Care Home Provider Handbook

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Version 10

Review Date: As part of the Care Homes Service Improvement Board schedule 2 monthly.

This document is designed to complement, not replace or reproduce formal guidance issued by regulatory and advisory bodies. Its purpose is to support providers with local working arrangements and to be a useful guide for staff on local practice and contacts.

To provide feedback, report inaccuracies or updates on this pack please contact: lou.bilenko@bradford.gov.uk

All feedback on the handbook and contents will be considered by the Contracts & Quality Team and any significant changes tabled at the SIB meetings.

The information contained within this handbook has been included for guidance purposes and makes use of links to third party websites and named products. Bradford Council does not endorse use of any particular brand or external training provider or service and is not responsible for your use of the information contained in or linked from these web pages.

The purpose of this handbook

To provide information on the local practices across Bradford and District. We are working collaboratively to support all providers of care home services to develop local ways of working that enhance the care experience for residents and the whole system.

It is intended to share good practice and local resources that can support delivery of high quality services. Whilst a large part of this handbook was introduced as part of Covid-19 working arrangements, the information has been reviewed and represents business as usual support that continues to be available and a guide to some of the key contacts across the district.

The Care Home Service Improvement Board (SIB) was established in 2017 following the implementation of the Residential and Nursing Framework 2016-2019. It was intended to further develop relationships between commissioners, partners and provider organisations in support of improved services and sharing of best practice. This handbook will be reviewed as part of this Board and opportunities for improved partnership working and practice sought as part of achieving the Care Home Provider List Quality Charter established 2021. We welcome new members from provider organisations, if you would like to be part of this group please contact us at CommissioningInbox@bradford.gov.uk

Topics covered in this handbook:

If you'd like to jump straight to a page listed above, try pressing Ctrl and F and type a key word or phrase into the Navigation box (e.g. Donning & Doffing) to jump straight to any mention of that key word or phrase. This handy tool can save you from having to scroll through every page of this document which can be useful when looking for specific guidance.

Summary: Suspected Coronavirus Care Pathway - Residential and Nursing Care People

Suspected Cases

Consider COVID-19 infection in a person with any of the following:

- **New continuous cough, different to usual**
- **High temperature (≥37.8°C), shivery, achy, hot to touch**
- **Loss or change to sense of smell or taste**
- **The new delta variant is presenting with headache, sore throat and runny nose etc.**

Care home people may also commonly present with non-respiratory tract symptoms, such as new onset/worsening confusion/sleepy or diarrhoea and other subtle signs of deterioration.

Record observations where possible: Date of first symptoms, Blood Pressure, Pulse respiratory rate and Temperature (refer to Thermometer instructions) – Remember to Maintain fluid intake

- **Reduce the risks of harm from COVID 19 (Delirium & Kidney Failure) by ensuring residents are supported to drink regularly**

For more support contact Immedicare using the laptop provided

Isolation for people who walk around for wellbeing (dementia, learning disabilities, autism)

Use standard operating procedures for isolating people who walk around for wellbeing ('wandering'). Behavioural interventions may be employed but physical restraint should not be used.

When caring for, or treating, a person who lacks the relevant mental capacity during the COVID-19 pandemic, please follow government guidance.

Communication with the NHS

- Local Restore2 Mini and SBARD materials are available at this link Restore2 (a deterioration and escalation tool). Where appropriate please ensure that people are offered advance care planning discussions and that their wishes are recorded.

Do you have NHS Mail?

Send emails directly to your GP, Community Team and Hospital

To get an **NHS.net email** complete this form and email it to: England DSPT North

Please register and use **Capacity Tracker** to support hospital discharge planning.

Isolate and Monitor

Person to be isolated for up to **10 days** in a single bedroom. Use Infection Control Guidance for person using PPE (guidance and how to wear and dispose). The person should take part in daily lateral flow testing from day 5 and can end isolation after receiving 2 consecutive negative tests 24 hours apart, or after 10 days' isolation. If the person refuses a follow up test on days 5 & 6, or 2 testes within 10 days that are 24 hours apart then they should isolate for the full 10 days' from when symptoms began, or from the date of the test if they did not have symptoms.

Due to sustained transmission PPE is to be used with all people. Additional PPE is required for Aerosol Generating Procedures as recommended here

Ensure the correct donning and doffing technique is used (video) Practice the 5 moments to hand hygiene here

Consider bathroom facilities. If no en-suite available.

- Designate a single bathroom for this person only / own commode in room

Record temperatures twice a day, including asymptomatic residents. Monitor oxygen saturations and observe for signs of deterioration.

PLEASE USE YOUR nhs.net ACCOUNT TO EMAIL YOUR OBSERVATIONS & ISSUES IDENTIFIED ON THE RESTORE2 MINI EVERY MORNING TO IMMEDICARE Digital.carehub@nhs.net FAO of the SUPER ROTA

An outbreak consists of 2 or more positive or clinically suspected linked cases of COVID-19, within the same setting within a 14-day period (this means where the cases are linked to each other and transmission in the care setting is likely). This applies to both staff and residents and includes PCR and lateral flow test results. In these instances, you should:

Contact: The Health Protection Team (Yorkshire and Humber)

Phone number: 0113 386 0300

Web link: Coronavirus Response Cell Yorkshire & Humber (yhphnetwork.co.uk)

Email: yorkshirehumberhpt@ukhsa.gov.uk

Update: Capacity tracker, your Local Authority and RIDDOR

How to access Personal Protective Equipment (PPE):

- Order PPE through your normal supplier.
- Contact your Local Authority or visit the Bradford Provider Zone for external suppliers.
- Guidance for Residential Care Providers

Resources and Support for Care Home Staff

- Guidance on how to work safely in care homes; COVID-19: management of staff and exposed patients or residents in health and social care settings
- COVID-19 Care Platform
- Bradford Provider Zone
- RIDDOR reporting of COVID-19
- Recognising & Responding to Deterioration – Module 1 – Softer Signs (includes RESTORE2 MINI) Module 2 – Measuring Vital Signs; Module 3 – Keeping Residents Safe Through Good Communication & Teamwork (includes SBARD)
- Care Home Staff – Malnutrition and Food First (rdash.nhs.uk); Malnutrition and Dehydration ; React to Red: Pressure Ulcer Prevention: Training Resources

Advice for care home workers concerned about a person displaying symptoms of respiratory diseases including COVID-19

- Care home staff concerned about a person who may have COVID-19 symptoms are being asked to contact Telemedicine through the laptop for fast access to urgent advice from a senior clinician.

- Before calling, record observations where possible: Date of first symptoms, blood pressure, pulse respiratory rate and temperature(refer to thermometer instructions). Please have access to any care plan, future wishes document for your person.

THINK: Telemedicine

If you are thinking of calling a 999,111 or a GP - Use Telemedicine instead

We're here 24/7 for any issue or concern

BENEFITS AND IMPROVED OUTCOMES FOR STAFF AND RESIDENTS

Timely access to clinical support and guidance 24/7

Electronic prescriptions available directly from the Immedicare Clinical Team when required as an outcome of a consultation, following a full clinical assessment

Prompt referral to other services including Urgent Community Response Teams where face-to-face Multi-Disciplinary assessments and interventions may be offered within the home

Reduction in onward referrals and hospital attendance

Sending a resident into hospital can have a detrimental effect as it can increase confusion, increase infection risks, result in delays in treatment, increase the risk of deconditioning and falls

No requirement to release staff to escort residents to hospital (90% remain at home)

Access to free virtual training for all staff in topics like Restore2, Falls, Catheter Care, Medication Support, Top to Toe assessment

You can arrange for staff training in **how to use the Telemedicine Service** by contacting your Relationship Manager, or by pressing option 5 from the call menu once you have commenced a call to "Nurses"

Remote virtual training sessions for care homes delivered by Immedicare

Training Features

Monthly virtual training sessions for registered and non registered practitioners

Post training evaluation available for delegates to submit feedback

Certificates sent to all delegates who attend training

12 x 1hr training sessions on the topics listed

- End of Life Care
- Falls
- Behavioural and Psychological Symptoms
- Catheter Care
- Diabetes
- Leg and Foot Ulcers
- Medication Support
- MSK Common Injuries
- Top to Toe Assessment
- Urinary Tract Infections
- RESTORE2
- React to Red (Pressure Ulcer Prevention)

MONTHLY TRAINING TIMETABLES WILL BE SENT TO YOUR CARE HOME EMAIL ADDRESS FROM IMMEDICARE

STARTED IN NOVEMBER

Medicines Management Training Sessions:

Virtual Training for care home staff on systems and processes in line with nationally accredited courses, to reduce the risk of medication administration errors and waste. Aim to help care home staff to support their residents to:

- Take their medicines correctly
- Avoid taking unnecessary medicines
- Reduce wastage of medicines
- Improve medicines safety

ACCESSING THE TRAINING

Click here to access the training or go to https://involve.moodlecloud.com/

You must create an account, and once you have an account you can register for the courses you'd like to attend.

For any queries relating to training, please contact acunningham@immedicare.co.uk

Telemedicine Service delivered by Immedicare

Care homes can access the telemedicine service at Airedale Hospital for new illnesses or episodes requiring on-the-day treatment. Each home has an Immedicare laptop which can be used to access the service.

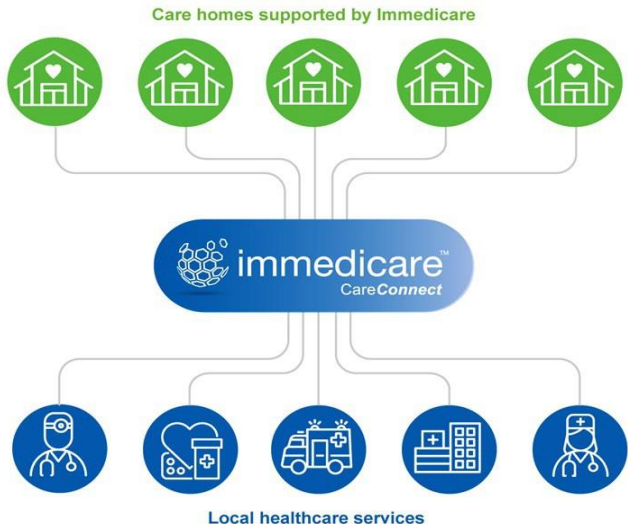
Please have the resident with you and their details ready:

- NHS number
- Full name
- Date of birth
- Care plan
- Medication sheet
- Any observations

Laptop maintenance

Keep your laptop plugged in and turned on so that you can quickly call us. Once a week restart the laptop so that any software updates can be automatically installed. A good time to do this is Sunday night, before the start of the new week.

CareConnect portal



The Immedicare CareConnect telemedicine portal allows GPs, Primary Care teams, Community teams, ED and ward teams, District Nurses, Social Care and Safeguarding teams to access all the Care Homes in their locality via a high definition, secure video link.

Care Homes should leave their telemedicine laptops turned on, plugged in and ready to accept video calls, just as they do with a telephone as this will enable easy access virtually from all health and social care professionals with access to the telemedicine portal.

To access the portal follow the instructions at this link.

The **CareConnect Portal** enables:

- GPs to do their ward rounds and virtual 'check ins'
- Community health and social care services to carry out initial assessments and/or follow up contacts
- Emergency departments to give advice
- Best practice in infection prevention and control
- Discharge Teams to initiate virtual discharge assessments with you in the Care Home

immedicare
Care. Health. Life.

Bradford District and Craven
Health and Care Partnership
ACTasONE

New Pathway for Category 3 and Category 4 999 Calls

A new pathway has been agreed with YAS where any calls received from Care Homes that are classified as **Category 3 or Category 4 will be routed from 999 to the Telemedicine Service** to see if they can support the residents and avoid an unnecessary attendance to hospital.
To cut down on handover processes and time please contact the **Telemedicine Service** before considering calling 999 unless it's clearly an emergency situation like someone is experiencing chest pain or stroke symptoms etc.

Category 3
90% in 120 minutes

Urgent Calls
e.g. non-severe burns, diabetes
In some instances patients may be treated by ambulance staff in their own home

Category 4
90% in 180 minutes

Less Urgent Calls
e.g. diarrhoea, vomiting, urine infection
In some instances patients may be given advice over the telephone or referred to another service such as a GP and Pharmacist

If you do call 999 you will need to have your laptop charged and ready for a video assessment to be carried out.
You can arrange for staff training in **how to use the Telemedicine Service** by contacting your Relationship Manager, or by pressing option 5 from the call menu once you have commenced a call to "Nurses"

Benefits of using Telemedicine as your first point of call

- Prompt referral to other services including Urgent Community Response Teams where face-to-face multi-Disciplinary assessments and interventions may be offered within the home
- Reduction in onward referrals and hospital attendance
- Sending a resident into hospital can have a detrimental effect as it can increase confusion, increase infection risks, result in delays in treatment, increase the risk of deconditioning and falls
- No requirement to release staff to escort residents to hospital (90% remain at home)

THINK: Telemedicine
If you are thinking of calling 999, 111 or a GP Could you use **Telemedicine** instead?
We're here 24/7 for any issue of concern

Gold Line

24/7 Support for people in the last year of life and those caring for them

Video call Telemedicine on your Immedicare laptop

What is Gold Line?

