a stroke? [Cited 25.05.2020]. Available from: https://www.stroke.org.uk/what-is-stroke/types-of-stroke

Amicus visual solutions.

Handout 1

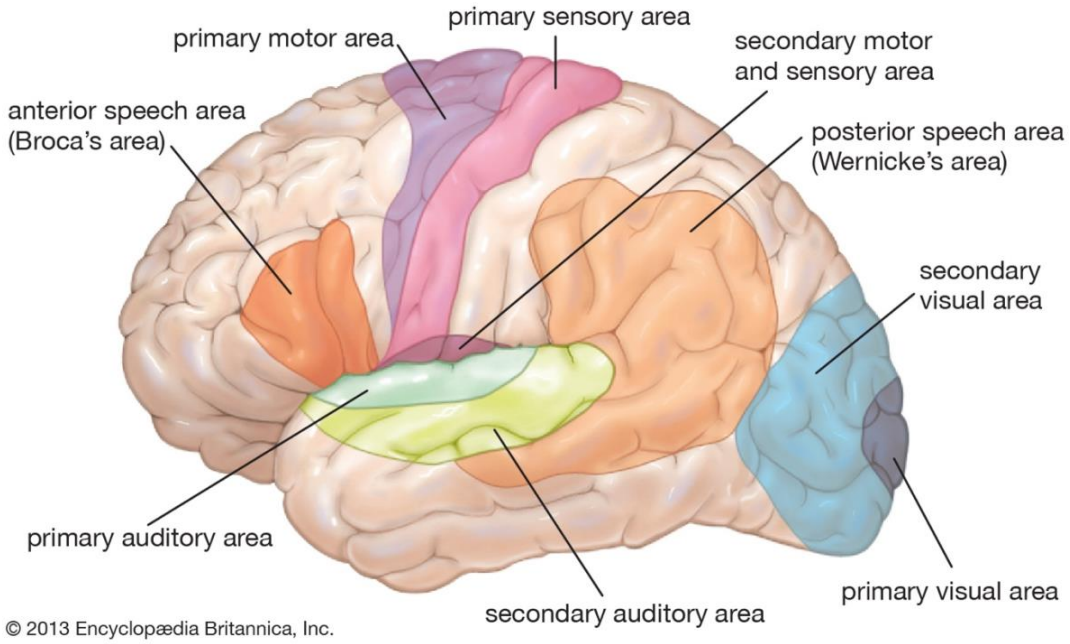
Stroke quiz.

1) A stroke can leave someone paralysed down one side – T
2) A stroke can leave someone wheelchair-bound- T
3) A stroke never affects speech- F
4) A stroke rarely causes disability- F (2/3 do)
5) People who have had a stroke have an increased risk of depression – T
6) Stroke is the 10th biggest killer in the UK (F- = 4th biggest)
7) 85% strokes are due to blood clots- T

Handout 2

What is a stroke?

- A clot blocking off the blood supply to part of the brain (ischaemic).
- Or- a blood vessel bursting inside the brain (haemorrhagic).
- This causes the blood supply to that part of the brain to be affected.
- The signs and symptoms that we see is determined by which part of the brain is affected.



Handout 3

How to recognise that your resident may have had a stroke:

FAST- face weakness, arm weakness, speech, time critical
Speech problems- slurred, nonsensical
Collapse
Dizziness/ off-balance
Leaning to one side
Drooling, choking

- Sudden numbness or weakness in the face, arm, or leg—especially on one side of the body
- Sudden confusion or trouble speaking or understanding
- Sudden problems seeing in one eye or both eyes
- Sudden dizziness, loss of balance or coordination, or trouble walking
- Sudden severe headache with no known cause

Other danger signs that may occur include double vision, drowsiness, and nausea or vomiting

What might you do?

Admission to hospital as soon as possible as long as the person doesn't have and advance care plan.

Risk-factors for a stroke:

High blood pressure
Diabetes
Smoking
Cholesterol
Blood thinning medication
Lack of exercise
Alcohol
Fatty diet
Atrial fibrillation (irregular heart beat)
Family history

Prevention programme:

Smoking cessation
Healthy diet- low fat, low salt
Exercise
Monitor blood pressure
Control medical conditions

Long-term consequences of a stroke:

Death
Disability
Speech disturbance
Muscle weakness
Incontinence
Bladder/bowel
Falls
Muscle weakness
Mobility problems
Pressure sores
Swallowing problems

How might we help?

Physiotherapist, O.T, dietician, speech and language, mental health

Handout 4

Case studies

1) Moira is a fit- and -well 76-year old. She came to you after her husband died, and she began to feel less confident managing in her own home. She is usually mobile, and independent with her ADLs, except for some assistance getting in and out of the bath. She isn't confused and enjoys all the activities in the care home, especially singing. She is a quiet but friendly lady who likes a cup of tea and a chat. You are bringing her a cup of tea and you notice that one side of her face doesn't move when she smiles. She was fine when you saw her at breakfast about one hour ago. What will you do next?

2) Alan can normally hold a conversation, even if he sometimes gets confused. But now, his speech is really muddled. He's using completely the wrong words, as well as seemingly struggling to find his words. He is on a blood thinner (apixaban). What will you do next?