Goldline is a service for patients (and their families/carers) on the Gold Standards Framework who are thought to be in the last year of their life. Experienced clinicians, who also deliver the Care Home Telemedicine service (Immedicare), provide emotional and clinical support and care co-ordination, helping patients to die on their own terms in the place of their choosing.

Goldline is delivered from Airedale NHS Foundation Trust's award-winning Digital Care Hub and is underpinned by electronic record sharing. It is changing the way palliative care services are delivered – providing new levels of access and convenience for patients, families, carers and healthcare professionals.

What will happen when I call?

- Senior nurses skilled in triage, assessment and support will answer your video call via your Immedicare laptop.
- With appropriate consent from the resident the Clinical team will be able to access the patient SystmOne electronic health record.
- The team can give advice, support you, and contact other services on your behalf.
- The hub will arrange admission to hospital where necessary but hope to support more people to stay in the place they call home when safe to do so.

Who is Gold line for?

- All patients who have a GP in Bradford District and Craven with life limiting illnesses and who may be considered to be in the last year of life. They will be on, or suitable for the Gold Standards framework (GSF) a term used to signify the increased level of support they need, and the priority treatment they are given.
- Patients on chemotherapy need to call the oncology helpline before the Gold Line unless they have been fast tracked as being in last few days of life.

How do Care Home teams refer a resident for the Gold Line service?

To access Gold Line services a referral is required, even when a home already has access to the Telemedicine service. Referrals can be completed by GPs, Specialist Nurses, District Nurses, Hospital and Primary Care/Community Teams via SystmOne.

Alternatively, you can speak to a GP or district nurse, agree the details then complete a **referral form:**
https://www.airedaledigitalcare.nhs.uk/resources/referral-forms/

Then email to digital.carehub@nhs.net or post to Gold Line, Digital Care Hub (A22), Airedale NHS Foundation Trust, Skipton Road, Keighley, West Yorkshire, BD20 6TD

Resources:
Further information:
https://www.airedaledigitalcare.nhs.uk/our-services/goldline/

Medicines Management

Useful Medicines information for adult social care providers:
Click on the links for further information

Electronic medicines administration records (eMAR) in adult social care
National Patient Safety Alerts in adult social care
Working with external healthcare professionals
Medicines care plans
Appropriate use of psychotropic medicines in adult social care
Medicines administration records in adult social care
Managing seasonal influenza (flu) vaccines in care homes
High risk medicines: clozapine
Delegating medicines administration
High risk medicines: valproate

Resources
https://www.cqc.org.uk/guidance-providers/adult-social-care/medicines-information-adult-social-care-services

Medicines management training:
A range of FREE training is provided by Health Education England (HEE) and they also provide access to competency assessments for staff working in Care Homes.

The handling medicines safely for social care staff e-learning is aimed at the non-registered medicines workforce, focusing on the skills necessary to handle and administer medicines safely. If you are a care worker working in a health and social care environment, handling medicines regularly and supporting people with their medicines, either in their own home or in nursing or residential care settings, then you should find this e-learning very useful.

4 modules

1. Introduction to Handling Medicines Safety
2. Administering Medication
3. Ordering, receiving, storing and disposal of medicines
4. Understanding Medicines

Click on the link to find out more-
https://www.hee.nhs.uk/our-work/medicines-optimisation/training-non-registered-medicines-workforce

Urgent Community Response

Our Urgent Community Response (UCR) service provides a **two-hour** response to people who are at risk of admission (or re-admission) to hospital due to a 'crisis' and are likely to attend hospital within the next two to 24 hours without intervention to prevent further deterioration and to keep them safe at home. **Referring into our UCR service could avoid a hospital admission or attendance at A&E as face-to-face interventions can be delivered directly in a care home or at a person's own home.**

Across Bradford District & Craven our UCR services operate 8am-8pm 7 days across Bradford District and 24/7 across Airedale, Wharfedale and Craven.

Nursing and residential homes will need to **contact the Telemedicine Service (TMS) in the first instance** for triage/advice/support/guidance regarding referral into the UCR service and if required the TMS will refer directly into the UCR service.

Who is the UCR service for?	The UCR service is not for people who are:
• Anyone aged 18 years and over • Is living in their own home or a residential/care home setting • Registered with a GP in the Bradford district and Craven place • Experiencing a crisis which can be defined as a sudden deterioration in their health and wellbeing ○ The crisis may have been caused by a stressor event which has led to an exacerbation of an existing condition or onset of a new condition or significant deterioration in clinical state or baseline functioning • Requiring an MDT approach to support their care/support/rehabilitation needs • Able to have their health and social care needs met safely within two hours in the home setting	• Under the age of 18 years • Acutely unwell or injured, requiring emergency care intervention and an admission into an acute hospital bed • Experiencing a mental health crisis and requires referral/assessment by a specialist mental health team. • In need of acute/complex diagnostics and clinical intervention which can only be delivered in an acute hospital setting.

Types of interventions offered by the UCR service

Interventions are time limited, usually between 24-72 hours and will cover a range of elements:

- Comprehensive Geriatric Assessment
- Diagnostics point of care testing e.g., bloods, urine
- Medication review
- Medical/nursing/therapy interventions

Virtual Ward

Virtual wards (VWs) provide hospital-level care and remote monitoring for patients who would otherwise be in hospital, either by preventing admissions or allowing them to return home sooner to continue their treatment at home (including care homes).

This innovative approach is delivering high quality care safely for people in the comfort of their own home –which is often where they would rather be.

In a VW, support can include remote monitoring using apps, technology platforms, wearables and medical devices such as pulse oximeters. Support may also involve face-to-face care from multi-disciplinary teams based in the community, Multidisciplinary teams ensure people receive the best, personalised care.

We have long established VW services across both acute trust sites, and we're currently expanding our capacity across Bradford District & Craven. Our current services are:

- Bradford Teaching Hospitals Foundation Trust (BTHFT) there is an Elderly Virtual Ward (EVW).
- Airedale NHS Foundation Trust (ANHSFT) there is the Collaborative Care Teams (CCTs).

Our expanded VW service will include supporting people with wide ranging conditions.

Nursing and residential homes will need to **contact the Telemedicine Service (TMS) in the first instance** to seek triage/advice/support/guidance regarding referral into a VW service and if required the TMS can refer directly into the VW service.

Benefits of a virtual ward:

Increased **patient choice** and **personalised care**, allowing patients to be treated in a more comfortable home environment.

Caring for people in their own homes can contribute to fewer hospital-acquired infections, falls and complications.

Reduced emergency department (ED) presentations and hospital admissions through the provision of timely multidisciplinary care.

Infection Prevention and Control

Infection prevention and control platform:

During the winter time cases of all respiratory infections increase and outbreaks of respiratory infections occur more frequently in social care settings.

The information here is relevant to the prevention of spread of Covid 19 and other respiratory viruses, including influenza, Respiratory Syncytial Virus (RSV) and other common respiratory infections. The main elements of infection prevention and control as laid out in the guidance below are:

- PPE and Hand Hygiene
- Isolation
- Vaccination
- Ventilation
- Testing

Guidance:
COVID-19 supplement to the infection prevention and control resource for adult social care - GOV.UK (www.gov.uk)

General information on infection control and respiratory infection can be found in the link below:

Infection prevention and control: quick guide for care workers - GOV.UK (www.gov.uk)

PPE Guidance
COVID-19 PPE guide for adult social care services and settings - GOV.UK (www.gov.uk)

BRADFORD COUNCIL IPC TEAM
CONTACT DETAILS:
MICHAEL HORSLEY 07582 102117
DARREN FLETCHER 07582 102163

Donning & Doffing

In your care home:

Different types of PPE are worn depending on the type of work people do and the setting in which they work.

Ensure the correct donning and doffing technique is used (video)

You can also use the poster on the right.

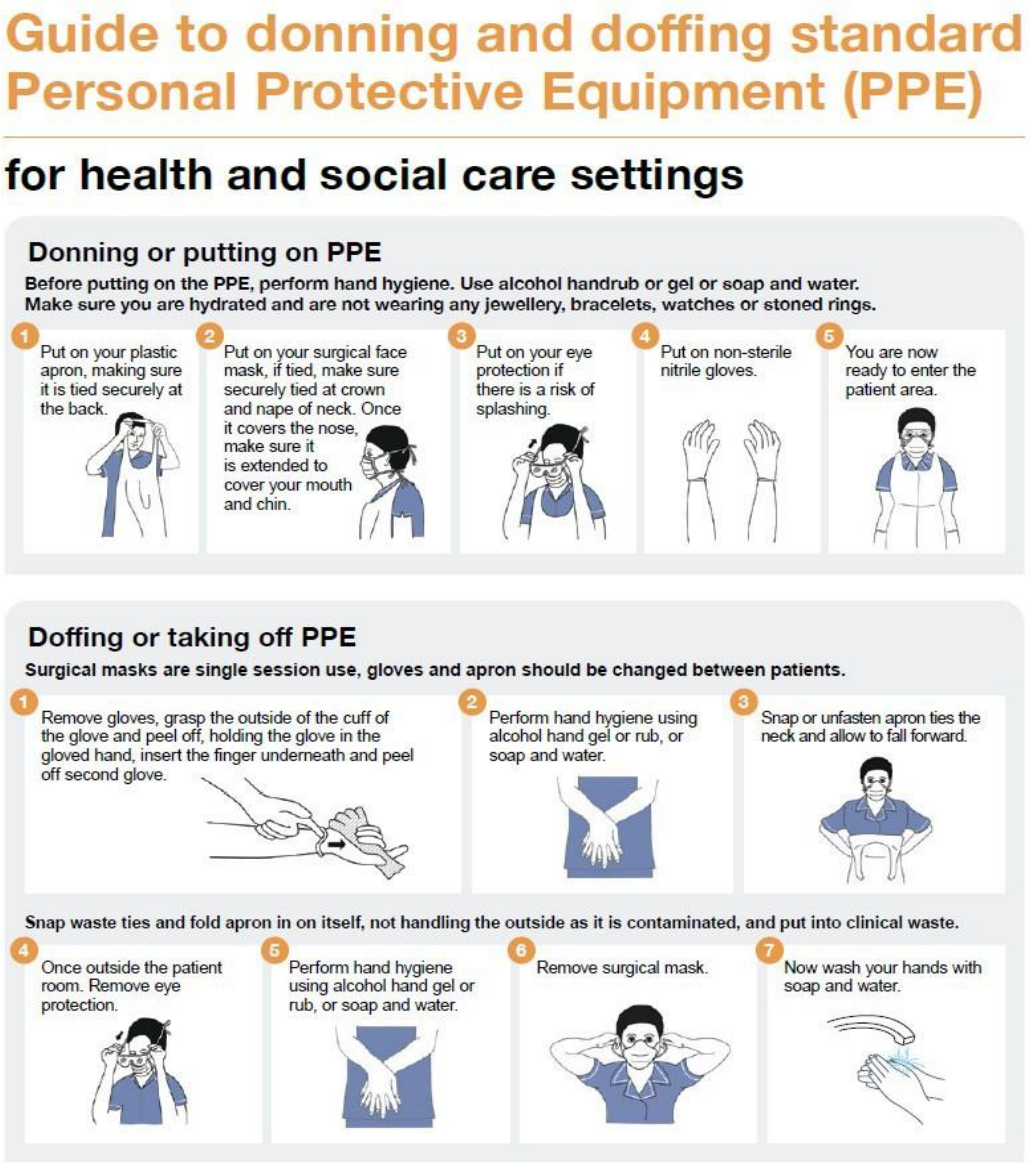
Why are people wearing different PPE?

You may see other people wearing different types of PPE, for example, paramedics, district nurses and GPs. This is because some roles will have contact with more people in different procedures and settings, who are possibly infected. In addition, there are a number of styles of PPE made by different manufacturers. You will see, for example, not all face masks will look the same.

PPE for Aerosol Generating Procedures

Some procedures require higher level of PPE due to the increased risk from the generated whilst performing the procedure. Click on the link below to access guides and videos for equipment used whilst undertaking aerosol generating procedures

COVID-19: personal protective equipment use for aerosol generating procedures - GOV.UK (www.gov.uk)



Covid-19 and Flu Vaccination

- Safe and effective vaccines are available for both Covid-19 and Influenza
- Strict approval processes mean we can be sure that the vaccine is safe and effective.
- The approved COVID-19 vaccines do not contain any animal products or egg. The Influenza vaccine is in available in an egg free format.
- Getting vaccinated means protecting yourself from the viruses so you can keep safe and be there for your family, friends and people you care for.
- There is a chance you might still get or spread coronavirus or influenza even if you have the vaccine. This means it is important to continue to follow the guidance
- The COVID-19 vaccine will not protect you against flu. All social care workers and older people should have the flu vaccination, which is free through the NHS.
- Both vaccines are given as an injection into your upper arm.
- There are no safety concerns with the vaccines in relation to women who are pregnant. Pregnancy is a recognised risk factor for severe illness in both Covid 19 and Influenza and pregnant women are on the list of those for whom vaccination is recommend. Both vaccinations can be safely given to women who are trying to get pregnant as well as those at any stage of pregnancy or those who are postnatal and breast feeding.