3) Leslie tells you that since 7am, his left arm has been 'all floppy' and he can't pick things up. Sure enough, its drooping by his side. You worry that this is serious and go to fetch your supervisor. When you go back ten minutes later, he says that it is better now. What will you do?

4) Julie is dying. She has advanced dementia, is bedbound, incontinent and very frail. She has had three admissions for sepsis in the last month. After the last admission, the GP and care home manager had a meeting with her family and decided that she should not be admitted any more as it would be kinder to provide palliative care in the care home. You go in to turn her and notice that one side of her face is drooping. It's hard to assess further as she cannot obey commands and she is too weak to assess muscle strength. What will you do?

Module 10. Hydration.

Aim of lesson

- To highlight the importance of good hydration
- To recognise when someone is dehydrated

End-point of lesson

- Learners can identify risk factors for dehydration
- Learners can put measures in place to protect against dehydration
- Learners can recognise dehydration

Structure of lesson

1) Activity 1. Introductory quiz. Handout 1.

2) Discussion 1. Overview of kidneys/bladder diagram. Handout 2.

3) Activity 2. *Think of a resident you know who doesn't drink enough. Can you brainstorm all of the reasons why they might not drink enough or may become dehydrated?* Handout 3.

4) What problems can result from dehydration? Handout 3.

5) Signs and symptoms of dehydration? Handout 3.

6) 'Is my resident well?' case study. Handout 4.

7) Discussion 2. *Brainstorm ideas to encourage residents to drink more.*

    a. *Mocktails, squash tasting, decorate drinks trolley, fruit, ice lollies, choice of drinks, water jugs out*

Resources:

Handout 1- 1 for trainer
Handout 2- 1 for trainer
Handout 3- 1 per participant
Handout 4- 1 for trainer

References:

Kent Surrey and Sussex Academic Health Science Network, Wessex Academic Health Science Network and NE Hants and Farnham CCG. The hydrate toolkit. Improving hydration among older people in care homes and the community. April 2016. [Cited 25.05.2020]. Available from: https://wessexahsn.org.uk/img/projects/Hydration%20toolkit%20V1.pdf

Oxford Academic Health Science Network. IMPLEMENTATION TOOLKIT -Good Hydration! - Implementing and sustaining structured drinks rounds in care homes to increase hydration and reduce UTIs. [Cited 25.05.2020]. Available from: https://www.patientsafetyoxford.org/wp-content/uploads/2019/05/48633_Good_Hydration_Toolkit_2019_Digital.pdf

NHS England. Guidance- Commissioning excellent nutrition and hydration. 2015-2018. [Cited 25.05.2020]. Available from: https://www.england.nhs.uk/wp-content/uploads/2015/10/nut-hyd-guid.pdf

Is my resident well? 10 questions to ask. NWL CCG.

UCLPartners, Essex County Council and The Evidence Centre. Improving resident safety in care homes Learning from the PROSPER programme in Essex. 2016. [cited 24.05.2020]. Available from: https://www.livingwellessex.org/media/571025/prosper-final-evaluation-report.pdf

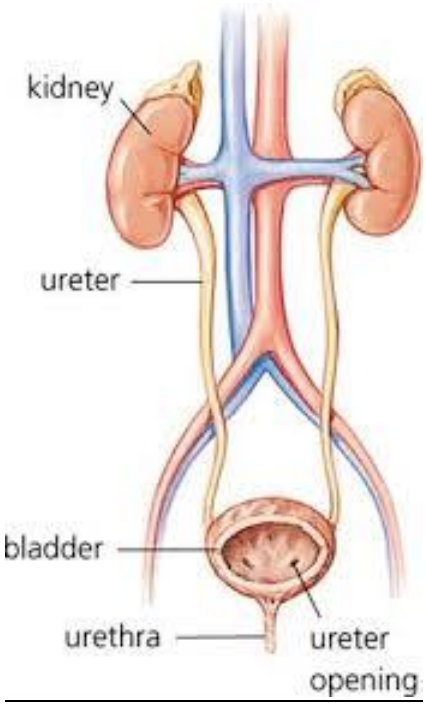
Picture of kidneys, ureters and bladder from: https://www.google.co.uk/search?q=picture+kidney+bladder&sxsrf=ALeKk02pweER0Wh6GtvmUIOuuT8oGZBPYA:1592426610091&source=lnms&tbm=isch&sa=X&ved=2ahUKEwiVk7Oz24nqAhW0ThUIHQHWA-kQ_AUoAXoECA0QAw&biw=783&bih=537

Handout 1

Hydration quiz

1) The response to the changes of salts in the blood that occur when an individual is dehydrated does not work as well as in older people as in younger people. T
2) There is reduced awareness of thirst in older people, especially in individuals with dementia and those who have had a stroke. T
3) There is reduced ability by the kidneys to conserve water. T
4) The total body water increases with age. F
5) The ability to taste reduces with age so drinks may taste different. T
6) Water in food doesn't count towards a person's intake. F

Handout 2



Handout 3

1) Risk factors
    a. The elderly have a reduced thirst so may not know when they are thirsty
    b. Unable to communicate (cannot say when they are thirsty)
    c. Pre-existing medical conditions e.g. diabetes, stroke-less likely to know they ae thirsty.
    d. Dementia -unaware thirsty, can't ask for drink, forget how to drink
    e. Medications e.g. diuretics – increase fluid loss
    f. Illness -diarrhoea, vomiting, fever
    g. Fear of incontinence due to drinking
    h. Dexterity issues – OA, Parkinson's disease
    i. Bedbound
    j. Excessive fluid losses

2) Consequences of dehydration
    a. Falls
    b. UTIs
    c. Constipation
    d. Pressure sores
    e. Low blood pressure
    f. confusion

3) Signs and symptoms of dehydration
    a. Dry mouth
    b. Headache
    c. Dizziness
    d. Tiredness
    e. Confusion or not wanting to take part in activities
    f. Constipation
    g. UTI (urinary tract infections)
    h. Colour of their urine
    i. Pressure ulcers
    j. Falls
    k. Kidney stones
    l. Low blood pressure
    m. Medication toxicity

Handout 4

'Is my resident well?' care study.

Lily has always needed lots of prompting to drink. For the past two days, she has had a cold and a temperature. Her oral intake has been even worse. She isn't quite herself. Use the booklet to ask questions to assess Lily.

Bowels- open yesterday, type 3 stool *(green)*
Breathing- normal *(green)*
Cough- no *(green)*
Pain- no *(green)*
Confusion- yes, drowsy *(amber)*
Well-being- yes, drowsy *(amber)*
Skin- normal *(green)*
Hydration- change to colour of urine, fewer toilet trips *(amber)*
Urine colour- colour 7 *(amber)*

What might you do?
Fluid chart, encourage, monitor urine output

Module 11 Nutrition.

Aim of lesson

- To discuss the importance of nutrition
- To recognise people at risk of malnutrution
- To screen for malnutrition

End-point of lesson

- Learners can recognise malnutrition and put measures into place to address it
- Learners know where to go for help with malnourished residents

Structure of lesson

1) Activity 1. Introduction to nutrition quiz. Handout 1.

2) Activity 2. Divide into groups. Think about residents that you have cared for who were undernourished. What put them at risk of malnutrition? What was it that initially made you worry about their nutrition? Is there anything that might make you want an ASAP G.P review? (red flags)? Handout 2.

3) Activity 3. Using MUST TOOL and paperweight arm band. Handout 3.

4) Activity 4. Case studies. *Work through individually then come back as a group.* Handout 4.

5) Discussion 1. Food first/leaflets. *Read through the leaflet as a group.* Handout 5.

6) Activity 5. Nutrition in dementia patients-ideas ladder. *Work through each idea and decide whether it is a good or bad idea.* Handout 6.

RESOURCES:

Handout 1- 1 for trainer
Handout 2- 1 for trainer
Handout 3- 1 per participant
Handout 4- 1 per participant
Handout 5- 1 per participant
Handout 6- 1 per participant

REFERENCES:

Age UK. Improving Nutrition and Hydration. 2019. [Cited 25.05.2020]. Available from: https://www.ageuk.org.uk/salford/about-us/improving-nutrition-and-hydration/nutrition-and-hydration-awareness-week-2019/

NICE guidelines. Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition. Clinical guideline [CG32]. 22 February 2006. Available from: https://www.nice.org.uk/guidance/cg32/chapter/1-Guidance#ftn.footnote_3

Bapen. Malnutrition Universal Screening Tool. [Cited 25.05.2020]. Available from: https://www.bapen.org.uk/pdfs/must/must-full.pdf

Wessex Academic Health Science Network, Burdett Trust for Nursing, Bournemouth University. Eating and drinking well- Supporting people living with dementia. [Cited 25.05.2020]. Available from: https://www.bournemouth.ac.uk/sites/default/files/asset/document/eating-and-drinking-well-supporitng-people-living-with-dementia-leaflet.pdf

Whittington NHS trust. Five nutritional tips to help prevent pressure ulcers.

Malnutrition Task Force. Eating and drinking well in later life. Are you eating enough? Advice for older people. [Cited 25.05.2020]. malnutritiontaskforce.org.uk.

Alzheimers.org. Eating and Drinking. [Cited 25.05.2020]. Available from: https://www.alzheimers.org.uk/get-support/daily-living/eating-drinking

Bedfordshire Community Health Services. 100 calorie boosters. Patient leaflet.

DHSSPS. Promoting Good Nutrition Food First Advice Leaflet for Community Setting. November 2015.

Handout 1

Nutrition and Hydration Quiz – answer sheet

1. **How many drinks should you have each day (in cups or glasses)?**

c. 6-8

2. **True or false: drinking tea and coffee makes you more dehydrated**

False: Tea and coffee contain a lot of water so are a great way to stay hydrated!