General COVID-19 vaccine information

Healthcare workers: A guide to the COVID-19 vaccination programme - GOV.UK (www.gov.uk)

Community languages and BSL: COVID-19 vaccination information videos in community languages and BSL

Pregnancy and breastfeeding: COVID-19 vaccination: all women of childbearing age, pregnant or breastfeeding**; Covid 19 Vaccines and Fertility**

Older adults: COVID-19 vaccination: guide for older adults

Flu and Covid vaccination advice

Flu vaccine - NHS (www.nhs.uk)

Reporting an outbreak in your care setting

WHAT TO DO IN CASE OF A RESPIRATORY OUTBREAK?

An outbreak of COVID-19 or any other respiratory infection is defined as ***two* or more people** in the care home diagnosed with symptoms compatible with Covid-19 or influenza.

Check the link below for the symptoms of Covid 19, and a printable poster on flu outbreaks:

- Coronavirus (COVID-19) symptoms in adults - NHS (www.nhs.uk)
- Influenza Outbreak Poster

If you have two or more new symptomatic people and these are the first new cases for over 28 days:

Notify outbreaks to: The Health Protection Team (Yorkshire and Humber)
Phone number: 0113 386 0300
Email: **yorkshirehumberhpt@ukhsa.gov.uk**
Web link: Coronavirus Response Cell Yorkshire & Humber (yhphnetwork.co.uk)
Inform Local Authority IPC Team and RIDDOR

Be aware that other respiratory viruses may present in similar ways to Covid 19 infections. If service users test negative for Covid consider whether it might be influenza or another respiratory virus. Consult with your linked clinician or HPT at UKHSA if you are concerned.

See slide on **PPE** for more information

Resources
COVID-19 Infection prevention and control (IPC): Guidance
British Geriatrics Society - Managing COVID-19 Pandemic in Care Homes: Guidance

Testing people and staff

Testing of people and staff, in combination with effective infection control measures, supports prevention and control of Covid-19 in care homes.

All care homes with older people and people with dementia can register for delivery of home testing kits for all staff and people, whether or not they have symptoms.

Staff are offered priority access to the tests, which is different from a member of the public requesting a test. The test involves taking a swab of the inside of a person's nose and sometimes from the back of their throat, using a long cotton bud.

The test confirms if someone currently has coronavirus.

Tests available for adult social care in England.

Ensure that you talk to and prepare the person for a test, *e.g.* easy read information, objects of reference, a demonstration video *etc*.

Carers and nurses who will be swabbing people in care homes should complete the online Care Home swabbing competency assessment, before carrying out swabbing. Register at www.genqa.org/carehomes

If you cannot access tests via the national portal, contact the Commissioning Team: Commissioning.Inbox@bradford.gov.uk as a matter of urgency who will direct you to a local supply.

Resources

Government Testing Guidance

Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk)

Think

- Are there any people who you suspect to have COVID- 19 symptoms?

Ask

- What is the latest advice on testing in care homes? This may change.

Do

If two or more people are symptomatic

- **Notify outbreaks to:** The Health Protection Team (Yorkshire and Humber)
- **Phone number:** 0113 386 0300
- **Email: yorkshirehumberhpt@ukhsa.gov.uk**
- **Web link:** Coronavirus Response Cell Yorkshire & Humber (yhphnetwork.co.uk)
- **Update: IPC and RIDDOR**

If there are no symptomatic people and for ongoing outbreaks, testing can be arranged via the DHSC portal at

Apply for coronavirus test kits - GOV.UK

or phone 0300 303 2713

Symptomatic care home staff should follow national guidance on self-isolation;

People with symptoms of a respiratory infection including COVID-19 - GOV.UK (www.gov.uk)

Outbreak testing

For Care Home testing during an outbreak of **Covid-19** please follow the testing guidance in the link below:

Care Home outbreak testing for COVID-19 flowchart: staff and residents (publishing.service.gov.uk)

Testing Regimes for outbreaks:

Day 1

- All staff and residents take PCR* and LFD tests.

Days 4 to 7

- Staff and residents take one PCR* and one LFD on one of these days.

Day 7 onwards

- No further testing until outbreak recovery testing unless individuals become symptomatic.

If an individual has had a positive PCR tests within the last 90 days, then they should test using LFD testing only. For detailed guidance on the information in the following sections please consult the guidance below:

COVID-19 supplement to the infection prevention and control resource for adult social care - GOV.UK (www.gov.uk)

Influenza testing information: https://bradford.connecttosupport.org/media/ac1f4nep/flu-testing-instructions-with-95kpa-bags-2021-v3-new-form.pdf

Influenza Testing Form: https://bradford.connecttosupport.org/media/kjtccjt2/flu-request-form_2022.pdf

Admissions to your care home

Briefly

- Prospective new admissions from the community or from another care setting should be tested no more than 72 hours prior to admission using a PCR test and tested on admission using a Lateral Flow test
- Discharges from hospital should be tested 48 hours prior to discharge using a PCR test
- Urgent admissions should be tested using a Lateral Flow test and isolated if the result is positive
- If the new admission tests positive the home can still admitted if the home can care for them safely
- Admissions who have tested positive should be isolated for up to 10 days
- They can be tested on day 5 and 6 after admission (the day of admission being day 0) and can come out of isolation once they have 2 consecutive negative results
- Admissions to the home who may have been in close contact with someone who has tested positive to Covid 19 do not have to isolate unless they develop symptoms
- Residents who have been in contact with someone in the home do not have to self- isolate unless they develop symptoms.

Admissions to hospital

During the COVID-19 pandemic, care homes are asked to continue to follow the Red Bag Hospital Transfer Pathway, by sending **all the documents associated within the pathway with the resident if they need to go into hospital** to ensure transfer of essential information continues. This includes:

- 'This is me' personalised information
- Red Bag Assessment and SBAR form to include COVID-19 status on admission
- MAR chart
- Other associated documentation as appropriate *e.g.* advance care plans.

Please **do not send the physical red bag** with **residents at this time**.

This is to prevent the red bags being a source of transmission of the coronavirus to and from the care home and hospital and reduce the risk of infection.

Social Care Visiting Guidance

Care Homes, Extra Care & Supported Living care settings reintroduction of visiting during COVID-19 pandemic.

Visiting is a central part of care home life. It is crucially important for maintaining the health, wellbeing and quality of life of residents. Visiting is also vital for family and friends to maintain contact and life-long relationships with their loved ones and contribute to their support and care.

Contact with relatives and friends is fundamental to care home residents' health and wellbeing and visiting should be encouraged. There should not normally be any restrictions to visits into or out of the care home.

The right to private and family life is a human right protected in law (Article 8 of the European Convention on Human Rights). In the event of an outbreak, each resident should be able to have one visitor at a time inside the care home. This visitor does not need to be the same person throughout the outbreak. They do not need to be a family member, and could be a volunteer or befriender.

Visitors are no longer subject to testing prior to visiting but should be advised not to visit if they have any symptoms of respiratory illness. They should be encouraged to wear a face mask whilst inside the home.

Care home residents can have visits out and do not need to isolate of test on return unless they have any symptoms of Covid19.

Visiting During an Outbreak

Visiting may be temporarily paused when and outbreak is suspected but should be re-instated following risk assessment. Residents would be allowed 1 visitor at a time inside the home. This does not need to be the same person each time.
Visitor should be advised of the potential risks to them of visiting during an on-going outbreak and supported to have contact in other ways if necessary.

Any implemented measures must be proportionate, and risk based. In specific situations, where the local or national risk assessment indicates that cases may be caused by a variant with vaccine escape potential or other concerns, additional measures may be advised.

Visiting professionals should not be required to test of provide proof of vaccination status on admission to the home. They are allowed to visit during an outbreak where the situation requires them to do so.

MCA. Visiting policies and procedure should clearly state how a provider will obtain consent & approach best interest decisions. Individuals should be supported in the least restrictive way possible within these guidelines and in line with Ethical Care Framework guidance.

MDT support - There maybe circumstances where complex best interest decisions may need to be made. Providers will be able to access support from the wider system to ensure a full MDT approach can be taken. Contact your Care Home Liaison Offer during office hours or Tele meds out of hours.

End of Life Visits - Providers should continue to support visiting at EoL as per current government guidance.

Virtual Visits - Sadly, it will not be possible for everyone to physically meet for a variety of reasons, *e.g.* shielding, ill health, proximity etc. Providers should continue to support by facilitating virtual visits. Please see NHS Technology resources available for providers. care@home newsletter 3/articles

Family & Carer support - Carers Resource are available to provide support to friends or relatives who may be struggling at this time.

Good Practice - Every providers approach to visiting will slightly differ to take in to account the needs of the people they support and the environment.

Recommendations around visits include:

- Asking each resident if they want visits, make sure they are aware of the risks. Where the individual lacks capacity to make a decision, then a best interest decision should be made by the care setting
- Care Providers may choose to develop a short individual plan for each resident
- There are no restrictions on the number of visitors that residents can have although providers will need to take into account the numbers of visitors they can safely accommodate at any one time

Effective Communication - Care providers will ensure that they communicate effectively with people and other key stakeholders in an open, transparent and accessible way about their approach to visiting. Care home staff will be expected to uphold the guidance with residents and visitors and report any breaches to the senior person on duty.

Resources:
IPC in Adult Social Care – Covid-19
https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-covid-19-supplement
Flu visiting poster (printable)
https://bradford.connecttosupport.org/media/boilccyb/flu_visitor-care-home-poster.pdf

Managing respiratory symptoms

A **new continuous cough** is one of the symptoms of COVID-19. However, coughing can continue for some time even if the person is getting better. This does not necessarily mean the person is still infectious, especially when other symptoms have settled down.

There are simple things you can do to help **relieve coughing** *e.g.* drinking honey & lemon in warm water, sucking cough drops/hard sweets, elevating the head when sleeping and avoiding smoking.

Worsening or **new breathlessness** may indicate that the person is deteriorating. However, people can also appear breathless because they are anxious, especially when they are not used to being on their own in a room, or seeing staff wearing PPE.

50% of people with mild COVID-19 take about 2 weeks to recover. People with severe COVID-19 will take longer to recover.

Resources
Supporting someone with breathlessness: Guide
Managing breathlessness towards the end of life: Guide

THINK

- Does the person look short of breath or have difficulty in breathing?
- Is this worse than the day before?
- Has the person already got an advance care plan for managing these symptoms?

ASK

- Does the person need another clinical assessment?
- Should observations or monitoring commence?

DO

- Try and reassure the person and if possible, help them to adopt a more comfortable position, *e.g.* sitting upright may help
- Consider increased monitoring
- If this is an unexpected change:
  - Contact Telemedicine through the laptop in the first instance
  - If directed by Telemedicine call the GP
  - In an emergency call 999
  - Be explicit that COVID-19 is suspected
- If this is an expected deterioration, and there is an advance care plan or ReSPECT in place:
  - Follow the care plan instructions
  - Contact Telemedicine through the laptop for further advice if needed
  - Call community palliative care team if they are already involved and further advice is needed

Supporting your people with learning disabilities

People with learning disabilities may be **at greater risk** of infection because of other health conditions or routines and/or behaviours. It is important that staff are aware of the risks to each person and reduce them as much as possible.

This will mean significant changes to the person's care and support which will require an update in their care plan. If the person needs to exercise or access to the community as part of their care plan, it is important to manage the risk and support them to remain as safe as possible.

You may need to help or remind the person to wash their hands:

- Use easy read signs in bathrooms as a reminder
- Demonstrate hand washing
- Alcohol-based hand sanitizer can be a quick alternative if they are unable to get to a sink or wash their hands easily.

People that are high risk may require shielding, which may be difficult in shared accommodation. It is important to ensure that you follow the government guidance as much as possible.

Resources

End of Life Care: guidance

VIP Hospital Passport

To monitor signs of deterioration – RESTORE2 mini

Action from learning: deaths of people with a learning disability from COVID-29 (identifying deterioration and use of RESTORE2 mini)

Bradford Hospital Visitors guidance

Government guidance on exercise

Protecting extremely vulnerable people: Government guidance

Care staff supporting adults with learning disabilities or autistic adults: Guide

To minimise the risk to people if they need to access health care services you should use supportive tools as much as possible such as a hospital passport.

If you are aware that someone is being admitted to hospital, contact your local community learning disability service or the Learning Disability Health Support Team.

Additional health support from learning disabilities community team is available here

THINK (Consider using Restore2 Tool)

- Is something different? Is the person communicating less, needing more help than usual, expressing agitation or pain (moving more or less), how is their appetite?
- Does the person need extra help to remain safe and protected?

ASK

- How can we engage the person to ensure that they understand th**e change in activities?**

DO

- **Allow time to remind the person why routines may have changed.**
- **Develop new care plans with the person and their family**

Supporting your people with learning disabilities

COMMUNITY RESOURCES

- **Social Care Referrals** – for Care Act assessments, respite services, day time activities:
  - Bradford social care – either Access point 01274 435400 or Community team learning disabilities CTLD.Frontdoorteam@bradford.gov.uk
  - Craven social care – Access point 01609 780780

- **Mental Health**
  - First Response (Tel: 0800 9521181) will support adults with learning disabilities if primary reason for referral is a mental health issue and the person's learning disability is mild

- **Bradford Teaching Hospitals** - Learning disabilities liaison nurse in post (sat in BRI Safeguarding team) Caroline Carass

- **Airedale General Hospital**
  Safeguarding adults: airedale.safeguardingadults@nhs.net Tel: 01535 292114

  Safeguarding children: airedalesafeguarding.children@nhs.net Tel: 01535 292389

- **Health support for people with LD** who struggle to access mainstream health services -
  - Health Support team based at Waddiloves and also office in Keighley and Craven. Contact Duty team on 01274 497121.

MCA / DOLS

The Mental Capacity Act has not changed. Covid presents a different situation however the same principles apply.

Best Interest decisions are personal to that individual, blanket approaches are not acceptable.

When considering best interests, this is entirely focused upon the interests of the individual and not the wider population where they live.

Clear documentation setting out what was done to undertake the capacity assessment, why, who assisted with the decision making and the outcome decision should be undertaken in every case.

For further advice, email: MCA Service
DoLS Referrals

Resources

MCA and DoLS COVID 19 guidance and summary

Supporting your people with dementia

Behaviours that care staff may find challenging are usually due to inability of people to communicate their needs or as a symptom of distress

People may behave in ways that is difficult to manage such as **walking with purpose** (wandering). Behaviour is a form of communication, often driven by need. Someone could be hungry, in pain or constipated, they might be scared or bored. Ask someone walking if there is something that they need, try activities with them and, if possible, go for a walk with them. Suggestions on supporting people with dementia who walk with purpose.

Some people **ask to go home** – this is often because people want to feel safe and secure. Talking about family that they are missing and looking at photographs can help.

People might find **personal care frightening** (it might seem like they are aggressive). Giving them time to understand what is happening, showing them the towel and cloth, encouraging them to do what they can and keeping them covered as much as possible can help

People with dementia may need help or reminders to **wash their hands**. Use signs in bathrooms as a reminder and demonstrate hand washing. Alcohol-based hand sanitizer can be a quick alternative if they cannot get to a sink or wash their hands easily.

People with dementia may find it frightening to be approached by someone wearing **PPE.** It may be helpful to laminate your name and a picture of your role and a smiley face.

If people with dementia become unwell they might get **more confused** (delirium). See the *Supporting people who are more confused than normal* page for more information.

THINK

- Is my person unwell or frightened?
- Does my person need extra help to remain safe and protected?

ASK

- Have I done all I can to understand my person's needs?
- What activities does my person like to do?

DO

- Introduce yourself, explain why you are wearing PPE
- Remind people why routines may have changed
- If your person is admitted to hospital, ensure you take the 'Red Bag' and copies of the 'This is Me' booklet

Consider

- If your person does not have a formal diagnosis of dementia, but you are sure this is happening, let the GP know at the weekly check in to arrange a diagnosis.

Resources

- SCIE Supporting people with dementia
- Meeting the needs of people with dementia living in care homes video
- Communication cards can help to talk about COVID-19
- HIN activities resources during COVID-19
- Mental Capacity Act and Deprivation of Liberty Safeguards (DoLs) COVID 19 guidance and summary
- British Geriatric Society short guide dementia and COVID-19

Supporting people who are more confused than normal

Delirium is a sudden change or worsening of mental state and behaviour. It can cause confusion, poor concentration, sleepiness, memory loss, paranoia, agitation and reduced appetite and mobility.
Delirium can be caused by infections, hospital admissions, constipation and medications.

You can help to **prevent delirium** by:

- Stimulating the mind e.g. listening to music and doing puzzles
- Physical activity, exercise and sleeping well
- Ensure hearing aids and glasses are worn
- Ensuring plenty of fluids and eating well
- Addressing issues such as pain and constipation

If you are concerned that a person has delirium contact Telemedicine through the laptop in the first instance and if directed by Telemedicine call the GP.

Delirium in people with learning disabilities may indicate a deterioration in the person's physical or mental health. Please contact the individuals lead contact to discuss any changes and seek guidance.

Reducing noise and distraction, explaining who you are and your role and providing reassurance can help. People with delirium may find PPE distressing - having your name, role and picture to show people may help.

THINK

- What can I do to help prevent my person becoming more confused than normal?
- Has my person changed – are they more confused?
- Has their behaviour changed?
- What can I do to support my person who is more confused than normal?

ASK

- The person's GP or Telemedicine for advice and guidance
- Why is my person more confused than usual?

DO

- THINK delirium
- Explain who you are and why you are wearing PPE
- Provide reassurance
- Add information on preventing new confusion to your person's care plan

Prevent it, Suspect it, Stop it.

Resources

- Delirium prevention poster
- Delirium awareness video
- Delirium and dementia video
- Time and Space Prompts to prevent delirium

Managing falls

Prevention is better than cure and continuing to implement falls prevention interventions such as strength and balance exercises is important.

To help prevent falls:

- Complete your local falls assessment and care plan
- Keep call bell and walking aid in reach of your person
- Ensure person's shoes fit well and are fastened and clothing is not dragging on the floor
- Optimise environment – reduce clutter, clear signage and have good lighting
- Ensure the person is wearing their glasses and hearing aids

People do not need to go to hospital if they appear **uninjured**, are well and are no different from their usual self. **People with learning disabilities or dementia may not be able to communicate if they are in pain or injured following a fall, take this into account when deciding on whether or not to go to hospital.**

Going to hospital can be distressing for some people. Refer to their **advance care plan/ ReSPECT form** to make sure their wishes are considered and take advice from Telemedicine and if directed by Telemedicine call the GP. Only ring 999 when someone is seriously ill or injured and their life is at risk.

Whilst waiting for an ambulance, keep your person as comfortable as possible. Offer a drink to avoid dehydration and painkillers such as paracetamol to ease discomfort - tell the ambulance staff what you have given the person.

THINK

- Is an emergency ambulance required for the person who has fallen?

ASK

- **Dietetics:** Bradford or Airedale, Wharfedale and Craven
- **Community Therapy services (preventing deconditioning):** Craven/Bingley/Keighley/Ilkley or Bradford North, South & Central
- Contact Telemedicine through the laptop and if directed by Telemedicine call the GP or community team for clinical advice and support
- Follow advice on NHS website on when to ring 999

DO

- Complete a multifactorial falls assessment (residential homes – refer to Falls prevention team via the GP for assessment and consider a strength and balance programme)
- Refer to dietetics and/or physiotherapy when indicated, especially if risk of deconditioning as a result of self-isolation/discharge from hospital
- Assess and observe, monitor for deterioration/injury following a fall
- If available and safe, use appropriate lifting equipment
- If it is unsafe to move someone who has had a fall keep them warm and reassure them until the ambulance arrives
- Ensure you have up to date moving and handling training
- Continue to implement existing falls prevention measures

Resources – prevention and falls

Greenfinches – Falls Prevention Resources
Simple set of exercises to stay active - video and a poster
Later life training you tube exercises including chair based exercises
Falls in care homes management poster
I STUMBLE falls assessment tool which is available as an app
What to do if you have a fall
Assisting someone who is uninjured up from the floor: Link
Using slide sheets in a confined space: Link
Using a hoist to move from floor to bed: Link
HSE - Moving and handling in health and social care

Mouth care

A clean healthy mouth should be fundamental to everyone's quality of life. Poor oral health can impact on a person's wellbeing, dignity, ability to eat, speak and may affect their general health.

Toothbrushing

Establishing good toothbrushing routines are important to help prevent gum disease and tooth decay. Care homes should encourage residents to:

- Brush their teeth twice a day, the most important time is last thing at night and on another occasion in the day.
- Use a small headed toothbrush with a pea sized amount of fluoride toothpaste 1350 -1500 ppm.
- Brush their teeth in a systematic way remembering to brush all surfaces of the teeth.
- If appropriate encourage spitting out the toothpaste and not to rinse with water.

Fluoride

- A higher concentration of fluoride provides better protection against tooth decay. A dental clinician may prescribe a daily use of a high fluoride toothpaste or a prescribed mouth rinse.

Diet

Care home residents can be at risk from dehydration and under-nutrition and may need a higher intake of food and drinks with sugar. Always remember that enjoyment of food is important and nutrition advice should be discussed with the care team for the individual resident if required.

Care homes should encourage residents to:

- Keep sugary snacks and drinks to mealtimes to reduce the risk of tooth decay.
- Drink plain water, tea or coffee (with no added sugar) in between meals.

Denture Care

Residents who have partial or full dentures should be provided with daily oral care.

Care homes should encourage residents to:

- Clean their dentures daily and rinse them after every meal.
- Clean all surfaces of their denture including the fitting surface and any clasps the denture may have.
- Use a specific denture cleaning paste or a fragrance-free liquid soap to the brush to remove plaque and food debris from their dentures.
- Clean their dentures over a sink with water or place a towel on the surface.
- Remove dentures at night and leave them in water, in a labelled denture pot.
- Have their dentures marked with their name.

Medication

If a resident is prescribed liquid medication, liaise with the medical practitioner to prescribe sugar free. If no sugar free alternative is available administering the medicine at mealtimes will help to reduce the risk of tooth decay.

Certain medications may impact on a resident's saliva flow which may make them higher risk for dental decay, cause oral discomfort and difficulty speaking/chewing. Advice should be sought from a dentist on how to manage these symptoms, saliva replacement medication may be required.

Mouth Care Assessments

Completing a mouth care assessment is important to identify residents that are at risk of developing problems with their health and highlighting additional support required.
A mouth care assessment and plan should be completed for every resident when they enter the care home. This will then identify if a patient is low risk or high risk for developing oral health problems.
Low risk is when the resident can independently care for their mouth and is not suffering from any condition that will increase any problems with their mouth. If a residents health status changes their plan should be reviewed every 7 days.
High risk residents should have a daily care plan completed and recorded. High risk groups include:

- Chemotherapy
- Delirium
- Dementia
- Dependant on oxygen use
- Dysphagia
- Frail
- Head and neck radiation
- ICU/HDU
- Immunosuppressant therapy
- Learning disabilities
- Nil by mouth
- Palliative care
- Refusing food or drink
- Severe mental health
- Stroke or other degenerative neurological conditions
- Unable to communicate
- Uncontrolled diabetes

Assisting residents with mouth care

Following the completion of a resident's mouth care plan, varying levels of assistance may be required. Their independence and ability to carry out their mouth care may change on a daily basis.

- If a resident requires assisted brushing, stand behind and to the side.
- A toothpaste that is non-foaming and should not contain Sodium Lauryl Sulphate (SLS) may be useful for high risk residents, in particular those with a swallow impairment.
- If a resident has reduced mobility to grip their toothbrush, adaptions can be made to the toothbrush.
- Prompting and reminding the resident may be the only requirement for toothbrushing or denture care.
- Staff should always provide reassurance when carrying out toothbrushing.

Dental Access

The Community Dental Service is a specialist service. Patients meeting specific access criteria and referred in by health professionals, are eligible for treatment. For more details visit : Dental services - Bradford, Airedale, Wharfedale, Craven - BDCT

For residents in care homes who:

- Are registered with a general dentist and are able to access their high street dentist, should continue their care with the dental practice.

- Are not registered with a general dentist and are able to access a high street dentist, should aim to register with a dental practice and/or may contact 111 if urgent dental treatment is required.

- Are unable to access care at a general dentist (e.g due to mobility issues, dementia, complex medical issues etc) may be eligible for care in the Community dental Service and can be referred if they meet the access criteria. The CDS is also able to provide domiciliary care where this is indicated for patients meeting the access criteria.