3. **True or false: your sense of thirst can decrease as you get older**

True: This is one of the reasons some people become dehydrated

4. **Which type of milk should you drink if you need to put on weight?**

c. Full-fat milk is recommended for people who need to put on weight. You can also mix in 2-4 tablespoons of milk powder to add extra energy, calcium and protein

5. **Apart from thirst, how can you tell if you are dehydrated?**
    a. The pinch-test – gently pinch the skin on the back of your hand, it springs back to normal you are well hydrated
    b. Look at the colour of your urine when you go to the toilet. It should be clear in colour and odour-free (some medications can affect this)
    c. Sunken eyes, dry lips and dry skin
    d. Headaches, dizziness, concentration
    e. UTIs

6. **True or false: Older people with a poor appetite can safely skip meals**

False: skipping meals can lead to weight loss and undernutrition. Eating well and maintaining a healthy weight is important to give you energy, stay independent and fight off any infections. Losing weight can be very dangerous for your health and independence.

7. **True or false: It doesn't matter whether an older person eats alone or with others – food is just fuel for the body**

False: Eating together promotes healthy eating, especially for those living alone. We naturally eat more around others and make better food choices. Have you ever thought it was pointless cooking a big, healthy meal just for one so opted for toast or biscuits instead? Why not find a new lunch club or invite a friend, neighbour or family member to eat with you?

8. **True or false: if an older person becomes undernourished there is not much they can do about it**

False: There are lots of steps you can take to increase your food intake, this includes:
    a. eating snacks between meals
    b. using full-fat food and drinks, including milk
    c. adding high-energy food to your meals and snacks, such as extra butter, cheese, cream, oil or mayonnaise
    d. using full-fat ready-meals to make meal preparation easier

9. **How many people aged 65 or above in the UK are suffering from undernutrition?**

d. 1.3 million people aged 65+ are suffering from undernutrition in the UK

10. **Of the older people in the UK suffering from undernutrition, what percentage live in the community either in their own home or with family?**

d – 93%, the majority of people who are at risk of undernutrition live in the community. This means it is important we are all on the look out for the signs of undernutrition so we can help people to make changes before it becomes a serious illness.

Handout 2

Risk factors for malnutrition:

- Depression
- Medication- clopidogrel/aspirin/ ssris/SEDATIVES
- Oa/ Ra/STROKE/PARKINSONS- problems physically eating
- Frailty
- Drugs/alcohol
- Social isolation
- Poverty
- Dementia
- Chronic disease- COPD, DM, CANCER, HEART FAILURE, RENAL FAILURE
- Poor dentures
- Poor mouthcare
- Constipation
- INFECTION/ILLNESS

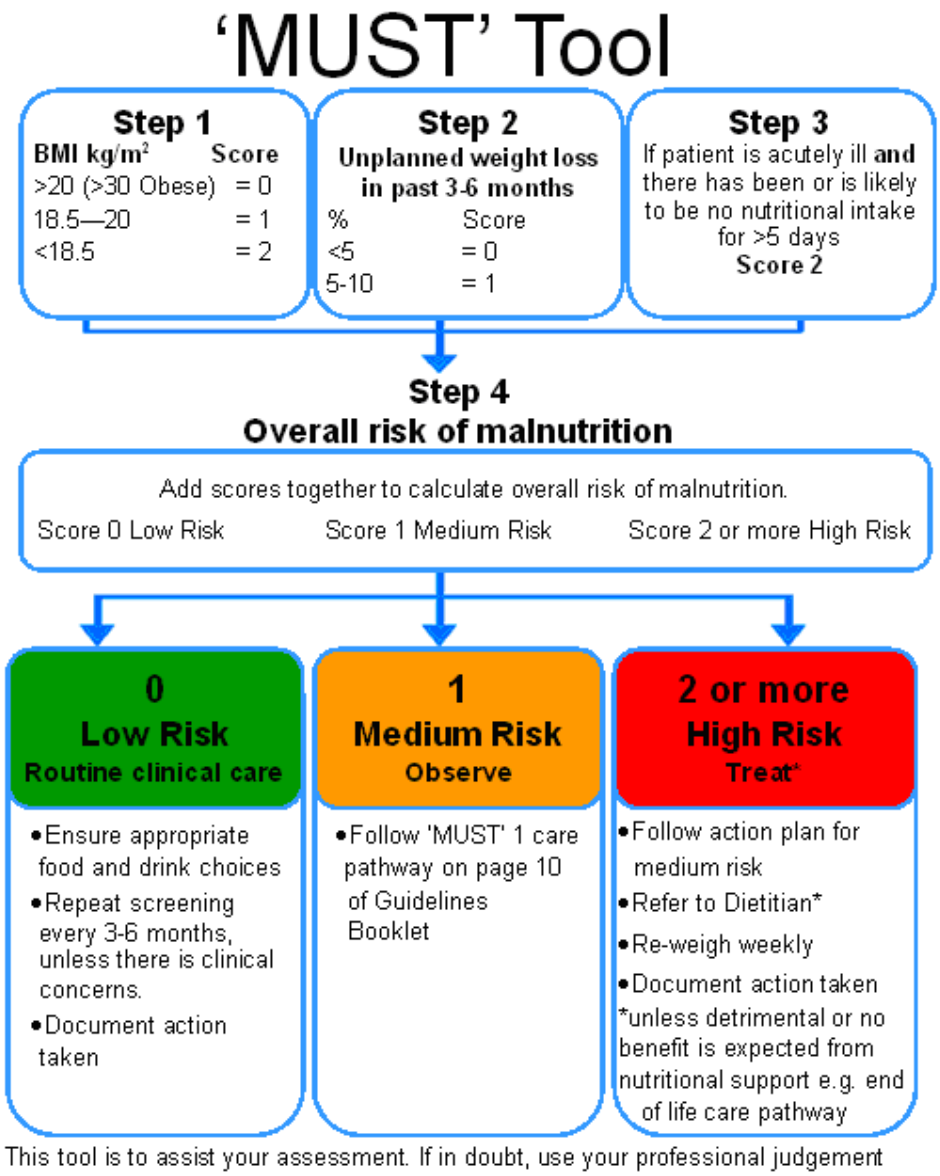
What was it that initially made you worry about their weight?

- Has the person lost weight without meaning to?
- Have they had a poor appetite?
- Low energy?
- Low mood?
- Do his/her clothes, shoes, jewellery or dentures look or feel loose?
- Does the person appear frail?
- Have family members commented upon the weight loss?
- Pressure sores or wounds that won't heal?

Red flags:

- Have they had sudden weight loss (10% of body weight in 3 months)?
- Do they have difficulties swallowing food or drinks?
- Do they get pain in their tummy when they eat?
- Has there been a recent change in their bowels (looser stools and/or increased frequency?
- Is there blood in the stool?
- Is there vomiting?
    - IF YES TO ANY- SIGNPOST G.P ASAP
- Do they have a sore mouth?
    - IF YES- SIGNPOST DENTIST

Handout 3


'MUST' Tool
Step 1
BMI kg/m²
Score
>20 (>30 Obese) = 0
18.5—20 = 1
<18.5 = 2
Step 2
Unplanned weight loss in past 3-6 months
%
Score
<5 = 0
5-10 = 1
Step 3
If patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days
Score 2
Step 4
Overall risk of malnutrition
Add scores together to calculate overall risk of malnutrition.
Score 0 Low Risk
Score 1 Medium Risk
Score 2 or more High Risk
0
Low Risk
Routine clinical care
•Ensure appropriate food and drink choices
•Repeat screening every 3-6 months, unless there is clinical concerns.
•Document action taken
1
Medium Risk
Observe
•Follow 'MUST' 1 care pathway on page 10 of Guidelines Booklet
2 or more
High Risk
Treat*
•Follow action plan for medium risk
•Refer to Dietitian*
•Re-weigh weekly
•Document action taken
*unless detrimental or no benefit is expected from nutritional support e.g. end of life care pathway
This tool is to assist your assessment. If in doubt, use your professional judgement

Handout 4

1) Betty has been your resident for some time. Lately, you notice that she picks at her food. She used to have a very good appetite. Sometimes, she won't join the other residents for her meals.
    a. Brainstorm what you can do to help Betty
    b. What questions might you ask her?
    c. What tests and checks might help?
    d. Who might you ask for help/involve?
    e. What can you, the carers, do to help?

2) Bill has been your resident for several years. He has mild dementia, but is relatively mobile and enjoys a good quality of life. He is friendly and likes walking around your home and talking to people.
    a. He is a good eater, but sometimes needs prompting to eat his food.
    b. He is recovering from a nasty chest infection and has lost some weight. When you weigh him, he is kilo down from last month.
    c. When you ask him about it, he says he just doesn't fancy food in the same way.
    d. There are no red flags for serious illness.

Handout 5

Food Enricher	Energy	Protein
Butter	✔	✘
Cream	✔	✘
Full Fat Milk	✔	✔
Skim Milk Powder	✔	✔
Oil	✔	✘
Crème fraiche	✔	✘
Cheese	✔	✔
Cream cheese	✔	✔ Low
Sugar	✔	✘

Food First Advice Leaflet
for Community Setting

A guide to eating well if you have a small appetite for clients in a community setting or on a community caseload

If you are eating less or have lost weight without planning to, simple changes to your meals and snacks may make a difference. You may be recommended foods that you would think are unhealthy. This is the recommended diet until your appetite improves.

Why do you need to eat well?

- If you have a poor appetite, you may have lost weight or be at risk of losing weight
- Eating too little may also affect your energy levels
- Lack of protein, minerals and vitamins may make you more prone to illness or delay the healing process
- It is important that you eat a balanced diet to provide all the necessary nutrients. These can be provided by simple meals and snacks.

Helpful Hints

- Aim for 3 small meals and 2 to 3 snacks a day if your appetite is poor
- Take drinks after your meal, not before or during as this can fill you up
- Drinks, snacks and meals can be fortified to make them more nutritious
- Smoking can reduce your appetite - try to cut down or stop smoking
- Eating breakfast may help you eat better for the rest of the day
- Add variety to your diet wherever possible to make meals more interesting
- Convenience foods can be useful if you find cooking difficult or tiring.

This dietary advice sheet gives some general information to help you make changes to your diet. If your appetite does not improve or you lose more weight or you find making these changes difficult, please discuss with your doctor.

Handout 6

Good or bad idea?

HOLD THEIR NOSE, AND WHEN THEY OPEN THEIR MOUTH, PUT THE FOOD IN (bad!)