Resources

For more information on mouth care matters resources visit: https://mouthcarematters.hee.nhs.uk/links-resources/mouth-care-matters-resources-2/

Nutrition Support Guidance for People in Residential Care

Bradford District and Craven Health and Care Partnership
ACTasONE
Nutrition Support Team

Care home guidelines for good nutritional care include:

- **All residents screened for malnutrition risk using the MUST screening tool.**
- **All residents at risk of malnutrition to have appropriate malnutrition care plan in place and actioned and ongoing monitoring.**
- **All residents at risk of malnutrition supported by using a food based, nutrient dense approach.** This means offering a fortified menu and drinks to increase calories, protein and other essential nutrients using everyday foods:

  - ✓ ***A little and often approach****, for those with a small appetite*
  - ✓ ***Follow the daily 3-2-1 advice:***
    3 *Fortified meals i.e. breakfast, lunch, evening meal*
    2 *Fortified drinks i.e fortified milkshake or warm drink*
    1 *pint of fortified milk – add 4 tablespoons of dried skimmed milk powder to 1 pint whole milk, use in drinks, on cereal, sauces, puddings, soups*
  - ✓ ***Include protein at each meal.***
  - ✓ ***Try nourishing drinks and snacks*** *between meals and before bedtime.*
  - ✓ ***Avoid*** *'diet', 'light', 'low fat' options.*
  - ✓ ***Use Food Fortifiers*** *such as whole milk, milk powder, eggs, cheese, ground nuts, nut butters, butter and cream.*

Further national support and guidance, including malnutrition care plans, can be found here if you need support now:

- Managing Malnutrition: Care Homes: Care Homes Fact Sheet: The Pathway: Making Malnutrition Matter (malnutritionpathway.co.uk)
- The 'MUST' Itself (bapen.org.uk)
- The Eating and Drinking Well with Dementia Toolkit | Bournemouth University
- Dementia Education And Learning Through Simulation 2 (DEALTS2) programme | Bournemouth University

STEW
Support | Train | Eat | Well

STEW – Support and Train to Eat Well is a dietitian led service, provided by the BDC Nutrition Support Team, offering training and support to care homes within Bradford District, Airedale and Craven.

STEW Catering Course and Carers Workshops to support the care of residents at risk of malnutrition

Dietetic support for individual residents at high risk of malnutrition

Course content and resources covering malnutrition screening, care planning, food and drink fortification and texture modification, menu planning and more

Rolling programme of training for new staff and annual refresher training and competency support

If you would like to **register your interest** and receive further information please email **anhsft.bdcnst@nhs.net**

Podiatry

Podiatry is a high risk service that accepts referrals for those people whose feet could potentially ulcerate or are currently ulcerated.

Suitable referrals for Podiatry that residents may present with:

- A wound on the foot (except pressure wounds) that may need debriding and/or offloading.
- An ingrowing toe nail where there is hyper granulation tissue present at the side of the nail that is ingrowing.
- Areas of thickened callus that cannot be filed down and the patient has additional circulatory and/or sensory complications.

Who and when to refer to Podiatry:

- Any person with Diabetes that develops a new foot wound that needs debriding (except a pressure wound). The referral should be made within 24 hours.
- Any other person that develops foot wound (except a pressure wound) that needs debriding.
- An ingrowing toenail with associated hyper granulation tissue that is causing minor ulceration in the nail sulcus.
- Heavy, thickened callus that may have the potential to breakdown beneath, usually associated with a foot deformity and/or a high medical need.

How to refer to Podiatry:
Referrals can be made via a GP or Health Care Professional on SystmOne by ICDR electronic referral.

If the referral is for a Diabetic Foot ulcer that is urgent then please call admin services on the number below.

Podiatry do not offer nail cutting or general Podiatry treatments for those who are not high risk or meet the eligibility criteria.

How to contact Podiatry:
Admin services: 01274 221165
Podiatry email: Podiatry.enquiries@bdct.nhs.uk

Diabetic foot checks
Diabetic Foot checks are normally carried out on a yearly basis to educate people about how Diabetes can affect the feet, how to prevent problems developing and how to manage if a person develops complications associated with Diabetes.

What a diabetic foot check includes-

- A foot check consists of a painless test for reduced sensation in the feet and pulses are checked using a doppler to ensure there is a good blood supply to both feet.
- The feet are checked visually for callus/deformity/ulcers.
- The person will be given advice around emollient use, nail care and footwear.
- The person is then given a risk category according to the results. If any problems are identified, they can be referred onwards if appropriate. They will automatically be seen again in approximately 12 months unless they are high risk.

Low risk residents will be referred to have their foot check at their GP practice.
Newly diagnosed, moderate and high-risk residents would be referred to the community podiatry service.

The Continence Service: Supporting you and your residents with improving and managing incontinence in the care home

Our philosophy is that incontinence should not be accepted as inevitable; everyone has the right to continence where achievable.
Bladder and bowel problems are very common in people of all ages. With appropriate investigation and management most people with incontinence can be cured, improved, or provided with special products to manage the problem.

Identifying a continence problem

Before considering a referral to the continence service for assessment, it is important to consider any treatable causes of incontinence, particularly if the problems have recently started. Please consider:

- Potential signs of urine infection such as confusion or change in behaviour, pain on passing urine, discoloured or smelly urine. Always speak with a GP if concerned and exclude a urine infection
- Bowel problems such as constipation can cause problems with overflow (watery diarrhoea like stools) and this can affect the bladder. Good bowel monitoring is essential to ensure problems are dealt with as soon as possible.

Deterioration in health. If the resident has suddenly become unwell and is unable to get up to the toilet as easily or in need of support, a period of monitoring would be appropriate to establish if the person is expected to improve. Winter viruses such as norovirus can cause temporary incontinence.

Fluid advice

What a person drinks (see link below for a helpful leaflet), **when** they drink and **how** much they drink are all significant factors in addressing urinary incontinence.
Often improvements to symptoms can be made by supporting residents in following a healthy fluid regime. By completing a bladder diary, we can often provide individual advice and support as we can identify where improvements can be made.

If a person has problems at night-time with toileting (more than twice is considered abnormal), or bedwetting, consider the time they are offered their last drink. It is advisable to stop drinking 2 hours before you intend to go to sleep to allow the bladder to empty and therefore promote a good night's sleep with less disturbance from the bladder.

The Continence Service: Supporting you and your residents with improving and managing incontinence in the care home

Toileting regimes

Prompting regular toileting (average of 3-hourly for most people) can really help to prevent or reduce incontinence in residents. It is so important to ensure a care plan is in place that recognises the needs of the individual person and promotes their dignity and offers any assistance with going to the toilet if needed.

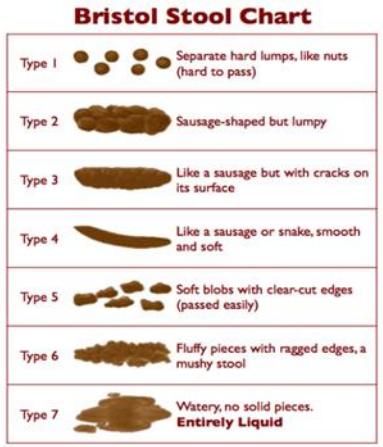
People with dementia and other cognitive difficulties

- Assess the resident's needs and set personalised times for toileting (TENA Identify or a bladder diary are helpful tools).
- Observe signs of needing to go to the toilet and help as needed. Fidgeting or becoming unsettled can be a sign.
- Maintain independence by ensuring clothes and incontinence products are easy to put on and remove, like TENA Incontinence Pants.
- Ensure resident knows the way to the toilet – clearly mark out toilet, light switch, and toilet seat.

- Leaving the toilet door open and the light on at night to make it easy to find. You could also put a commode next to the bed at night.
- Have easily accessible personal hygiene products so resident can maintain hygiene and skin health.
- Use mobility aids like a raised toilet seat and handrails.

useful link: How Alzheimer's Disease and Dementia affect continence, and how to manage it. (tena.co.uk)

Healthy bowels



It is really important to monitor the bowel habits of your residents whenever possible. This can pick up any issues in a timely manner such as constipation which may require a GP review. Along with bowel habits, stool types need to be monitored and a type 3-5 stool is considered most normal. A high fibre balanced diet and good fluid intake are essential for bowel health.

RED FLAGS: change in bowel habit, blood in stool, persistent loose stools or mucous must be reported to a GP for investigation as they can be signs of bowel cancer **

The Continence Service: Supporting you and your residents with improving and managing incontinence in the care home

Continence products and alternatives

Did you know that there are several alternative continence management options other than containment products (pads)?
The continence service will assess and support in identifying appropriate continence management options for your resident. When appropriate we may refer or advise you to refer directly to the *Nightingales Service* who can also visit you to assess your resident and provide support and training to staff on alternative systems such as sheaths for men.
It is extremely important that the pads or alternatives are managing the incontinence of the individual, to avoid breakdown in the residents' skin integrity and to ensure comfort and dignity.
Nursing Service (nightingaledelivery.co.uk)

Skin care

Moisture acquired skin damage (MASD) or incontinence associated dermatitis, is a very serious result of incontinence that is not well managed. Using **appropriate** barrier creams which protect the skin from the damaging effects of urine and faeces, can be very effective in conjunction with appropriate continence aids. It is essential to use the treatments carefully and ensure they are suitable when using continence pads. Some barrier creams can prevent the pad from absorbing urine effectively and can increase the risk of skin damage.
Click on the file below for a guide to the management of incontinence associated dermatitis used within **Bradford District Care Trust.**

Incontinence Associated Dermatit

Referring for an assessment

Help us to help you! Please ensure when you refer a patient for a continence assessment, that you complete the forms in full to avoid the referral being declined and a delay in assessment for your resident. All the information that we request is very important and ensures that we can support you in managing the continence needs of your resident in the best way possible. If you need any more help in referring, **please call us on 01274 221167.**

The Continence Service: Supporting you and your residents with improving and managing incontinence in the care home

Training and education

The Continence Service can support you in any training and education needs that you have. Please contact your link **Assistant Practitioner** (all care homes should be aware of who this is, but please call us if you are not sure) who can support you further. we also work closely with Sharon Jackson, who is our TENA representative and provides bespoke training on a variety of aspects on continence management. Sharon can be contacted by email Sharon.JACKSON@essity.com

You can also access the excellent TENA online training modules at convenient times for you and your colleagues. This package includes modules such as:

- Dementia & Incontinence
- Night care & Incontinence
- Skincare

Here is the link to access the training Online training (tena.co.uk)

Useful resources

Below are a number of useful articles and links to websites that can offer additional information and guidance:

Continence Care in Residential and Nursing Homes | British Geriatrics Society (bgs.org.uk)

NHS England » Excellence in Continence Care

How Alzheimer's Disease and Dementia affect continence, and how to manage it. (tena.co.uk)

Promoting good skin health: hands-on tips for nurses (tena.co.uk)

Nursing Service (nightingaledelivery.co.uk)

Adult Safeguarding

Safeguarding is defined as 'protecting an adult's right to live in safety, free from abuse and neglect'. Adult safeguarding is about preventing and responding to concerns of abuse, harm or neglect of adults.

If you become aware of a safeguarding issue then a Safeguarding Concern needs to be reported to Bradford Council's Safeguarding Adult's Service within 24 hours.

Action to be taken by the reporter:

*is this an adult that meets the section 42 criteria?
*gather information
*evaluate risk
*take action to safeguard the Adult (and/or others)
*establish the Adult's views, wishes and outcomes
*where required assess mental capacity and act in 'best interests'

The full arrangements for adult safeguarding are set out in the **Joint Multi-Agency Safeguarding Adults Policy and Procedure (2018)** West Yorkshire, North Yorkshire and York. This document can be accessed at: https://saferbradford.co.uk/adults/

The Care Act 2014:

Section 42(1)
where the local authority has reasonable cause to suspect that an adult in its area has
(a) needs for care and support, AND
(b) is experiencing, or is at risk of, abuse or neglect, AND
(c) as a result of their needs is unable to protect themselves

Section 42(2)
the local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether and action should be taken in the Adult's case…and, if so, by whom

To report a safeguarding concern

Complete the online form at:
https://saferbradford.co.uk/report-a-concern

Safeguarding Adults Service, 5th Floor Britannia House, Hall Ings, BD1 1HX. **01274 431077** (office hours)
Email: safeguarding.adults@bradford.gov.uk
Out of hours Emergency Duty Team 01274 431010

Airedale and Bradford Community Therapy Services

Support and advice for people in nursing and residential care homes at risk of deconditioning

Rehabilitation from occupational therapists, physiotherapists and therapy assistants

Q. What is deconditioning?

Deconditioning refers to generalised weakness or loss of strength because of lack of muscle use, which can happen due to bed rest and inactivity during hospitalisation or illness. It results in functional losses in such areas as mental acuity, strength and the ability to manage activities of daily living including walking and other activities the person enjoys.

Who can be referred to community therapy teams?
People who:

- are at high risk of falls
- have deteriorating strength and mobility
- have problems with fatigue
- are struggling to manage daily living activities they can normally do

How do I get support from a community therapy teams?
Care homes can refer directly to the team by emailing:

Craven/Bingley/Keighley/Ilkley - anhsft.communityrehab@nhs.net

Bradford - bth.ot.physionorth@nhs.net, bth.ot.physiosouth@nhs.net, bth.ot.physiocentral@nhs.net

Top tips to help people who are at risk of deconditioning:

- Aim to maintain people's current levels of ability—continue to encourage people to 'do what they can' when washing and dressing and other functional tasks.
- Encourage patients to mobilise frequently—even if it is only a few steps.
- If people are unable to mobilise, try to get them to stand on the spot and count to 10 or complete some sit to stand exercises.
- Encourage people to keep moving their arms and legs when in bed and in their chair.
- Try to set up and engage people in a simple chair-based exercise group.