ENCOURAGE THE RESIDENT TO EAT WITH OTHERS

FIND OUT WHAT THE RESIDENT LIKES TO EAT FROM FAMILY

DON'T LET THE RESIDENT LEAVE THE TABLE UNTIL THEY HAVE FINISHED EATING (bad)

PROVIDING FINGER FOOD MAY HELP

SMALL, FREQUENT MEALS

HIGH CALORIE SNACKS

MINIMISE DISTRACTION

SIT UPRIGHT IF POSSIBLE

LIGHTWEIGHT CUPS, HIGH-SIDED BOWLS, TWO-HANDED CUPS

ALLOW MORE TIME

GIVE BLAND FOOD (bad)

DEMONSTRATE CHEWING AND SWALLOWING
GUIDE THE RESIDENTS HAND TO THEIR MOUTH

START CONVERSATIONS ABOUT FOOD

PROVIDE PICTURES OF FOOD TO HELP WITH CHOOSING

FORTIFYING FOOD CAN HELP/FOOD FIRST

DON'T GIVE A MEAL IF THE RESIDENT DOESN'T SAY THAT THEY ARE HUNGRY (bad)

ALWAYS BLEND FOOD FOR DEMENTIA PATIENTS

ARRANGE THEMED FOOD DAYS

DEMENTIA PATIENTS SHOULD BE FED INTRAVENOUSLY (bad)

OFFER DRINKS AFTER A MEAL AND NOT BEFORE

ADD SWEET FOODS EG JAM AND HONEY TO PORRIDGE

ENCOURAGE DRINKS THROUGHOUT THE DAY

EXERCISE CAN STIMULATE APPETITE

ACTIVITIES AROUND FOOD PREPARATION CAN STIMULATE APPETITE

DO NOT LET THE RESIDENT HAVE A SAY IN THEIR MEAL CHOICES SINCE THEY CANNOT CHOOSE A BALANCED MEAL (bad)

DO NOT ALLOW THE RESIDENTS TO EAT SWEETS OR BISCUITS AS IT MAY ROT THEIR TEETH (bad)

REPORT ANY COUGHING OR CHOKING AT MEALTIMES TO THE G.P AS SOON AS POSSIBLE

EATING LESS OFTEN HAPPENS AS THE DEMENTIA PROGRESSES

IF THE PERSON IS AWAKE AT NIGHT- OFFER FOOD THEN

DO NOT GIVE THE RESIDENT DESSERT IF THEY HAVEN'T EATEN THEIR MAIN MEAL (bad)

IF SOMEONE STRUGGLES TO EAT, TRY SOFT FOOD BEFORE PUREE

FLOWERS ON THE TABLE AND SOFT MUSIC MAY HELP

DO NOT ALLOW THE RESIDENT TO HAVE UNUSUAL FOOD COMBINATIONS AS THIS WON'T TASTE VERY NICE (bad)

Module 12- Lower respiratory tract infection

Aim of lesson

- To help learners understand what a lower respiratory tract infection is
- To consider risk factors for lower respiratory tract infection
- To support learners in recognising when a resident has a lower respiratory tract infection
- To help learners to recognise when a resident is very unwell

End-point of lesson

- Learners can identify which residents are more at risk of a lower respiratory tract infection
- Learners can recognise when a resident has a chest infection
- Learners can use 'Is my resident well' to identify when a resident is very unwell

Structure of lesson

1) Discussion 1. Anatomy of respiratory tract. Handout 1.
2) Discussion 2. *What is a chest infection?*
3) Risk factors for lower respiratory tract infections. Handout 2.
4) Signs and symptoms of chest infections. Handout 2.
5) 'Is my resident well- 10 questions' case study. Handout 3.
6) Admission to hospital vs keeping in the care home.
    a. CRB-65 score of 1 or more (confusion, respiratory rate over 30, blood pressure below 90, aged over 65)
    b. Sats- oxygen levels
    c. No response to antibiotics after 24-48 hours
    d. ACP- discuss

RESOURCES:
Handout 1- 1 for trainer
Handout 2- 1 per learner
Handout 3- 1 for trainer

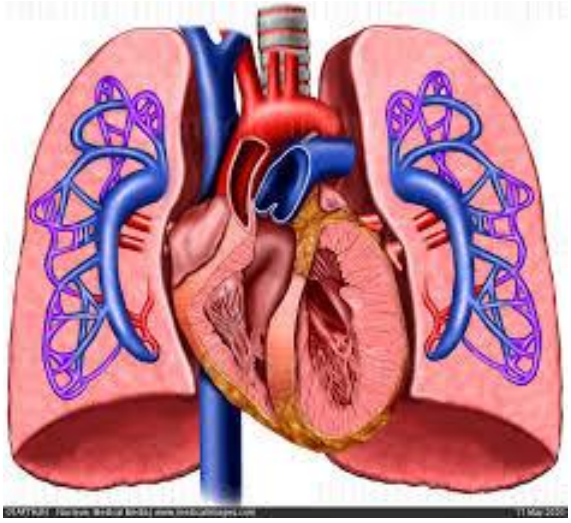
REFERENCES:

GP Notebook. CRB65 score in the assessment of community acquired pneumonia (CAP). [Cited 25.05.2020]. Available from:
https://gpnotebook.com/simplepage.cfm?ID=x20100126103546017540

Is my resident well?. NWL CCG.

Picture from heart and lungs:
https://www.google.co.uk/search?q=heart+and+lungs&sxsrf=ALeKk00iT7FpPm_nElAVQm0mfHHbvF_-uw:1592426766011&source=lnms&tbm=isch&sa=X&ved=2ahUKEwjU09_924nqAhV4TBUIHeJ4CEQQ_AUoAXoECBEQAw&biw=783&bih=537

Handout 1



Handout 2

Risk factors for lower respiratory tract infection.

1) Lung conditions
    a. Asthma
    b. COPD
    c. Lung cancer
2) Bedbound
3) Aspirating- dementia, stroke, Parkinson's
4) Flu
5) Supressed immune system- diabetes, chemo, methotrexate
6) Frail
7) Malnutrition
8) Smoking
9) Dehydration
10) Reduced conscious level

Signs and symptoms of lower respiratory tract infection.

The main symptom is **coughing**. The resident may feel generally unwell, weak and tired, and may have at least one of these symptoms too:

- coughing up mucus that may become yellow or green
- a high temperature – you might also sweat and shiver
- difficulty breathing or getting out of breath quicker than normal
- chest pain or discomfort
- loss of appetite
- reduced mobility
- weak

More severe cases may also cause:

- quick breathing
- confusion
- low blood pressure
- coughing up blood
- rapid heartbeat
- nausea and vomiting
- confusion

Handout 3

'Is my resident well?' Case study.

Bill has been coughing for two days. You notice that he is more breathless when he walks to the toilet. He is comfortable at rest and not in pain. His appetite is less but he is drinking and passing urine normally. His bowels are fine. He isn't confused but does seem a bit more sleepy than usual.

Breathing- *amber*
Cough- *amber*
Confusion- *amber*
Well-being- *amber*

All else green.

Bill needs a same-day review by the G.P or a member of CHAT team.

Module 13. Getting help for residents.

Aim of lesson

- To support learners in considering all the ways to escalate the care of unwell residents
- To encourage learners to consider advantages and disadvantages of hospital admission
- To be aware of all local support services

End-point of lesson

- Learners are able to name local support services
- Learners are better able to make decisions about how to escalate patient care

Structure of lesson

1) Activity 1. Quiz. Handout 1.
2) Activity 2- *list as many adverse effects of admission as possible.* Handout 2.
3) Activity 3- *can you think of any situations where the best course of action is usually to admit the resident to hospital?* Handout 2.
4) Activity 4. Case studies. Handout 3.
5) Activity 5. *Bite-sized bullets- who to call when.* Handout 4.

Resources:

Handout 1- 1 for trainer
Handout 2- 1 per learner
Handout 3- 1 per learner
Handout 4- 1 per learner

References:

Macmillan UK. End of life policy. https://www.macmillan.org.uk/_images/MAC16904-end-of-life-policy-report_tcm9-321025.pdf

Steventon A et al. Health org. Briefing: Emergency hospital admissions in England: which may be avoidable and how? [Cited 25.05.2020]. Available from: https://www.health.org.uk/sites/default/files/Briefing_Emergency%20admissions_web_final.pdf

NHS Improvement. Reference costs are the average unit cost to the NHS of providing secondary healthcare to NHS patients. Feb 2020. [cited on 24.05.2020]. Available from: https://improvement.nhs.uk/resources/reference-costs/

The English National Point Prevalence Survey (Health Protection Agency 2012). [Cited 25.05.2020]. https://www.gov.uk/government/publications/end-of-life-care-profiles-february-2018-update/statistical-commentary-end-of-life-care-profiles-february-2018-update

NHS digital. Hospital admissions patient care and adult critical care activity. 2018-2019. [Cited 25.05.2020]. Available from: https://files.digital.nhs.uk/F2/E70669/hosp-epis-stat-admi-summ-rep-2018-19-rep.pdf

Wolters A, Santos F, Lloyd T, Lilburne C, Steventon A. Emergency admissions to hospital from care homes: how often and what for? Improvements Analytics Unit Briefing. The Health Foundation. July

2019. [cited 24.5.2020]. Available from: https://www.health.org.uk/sites/default/files/upload/publications/2019/Emergency-admissions-from-care-homes-IAU-Q02.pdf

Handout 1

Hospital admission quiz.

1) There was a 3.6% increase in unscheduled hospital attendances in 2018-19 compared with the previous year. (T)
2) There was a 10% increase in unscheduled hospital attendances in 2018-19 compared with ten years ago. (F- 27.9% increase c/w 10 years ago.)
3) The age group with the highest number of episodes was the **70-74 year group** (1.9 million). (T) This accounts for **9.2 per cent** of all episodes
4) In 2016, 25% of deaths occurred in hospital (F- 46.9%)
5) What percentage of people with terminal cancer would prefer to die at home? (64%)
6) What percentage of people with terminal cancer end up dying in their own homes? (30%)
7) What percentage of the overall number of A&E attendances in the 65+ age group were from care homes? (6.5%)
8) What percentage of these emergency admissions may have been avoidable (conditions that are potentially manageable, treatable or preventable outside of a hospital setting)? (41%)
9) What percentage of total NHS expenditure was spent on unscheduled hospital admission in 2015-2016? (26%)
10) T or F. Bed occupancy rates have increased and are now routinely above 90% in England. (T- this makes it hard to respond to emergency situations.)
11) True or False. In 2011, 5% of in-patients developed a Hospital acquired infection? (F- 6.4%)
12) True or False. Patients with dementia are at risk of delirium if admitted to hospital. (T)