Contact details:

Craven/Bingley/Keighley/Ilkley 01535 295632

Bradford North 01274 322 071
Bradford Central 01274 276 435
Bradford South 01274 366 419

Equipment, Walking aids & Wheelchairs

What care homes are expected to provide:
Care homes should have the appropriate equipment to meet the needs of residents and to provide a comfortable and safe environment. Staff should be trained to use the equipment correctly, and regular maintenance and checks should be carried out to ensure it is in good working order. This includes adequate seating, toileting aids and moving & handling equipment.

It is the care homes responsibility to arrange assessments for equipment. All types of assessments must be undertaken by a competent person who has received the appropriate training to carry it out.

Guidance on using equipment:

- Equipment should only be used by the person it was prescribed to. If equipment is no longer required, it should be returned.
- New equipment should only be issued following an individual assessment by a health or social care professional to ensure that it is appropriate and safe to use.
- It is advisable to record any pieces of equipment used by a resident in their care plan.
- Do not adjust height once it's been issued by a therapist.
- Check the weight limit for the aid if a person's situation has changed.

Visual checking of equipment
Equipment should be regularly checked to ensure that it is safe, clean, comfortable, and suitable for use by residents.

Check that equipment is not:

- ✓ Bent, Broken or corroded
- ✓ Missing screws
- ✓ Worn e.g. ferrules (rubber ends)
- ✓ Hand grips are not spilt or loose
- ✓ That all the parts are moving freely

If equipment is damaged or broken, please seek advice from the service who provided it.

The NHS and the local authority can provide certain pieces of specialist equipment following an appropriate assessment.

BACES (Bradford and Airedale Community Equipment Service | Bradford Council)
A partnership between Bradford Social Services and the NHS in Bradford and Airedale. The service provides a wide and varied range of nursing and 'aids to daily living' equipment to help support people leaving hospital following discharge, or to prevent a hospital admission. Most equipment from BACES is loaned free of charge.

Care Homes/Hospices must keep a record of BACES equipment on loan to their residents in case of any queries. Care Homes/Hospices will be liable if BACES equipment is damaged or lost.

What equipment can BACES provide?
The circumstances where BACES will provide equipment is outlined in the 'community equipment protocol care homes and hospices' please see the provider zone for further detail.

What do I do if I need new equipment?
Your resident will need a referral and assessment from a health or social care professional to access new equipment.

What do I do if the equipment is broken or no longer required?
Please contact the BACES receptionist for help and advice. The team will organise a repair or to replace equipment. If the equipment is no longer needed by the person, you must notify BACES so arrangements can be made to have it collected.

Contact details:

BACES- Bradford and Airedale Community Equipment Service

Phone: 01274 435260 **Email:** ot.stores-hds@bradford.gov.uk

Walking aids
In some circumstances the NHS can prescribe some types of walking aids for an individual resident. Speak to a health, or care professional to find out more. You might have to pay a small deposit.

Types of walking aids:

- Zimmer frames – wheeled, non-wheeled (Instructional video)
- Gutter frames
- 3 and 4 wheeled walkers
- Sticks (Instructional video)
- Elbow crutches

Wheelchairs
You will need a referral from a health professional to access this service. A therapist will initially assess a resident's suitability for a wheelchair. If appropriate a further assessment of environment, posture, body position and function will be conducted by the therapist. This is to ensure the resident receives the most appropriate mobility device for them.

- *Wheelchairs* are not intended to be sat in for prolonged periods of time. Care homes should provide adequate static chairs.

Wheelchair services **do not** provide:

- Attendant pushed wheelchairs for general use by multiple people in a care or nursing home.
- Wheelchairs for portering purposes, for example, transferring residents from room to room in a care or nursing home.
- Powered outdoor-only wheelchairs.
- Mobility scooters.

For repairs and returns please contact the numbers below:

Wheelchair Services Bradford: 01274 322555
Wheelchair services Airedale: 01535 292228

Live well and Safe Bradford
(https://equalitytogether.org.uk/get-support/live-well-safe-bradford/)
If you prefer you or your resident can purchase your own equipment and Live well and safer Bradford can help you with this. A charity that provides free and impartial advice about equipment and has equipment on site for you to see and try.

You can book an appointment on 01274 594173.

Resources:

- Guidance and support around postural management in care homes (https://accora.wistia.com/medias/us9ivrku19#content)

- Care Home equipment guidance, Royal College of Occupational Therapists (https://www.rcot.co.uk/care-homes-and-equipment)

- HSE Health and safety in care homes (https://www.hse.gov.uk/pubns/priced/hsg220.pdf)

Speech and Language Therapy

Speech and Language Therapy services for people with suspected Dysphagia or Communication Difficulties, including those with or recovering from COVID-19

What issues might be presenting?

- Difficulties with swallowing; coughing whilst eating or drinking; chest infections
- Changes to voice
- Difficulties expressing self
- Difficulties understanding

Q. Who can be referred to Speech and Language therapy (SALT)?

People where there is**:**

- Significant/new concern around eating drinking and swallowing safety
- Significant/new concern around voice quality
- Significant/new concern around communication (expressive/ receptive skills)
- Active Covid-19 OR Post Covid-19 recovery (including recent hospital discharges)
- Non-Covid conditions that can cause issues with swallowing *e.g.* COPD, Post Stroke/Head Injury, Cancer, Progressive neurological conditions, Dementia.

Questions to ask before referring:

- Has the resident been referred to SALT previously?
- Is there feeding /communication advice from SALT in place? What IDDSI levels were recommended for food and drink?
- Has the resident also been referred to a dietician?
- Are these swallowing/ communication issues new or has there been gradual onset?

How do I get support from SALT or refer a resident?
You can contact the SALT team for advice and support directly during normal working hours using the contact details below:

- **Bradford** - 01274 221166
- **Airedale, Wharfedale and Craven -** 01535 295085

GPs can refer the patient via **SystmOne**

- Bradford **IDCR SALT Adults e-referral**
- Airedale **ANHST Referral Gateway**

Referral forms are available on the Airedale website or on 01274 221166 (Bradford) and can be emailed securely to the appropriate services:

- **Bradford:** **Fax-HPK.Admin-Hub@bdct.nhs.uk**
- **Airedale : agh.therapyservicesadmin@nhs.net**

Once the referral is received it will be triaged and assigned as urgent or routine.

Using technology to work with health and care professionals

COVID-19 is changing how we access services - this is particularly relevant to care homes as many healthcare professionals can no longer visit your homes.

Through utilising digital tools, you can ensure you can continue to access advice, support and treatment for your people from a range of health and care professionals. Digital tools can help ensure information on people is sent and received securely and help facilitate remote monitoring which can support clinical decision about your people.

To effectively utilise these tools, you will need to think about the current technology you have in your organisation:

What you will need:

- Minimum 10mb broadband speed and adequate coverage across your home - click here to test your broadband speed.
- An email address, preferably NHS mail. Signing up to NHS mail is easy and allows you to share confidential information securely. To request an **NHS.net email** complete this form and email it to: England DSPT North
- A device which can be taken to the person or a confidential space.
- Good internet connectivity is key to accessing care through digital connections. To support care homes seeking to enhance their connectivity, NHSX and NHS Digital have negotiated and published on the NHSX website a range of internet connection offers with telecom companies. This is complemented by two new pieces of guidance; choosing an internet connection for your care home and how to use digital services in your care home.
- Please consider taking these opportunities to enhance connectivity in your home during this period when a strong digital connection is the route to a range of specialist, high quality clinical care.

THINK

- Do I have at least 10mb broadband speed in place for remote consultations? If you need support with increasing the Wi-Fi speed, please email England.CareHomesDigital@nhs.net
- Do I have the technology in place to take observations and share them with a healthcare professional?
- Do I have a way of sharing person information with health and social care securely? NHSmail can provide you with a secure way of securely sharing information with the system.
- Do I know how to make a remote consultation using the technology I have? E.g. Teams.

ASK

- What do I need to do to enable remote consultations?
- How do I access NHSmail?
- Can my Local Authority or CCG support me?
- How will the use of technology be resourced?

DO

- Access training resources and webinars by Digital Social Care
- Sign up for NHS.net email
- Ask your Local Authority/CCG/AHSN for support adopting new technology

Resources

Digital Social Care and telephone Helpline

YouTube video for staff using secure NHSMAIL at care home sites

MDTs and virtual consultations

These are the digital platforms that can be securely used to conduct consultations between people in care homes, GPs and other Professionals.

- **AccuRx** can be used by healthcare professionals to video call or message people.

- **Microsoft Teams** can be used for discussions with BDCFT, BTHFT and AFT as long as you use this outside of the VDI session so it does not slow down SystmOne. As you have an nhs.net account, you can also set up your own MS Teams MDT. You don't need an nhs.net account if you are dialling in to an MS Teams meeting that someone else has set up.

- **Telemedicine portal:** see page 6

- **Zoom** must only be used for meetings and not for discussing any patient confidential information.

Living Well

Living Well aims to make the healthy choice the easy choice for people in Bradford District.

Our health can be affected by choices we make and the communities where we live, work and play.

Lots of people live with long term health conditions. Our goal is to lower the cases of these often-preventable health conditions and to help people live longer, healthier lives.

If you would like more information and support to lose weight, increase physical activity or stop smoking then visit the following Living Well webpages:

The Living Well '**Choose what works for you'** weight management offer is available for people living in Bradford district.

You can choose 12 weeks' FREE membership with:

- Weight Watchers (WW)
- Slimming World

To find out more visit: Weight Management in your community? | Living Well (mylivingwell.co.uk)

Living Well Stop Smoking Support
Tel: 01274 437700
For advice and support to help people stop smoking visit:
https://mylivingwell.co.uk/smoking/support-to-quit

Living Well BEEP Exercise Referral Team
Bradford Encouraging Exercise in People (BEEP) is a free physical activity referral service that encourages people who are inactive, to become more active, with a 52-week support programme.
BEEP is also a great way for people living with long term health conditions to increase their physical activity levels and improve their health.

Your exercise referral officer will use these results to track your progress throughout the year. They will create a bespoke exercise training programme which is created specifically for you. After your consultation, you may also be offered discounted exercise options.

If you are 16 years or over, and you are currently inactive, have a long-term health condition and/or a BMI of 25 or more then ask your GP about a referral.

For more information visit: https://mylivingwell.co.uk/physical-activity/beep-bradford-encouraging-exercise-in-people or call the BEEP Team on: 01274 435388

Supporting people's health and well-being

Your role is important in helping people in your care to enjoy their daily life and take a full part in it as much as they can and is possible. When choosing activities, it is important to take in to account, the likes and preferences of your people.

Living Well and The National Centre for Sport and Exercise Medicine have produced a Guide to Staying Active and Able4Life Bradford can help you build a healthy ageing plan. For more information on looking after yourself, living a healthy lifestyle and focussing on what you can do, rather than things you can't, take a look at our Self Care resources.

Some of your people may have lost friends that they live with, care staff or family. At a Loss recommends speaking to the bereaved or offering help, listening (ask, don't give solutions), showering them with good things, ensuring others do too, and keeping it up.

Cruse Bereavement Services also recommends ways to support someone who is grieving. Be honest. Acknowledge the news by sharing your condolences, saying how sorry you are that their friend or relative has died. Share your thoughts about the person who died (if appropriate), tell your friend or relative how much the person will be missed and that you are thinking of them.
Remind them that you are there for them, as much as you can be.

THINK

- How it can feel when you have nothing to do all day or nobody to talk to
- How can I engage my person in activities they like and enjoy?
- How can I enable and support people to make video calls?

ASK

- "What do you enjoy?", "what do you like to do?"
- Family members about their loved one's preferences
- Check the care plan to learn more about your person's family and social history
- Can the Local Authority and CCG support us?

DO

- Use the NHS live well resources
- Make activities fun and engaging

Resources

Physical activity for adults and older adults poster
Simple set of exercises to stay active - video and a poster
Later life training you tube exercises including chair based exercises
Relatives & People's Association helpline
At a Loss tips to help someone bereaved at this time here
Cruse Bereavement Services – what to say when someone is grieving here.
Death & Grieving in Care Homes during COVID-19: Guidance

Talking to relatives

Conversations with relatives about health issues can be challenging.

THINK

- What information do I need to tell the relative?
- How can I keep the language simple?

ASK

- If the relative is ok to talk
- What the relative already understands about their loved one
- If they have any questions or need any other advice or support

DO

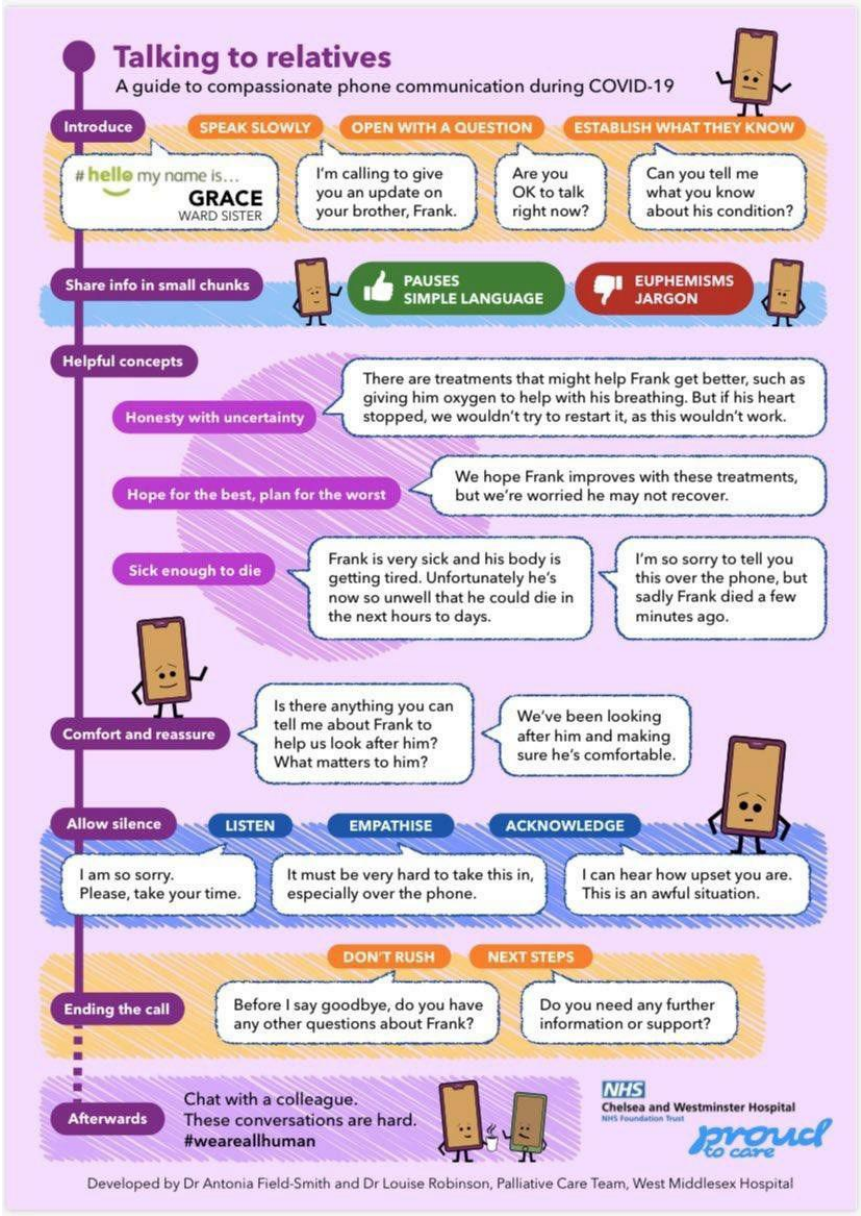
- Introduce yourself
- Comfort and reassure
- Allow for silence
- Talk to colleagues afterwards

Resources using Covid-19 as an example

Real Talk evidence based advice about difficult conversations

Health Education England materials and films to support staff through difficult conversations arising from COVID-19.

How we are keeping you safe and how to help us keep you safe



Advance Care Planning ‘My future wishes’ and ReSPECT

Open and sympathetic communication with people and those important to them enables care wishes to be expressed. It is important that people do not feel pressurised in to such conversations and decisions before they are ready.

Advance care planning discussions should be documented so that urgent care services can view the person’s wishes.

Some residents will also have an Emergency Care Plan or ReSPECT documents detailing their wishes in an emergency. If a ReSPECT form is in place that says a patient is not for resuscitation, a separate DNACPR form is not required.

People can start their own plan with family or staff support. That initiated work is then checked, edited and signed off by an appropriate health care professional making it visible to all appropriate users including Urgent Care Services. ReSPECT and DNACPR are a small part of general Advance Care Plans and are clinical documents. Patients and families should have the ability to talk to clinicians about their wishes, though these can be started by the home.GP practices are responsible for completing the forms and adding it to the patient records. Alternatively, Nursing Homes can register to use CMC directly.

THINK

- Does the person have an Advance Care Plan?
- If not, could the person with support start a plan?

ASK

- The person if they would like to talk about their wishes and preferences if they become unwell. Involve those who matter to them in conversations
- The person if their advance care planning discussions can be shared

DO

- Help people (that wish) to complete an Advance Care Plan
- Work with the person and GP/community nurses/palliative care teams to develop, review and share plans.

Resources

- Further Information about ReSPECT click here
- Short 2 minute Video on ReSPECT
- One-hour recorded training session, delivered by the education hub leads from St Gemma’s Hospice in Leeds and Wakefield Hospice: https://vimeo.com/421448975
- ReSPECT and you – planning together
- ReSPECT information leaflet
- My future wishes, supporting slide pack
- A guide to Advance Care Planning: here
- My Future Wishes Conversation Starter Pack – tool to enable people with any long term health condition to discuss and plan future wishes here

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)

Resuscitation and DNACPR

What is Cardio Pulmonary Resuscitation (CPR)?

CPR was introduced in the 1960s as a medical treatment to try to re-start the heart when people suffer a sudden cardiac arrest from a heart attack from which they would otherwise make a good recovery. Since then, attempts at CPR have become more widespread in other clinical situations.

CPR involves chest compressions, delivery of high-voltage electric shocks across the chest, attempts to ventilate the lungs and injection of drugs. The likelihood of recovery varies greatly according to individual circumstances; the average proportion of people who survive following CPR is relatively low.

- Out of hospital arrests < 1 in 10 survive
- In hospital arrests success 1 in 5 survive to discharge
- Features associated with almost no chance of success are advanced cancer, gross frailty, multiple co-morbidities, multi-organ failure

Therefore, CPR is started if there is a realistic expectation of it being successful and if there is no valid Do Not attempt Cardio Pulmonary Resuscitation

What is Do Not Attempt Cardio Pulmonary Resuscitation?

When cardiac arrest occurs and we do not attempt to restart the heart but allow a natural death.

It should be noted that DNACPR does not mean that other appropriate and sometimes invasive treatments are not given e.g. painkillers, antibiotics, drugs for symptom control, feeding or hydration (by any route), investigations and treatment of a reversible condition

A DNACPR can be put in place where:

- A patient with capacity declines CPR
- A clinician considers that attempting resuscitation is likely to be futile (i.e. it will not work); and/or
- It is not in the patient's best interests (for example because they are unlikely to have a good quality of life even if resuscitation is successful).
- The decision as to whether CPR should be attempted is a medical decision and can only be made by a clinician. It cannot be overridden by a patient or a family member, even someone with legal power of attorney for health and welfare.

DNACPR and RESPECT forms

ReSPECT forms include instructions about attempting resuscitation and so a separate 'DNAR form' is not required.

If a resident has an old DNAR form that is fine and still stands until a ReSPECT form is put in place

Supporting care in the last days of life

Some people will have expressed their wishes to not go to hospital and to stay at the care home and be made as comfortable as possible when they are dying.

A family member is able to **visit their relative** who is dying. If they are unable to visit, they can be supported to connect using technology.

Common symptoms at the end of life are fever, cough, breathlessness, confusion, agitation and pain. People are often sleepier, agitated and can lose their desire to eat and drink.

Breathing can sound noisy when someone is dying – due to secretions, medicine can be given to help.

Some people can become agitated or distressed when dying – provide reassurance and things the person would find comforting
e.g. music.

PALLIATIVE CARE PHARMACIES

Opening times for pharmacies stocking a full range of palliative care drugs are at this link

Palliative Care drugs list

Resources
Guidance on visitors for people in their last days of life:
Guide End of Life Care: Support during COVID-19: Guide
Key to care: End of life care
Royal College of GPs COVID: End of Life Care in community
NICE COVID-19 rapid guidelines managing symptoms in community

THINK

- Have we contacted the family?
- Does the person have an Advance Care Plan / ReSPECT? – What are the people's wishes and preferences?
- Does the person have a valid DNACPR form or a ReSPECT form detailing a DNACPR decision?
- Do I know how to contact Telemedicine in the last hours and to verify death?

DO

- We have the medication needed to help relieve symptoms (e.g. pain, nausea, breathlessness)?
- Can I make the person more comfortable - are they in pain (look or grimacing), are they anxious (can make breathlessness worse)?
- Can I use a cool flannel around face to help with fever and breathlessness?
- Sitting up in bed and opening a window can also help. Portable fans are **not recommended**
- If the person can still swallow, honey and lemon in warm water, or sucking hard sweets can help with coughing
- If having a full wash is too disruptive, washing hands face and bottom can feel refreshing
- Have the laptop on charge for a swift response from Telemedicine

ASK

- The family and person if they want to connect using technology
- The GP or palliative care team or Telemedicine if urgent for advice about symptom control and medication
- Ask the District Nurse to register any Anticipatory Medications as soon as they are prescribed by a GP (for Residential Homes)
- GPs and Palliative Care Team are available for urgent support

Verification of Death

Background
During the Covid pandemic Bradford district and Craven place developed a pathway to support the Verification of Expected Death (VOED) in the community setting. This update relates to Care Homes (CHs) and expected deaths only.

- Expected death is the result of an acute or gradual deterioration in the patient's health and often due to advanced disease and/or terminal illness.
- Sudden or Unexpected Death that is not anticipated or related to a known illness that has been previously identified.

Current position
Any Care Home that has staff that feel comfortable, confident, and able to verify death can continue to do so by following the previously issued procedure/local guidance.

Future consideration
In January 2023 we have established a new working group to review all elements within the Enhanced Health in Care Homes (EHCH) framework. This will include end of life care so we will include VOED within the scoping discussions to understand if any further actions are required during 2023 to further implement this and widen the coverage of VOED across our place.

Important to note

1. VOED is not a mandatory or contractual requirement for Care Home staff to undertake.
2. Care Homes may choose to deliver this task if they have staff that feel confident and competent to do this and this may change dependent upon which staff are on duty.
3. Care Home staff MUST not be pressured into verifying death if they don’t feel confident and competent to do this.

What is an Expected Death?

- An expected death is the result of **acute or gradual deterioration in the persons health and often due to advanced disease and terminal illness**. For example, a person having an expecteddeath due to metastatic cancer, advanced dementia or severe frailty.

Call the Telemedicine Service 24/7

Recognising when not to assist with remote verification of death:

- If you or your staff member do not feel competent or comfortable to help the Telemedicine Nurse verify the death – remember no one should feel pressured to help with this
- If you are unsure whether remote verification is suitable, please discuss with the Telemedicine Service which is available 24/7. Remote verification is not always possible if:
  - the death is notifiable to the coroner's office
  - the person has not been seen by a health care professional in the last 28 days (extended from 14 days during COVID-19 pandemic)
  - If the death is unexpected or sudden
- If anything about the death seems suspicious e.g., an actual or potential safeguarding situation or criminal activity please call 999

What is an Unexpected Death?

- These are deaths where the resident has **died suddenly or without the cause being expected** due to illness, or where the cause is unknown.
- This will include all cases where the death may be due to accident, apparent suicide, violent act and any other death that is not medically expected
- The GP will lead this process and the coroner will need to be notified

During core hours (Mon-Fri 8am to 6pm) call the person's registered GP

Outside of core GP practice hours (Mon-Fri 6pm to 8am and weekends): call the out of hours GP service & please contact the regular GP practice the next working day

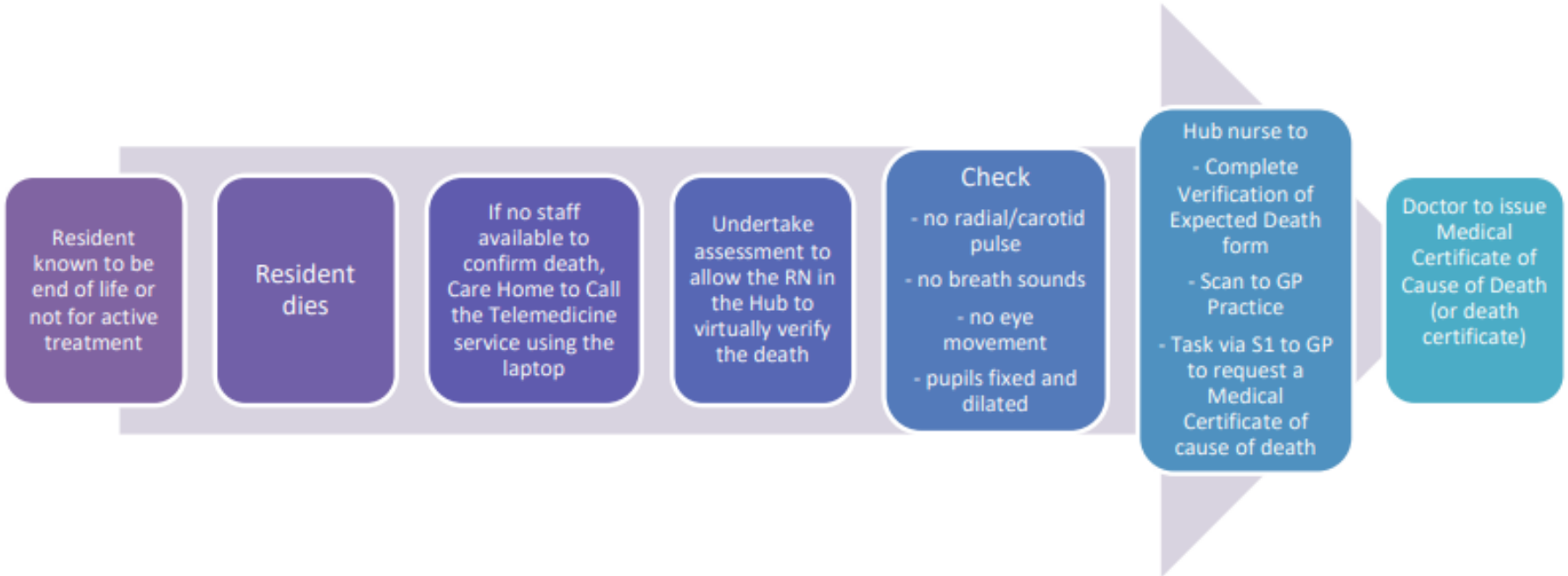
If suspicious circumstances ring 999

How to obtain remote support:

- Call the Telemedicine Service 24/7

Equipment you will need to verify death:

- Pen
- Immedicare laptop
- Light – a pen torch (or use the torch on your phone)
- PPE
- Bag to dispose of PPE (follow universal precautions)



Process of verification

Check the identity of the person – for example photo ID.