Handout 2

Disadvantages of admission

Fear, disorientation, loneliness, worsening dementia, hospital-acquired infections, falls, reduced mobility, poor nutrition

Circumstances where admission may be best

Major fractures (e.g. hip), strokes, infections not getting better with oral antibiotics

Handout 3

Put each case to the group. Make them physically choose between GP, CHAT, rapid response, 999, 111 or monitoring.

1) Peter is 78 years old. He has mild dementia, occasionally muddling times and dates, but generally he functions ok. He can manage most aspects of his self-care and can hold a conversation. He likes to go down to the day room to chat with the other residents. One morning, he doesn't get out of bed. He is drowsy but will rouse to tell you that he doesn't feel like getting up.
    a. What will you do?
    b. Who will you call?
2) Josephine has had a fall. She isn't badly hurt and is back to walking around with her stick. She's got a slight bruise on her leg. You are worried because this isn't her first fall.
    a. Who would you call?
    b. Would this change if it was 3am?
3) Mohammed is 76. He was seen 2 days ago by CHAT and diagnosed with a chest infection. He has been started on antibiotics but unfortunately hasn't improved. He's now struggling with his breathing and hasn't drunk anything all day. His lips are blueish and he is breathless at rest. He is usually reasonably well- he is self-caring with just a bit of prompting. There have never been any conversations before about Advanced Care Planning.
    a. Who will you call?
4) Suki is 98. For the past few months, her dementia has been getting worse. She is now bedbound and has been for a few months. She has also become doubly incontinent. In the last few days, she has become increasingly drowsy and isn't taking anything orally. She has an Advanced Care Plan in place to say 'for full treatment within the care home.'
    a. Who will you call?
    b. What if there was no Advanced Care Plan in place?
5) Maisie is 95 with severe COPD. After her last hospital admission, and Advanced Care Plan was put in place to say that she should not be admitted anymore with chest infections as she found it very distressing. The focus is now comfort care, with a view to treating any chest infections with antibiotics within the care home. You are on shift at 9pm and hear a scream. You go to Maisie and find her lying on the floor. Her leg is twisted at a very funny angle. She cannot get up, even with help. She is screaming with pain.
    a. What will you do?
6) Barry is 75 and in reasonable health. He was admitted to your care home because of a history of falls. In fact, he was generally neglecting himself and not eating and drinking properly. Since being in your care home, he is eating better and his weight has gone up. He has full capacity and says he wishes for everything to be done if he gets unwell. One day, you go into his room and realise that his face is drooping on one side and he cannot move his arm.
    a. What will you do?
    b. Would this change if he didn't have capacity?

7) Danlyn has said many times that she wishes to spend the rest of her days in your care home. She is 92 with dementia and her capacity fluctuates. She has got frailer over the last few weeks- she isn't eating very well and spends a lot of time in bed.
    a. Who will you call?

Handout 4

Who to call when- bite-sized bullets.

1) Quiz- what's what/true or false:
    a. 111 service is only for children -F
    b. 111 star 6 is a special service for care homes- T
    c. Medicus is a special service for evening and weekends- T
    d. Calling 999 is always the best option if someone has had a fall- F
    e. The usual G.P should be called out if there is a problem in the day-T
    f. The CHAT team can offer a same-day assessment- T
    g. The rapid response team won't come to care homes- F
    h. Using the district nurses and palliative care team may help prevent unnecessary admissions – T
2) Who's who-discussion:
    a. 111
        i. You need medical help fast but it's not 999 emergency
        ii. You wonder if you need 999
        iii. Should be used out-of-hours only
        iv. You need information on what to do next
        v. Often tell you to go to hospital
        vi. Better to call CHAT or Medicus if it's an evening or weekend
        vii. 111*6 is a tailor-made 111 for care homes
        viii. Usual 111, say location, then press *6
    b. Medicus
        i. On-call G.P for evenings and weekends
        ii. Same-day assessments
        iii. Work closely with CHAT
        iv. Would advise calling to discuss any patient you want to admit
    c. CHAT
        i. Care-home assessments team
        ii. Senior matron
        iii. MDT input- access to O.T, physio, mental-health
        iv. Same-day assessments
        v. Work closely with Medicus
    d. 999
        i. For life-threatening emergencies only
        ii. For residents who could not wait for a same-day assessment from Medicus, G.P or CHAT
        iii. Only for patients for whom hospital admission is appropriate
    e. G.P (often will be medicus G.P)
        i. Between 0830-1830 weekdays
        ii. Can usually offer same-day assessments
        iii. Would rather know about unwell patients early
        iv. Would rather you called us than just sent someone into hospital
        v. Also for routine referrals and medication queries
    f. Pharmacy
        i. Will often do a short supply of medications if you are about to run out
        ii. There will be a duty pharmacist open out of hours