Record the full name, date of birth, address, NHS number and ideally, next of kin details.

The time of death is recorded as the time at which verification criteria are fulfilled.

Record who was present at the time of death

Record the Funeral Director if known

Care after death – using PPE and IPC

Following Verification of Death, care after death must be performed according to the wishes of the deceased as far as reasonably possible. The deceased should be transferred to the mortuary/funeral directors as soon as practicable. PHE guidance on the care of the deceased with suspected or confirmed coronavirus must be followed. Click on this link for more information.

- PPE should be used, consisting of disposable plastic apron, disposable plastic gloves and a fluid-resistant surgical mask. Click on this link for more information

- If there are any concerns about respiratory infection, ensure that all people maintain a distance of at least two metres, or are in another room from the deceased person and avoid all non- essential staff contact with the deceased to minimise risk of exposure.

- You should follow the usual processes for dealing with a death in your care home, ensuring that infection prevention and control measures are implemented.

- Staff in care home settings are requested to inform those who are handling the deceased when a death is suspected or confirmed to be COVID-19 or other known infection as required. This information will inform management of the infection risk.

Supporting care home staff well-being

Supporting vulnerable adults can affect us all in many ways: **physically**, **emotionally**, **socially** and **psychologically**. It is a normal reaction to a very abnormal set of circumstances. **It is okay not to be okay** and it is by no means a reflection that you cannot do your job or that you are weak. Some people may have some positive experiences, such as taking pride in the work, or your work may provide you with a sense of purpose. Managing your emotional well-being right now is as important as managing your physical health. If you are concerned about your mental health, your GP is always a good place to start. If it is outside of working hours, contact Our Frontline which offers **round-the-clock one-to-one support, by call or text**, from trained volunteers, plus **resources, tips and ideas to look after your mental health** or if you are known to services, please call the service responsible for your care.

Below are some things to consider to support your own wellbeing:

- These times are temporary and things will get better. Consider and acknowledge how you are feeling and coping, reflecting on your own needs and limits
- Ask for help if you are struggling. Asking for help when times are difficult is a sign of strength
- Stay connected with colleagues, managers, friends and family. Where possible do check on the needs of colleagues and loved ones
- A lot of things might feel out of your control at the moment. It can help to focus on what we can control rather than what we cannot
- Acknowledge that what you and your team are doing matters. You are doing a great job!
- Choose an action that signals the end of your shift and try to rest and recharge when you are home

TO SPEAK TO SOMEONE:

- Our Frontline support for **healthcare workers** to talk by text, **text FRONTLINE to 85258** any time. To talk by phone for free, **call 0800 069 6222** from 7am to 11pm if you're in England, or **call 116 123** any time if you're elsewhere in the UK. Support for **social care workers** to talk by text, **text FRONTLINE to 85258** any time. To talk by phone, **call 0300 131 7000** from 7am to 11pm if you're in England, or **call 116 123** any time if you're elsewhere in the UK.
- Visit **Bereavement Support Online** or call the free confidential bereavement support line (Hospice UK), on **0300 303 4434,** 8am – 8pm
- **NHS Psychological therapy (IAPT):** Search here to find out how to get access to NHS psychological therapy (IAPT)
- **Finances:** If you are financially effected by COVID-19, access the Money Advice Service web-chat or **call 0800 138 1677**, from www.moneyadviceservice.org.uk

See next slide for more resources

Staff mental health and emotional well-being

EVIDENCE-BASED APPS AND PERSONALISED ONLINETOOLS:

- **Worry and anxiety:** The free Daylight phone app teaches you to manage worry and anxiety by offering audio-led guidance tailored to you
- **Sleep:** Sleepio is a highly personalised free digital sleep-improvement program which helps you get to the root of poor sleep
- **Substance misuse:** Breaking Free is an evidence-based digital treatment and recovery programme that allows users to recognise and address the issues that are driving their use of alcohol and/or drugs.

WORK, HEALTH AND WELLBEING:

- **Welcome to our new Health and Wellbeing Virtual Hub**. The Health and Wellbeing Virtual Hub has been developed in collaboration with our partners, for everyone working in the health and social care sector across Bradford District and Craven. Our workforce - Bradford District & Craven Health & Care Partnership (bdcpartnership.co.uk). This resource has been put together to signpost our workforce to the best practice health and wellbeing resources and support, which is accessible to all our health and care colleagues.
- **West Yorkshire & Harrogate Workforce Health and Wellbeing** find support all areas of life, care, and work for Yourself, Team and Others
- **Self-Care Resources** for looking after yourself, living a healthy lifestyle and focusing on what you can do, rather than things you can't
- **Going Home checklist:** Find simple steps to help you manage your own wellbeing at the end of each working shift in this video
- **Support and resources for BAME staff and communities**
- **Preventing work related stress:** Use Health and Safety Executive's talking toolkit for preventing work related stress here
- **Mental Health and Psychosocial Support** for Staff, Volunteers and Communities in an Outbreak of Novel Coronavirus': Guidance from the British Red Cross for staff, volunteers and communities. Can be found here
- **Mental Health at work:** Information and resources for managers on taking care of your staff. Learn how to support your staff here
- **Anxiety and worry:** Access the guide to managing worry and anxiety amidst uncertainty from Practitioner Health (Psychology Tools) here
- **Skills for Care – Support for Registered Managers**
- **Getting through a difficult day**
- **BDCT Psychological Helpline**
- **Postcard of Resources** **and** **Kindness**
- **Queen's Nursing Institute listening service for registered nurses**
- **Recovering from COVID– 19 Support for staff - Primary Care Wellbeing Service**
- **The Cellar Trust Training** **and** **Website Link**

FURTHER RESOURCES:

- **The stigma of COVID-19** can cause distress and isolation. Learn how to fight it here
- Building your own resilience, health and wellbeing website is a resource from Skills for Care
- **Reflective debrief after a death:** Support carers to take time grieving and reflecting together about the person that has passed away, what happened leading up to the death, what went well, and what didn't go so well, what could have been done differently, and what needs to change as a result of the reflection. Resource from 'What's Best for Lily' by UCL Partners. Find out how to do this by downloading resources here.
- **Care Workforce COVID-19 app:** Get information and advice, swap learning and ideas, and access practical resources on looking after your own health and wellbeing. Signup here or download the app using an Apple or Android phone.
- For access to more tips, free guides, assessments and signposted resources, visit Good Thinking

Beat the Heat: Keep your residents hydrated and avoid dehydration and acute kidney injury during hot weather

Summer is here and we are all enjoying the hot weather but it's also important to maintain hydration levels to ensure our health and wellbeing. This is especially true for frail, elderly people in hospitals or living in a care home and it is important that residents are supported to keep safe and well during the hot weather.

Over the last few days of hot weather we have started to see a few admissions in Elderly Care Wards primarily due to a **degree of dehydration** and **acute kidney injury** (AKI) often presenting as **falls, generally 'off legs' and confusion**.

This has mainly been patients from residential and nursing homes. All of the residents seem to be on varying doses of diuretics (Furosemide, Bendroflumethiazide etc.) or ACE inhibitors (Ramipril, Enalapril etc.).

Any resident with **any inter-current illness**- for example D&V, a UTI, chest infection, recent fall or reduced mobility is particularly susceptible and may develop **Dehydration and AKI**

Please can we ask:
If you have any residents who are off colour and especially those on diuretics and ACE inhibitors Alert Immedicare (telemedicine) or Your GP practice at the weekly check in,
who may consider reducing or stopping these medications for a few days

You may find the below resources useful to **raise awareness with your staff and to also ensure that as a provider that you have the mechanisms in place to promote hydration for your residents (and staff)**:

- I-Hydrate | University of West London (uwl.ac.uk)
- Hydration at Home (wessexahsn.org.uk)
- GULP DEHYDRATION RISK SCREENING TOOL.pdf (lscft.nhs.uk)
- Lancashire and South Cumbria NHS Foundation Trust | GULP Assessment (lscft.nhs.uk)

Change Log last update: 10/10/2023

Description of change(s) & page heading	Name & Date
Disclaimer added to page 1 (no page heading)	Matty Clark, Lou Bilenko, Deborah Green – 08/02/23
Verification of Death pages added to document, included within contents page.	Matty Clark, Lou Bilenko, Deborah Green – 15/02/23
Updated IPC guidance for isolation on the Suspected Coronavirus pathway	Matty Clark, Darren Fletcher – 15/02/23
Removal of “(see pages 2-3)” in Verification of Death section	Matty Clark, Lou Bilenko, Louise Keighley – 16/02/23
Added Nutrition Support Guidance for People in Residential Care page	Matty Clark, Lou Bilenko, Louise Keighley – 15/03/23
Added additional mouth care pages to the Mouth Care section	Matty Clark, Lou Bilenko, Sharon Walker – 12/04/23
Updated Managing Falls wording	Matty Clark, Lou Bilenko, Kate Hilditch – 03/07/23
Replaced Mouth Care section with new up-to-date content	Matty Clark, Lou Bilenko, Kate Hilditch – 03/07/23
Replaced Podiatry section with new up-to-date content	Matty Clark, Lou Bilenko, Kate Hilditch – 03/07/23
Added Medicines Management section	Matty Clark, Lou Bilenko, Kate Hilditch – 03/07/23
Added Living Well section	Matty Clark, Lou Bilenko, Kate Hilditch – 03/07/23
Added Goldline section	Matty Clark, Kate Hilditch – 11/07/23
Updated CRT contact details on ‘Airedale and Bradford Community Therapy Services’ & ‘Managing Falls’	Kate Hilditch- 15/09/23

Change Log last update: --/--/----

Description of change(s) & page heading	Name & Date
Replaced Nutrition support guidance for people in residential care with new up-to date content	Kate Hilditch- 10/10/23.
Added Equipment Walking & Wheelchairs	Kate Hilditch -10/10/23

Glossary

AGP	Aerosol Generating Procedures
AHSN	Academic Heath Service Network
AIA	Access Information Adviser
ANHSFT	Airedale NHS Foundation Trust
BDCFT	Bradford District Care NHS Foundation Trust
BTHFT	Bradford Teaching Hospitals NHS Foundation Trust
BRI	Bradford Royal Infirmary
CCG	Clinical Commissioning Group
CCT	Collaborative Care Teams
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease 2019
CTLD	Community Team Learning Disabilities
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
DoLS	Deprivation of Liberty Safeguards
EoL	End of Life
EVW	Elderly Virtual Ward
GP	General Practitioner
HSE	Health and Safety Executive
ICE	Requesting Pathology / Microbiology Tests IT System
IDDSI	International Dysphagia Diet Standardisation Initiative
IPC	Infection Prevention and Control
LA	Local Authority
LD	Learning Disabilities
LeDeR	Learning Disability Mortality (Death) Review Programme
Mb	Megabytes
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
NHS	National Health Service
NHSE	National Health Service England
NHSX	A joint unit driving the digital transformation of care
PHE	Public Health England
PPE	Personal Protective Equipment
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulation 2013
RNVoEAD	Registered Nurse Verification of Expected Adult Death
SALT	Speech and Language Therapist/Therapy
SBAR	Situation, Background, Assessment, Recommendation Communication Tool
UCL Partners	A partnership of world leading academic and clinical research centres, NHS organisations, industry, people and others
VOC	Variant of concern