Care Home Provider Handbook

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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

THINK: Telemedicine

Immedicare
Here for you

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 or concern

- Falls
- Behavioural issues
- Medication advice
- Flu-like illness
- Swallowing difficulties
- General pain management
- Suspected infections
- Seizures/ drowsiness
- General deterioration
- Abdominal pain

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".

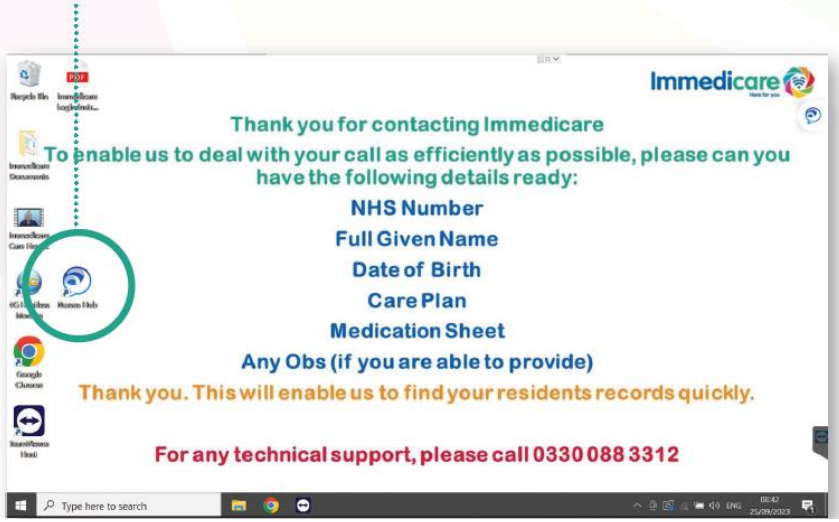
How to use Telemedicine

Immedicare
Here for you

Ensure your care home laptop is fully charged and staff know where to find it when needed.

Step 1

To make a call, click the Nurses Hub icon on your deskop

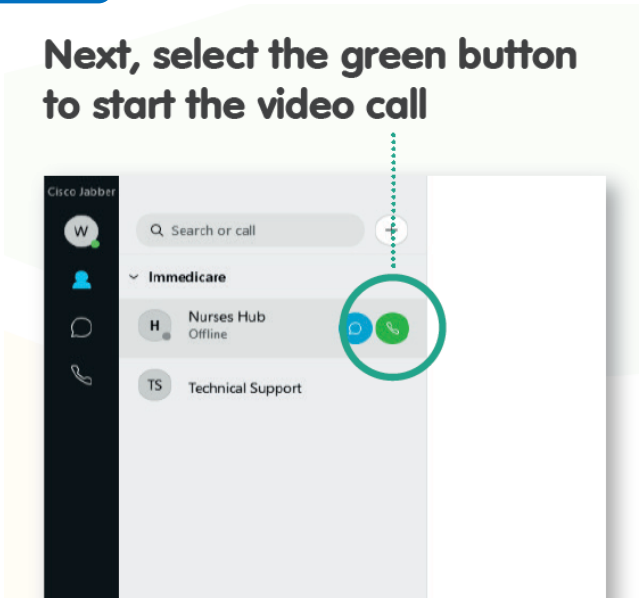


Please have the resident with you and their details ready:

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

Step 2

Next, select the green button to start the video call



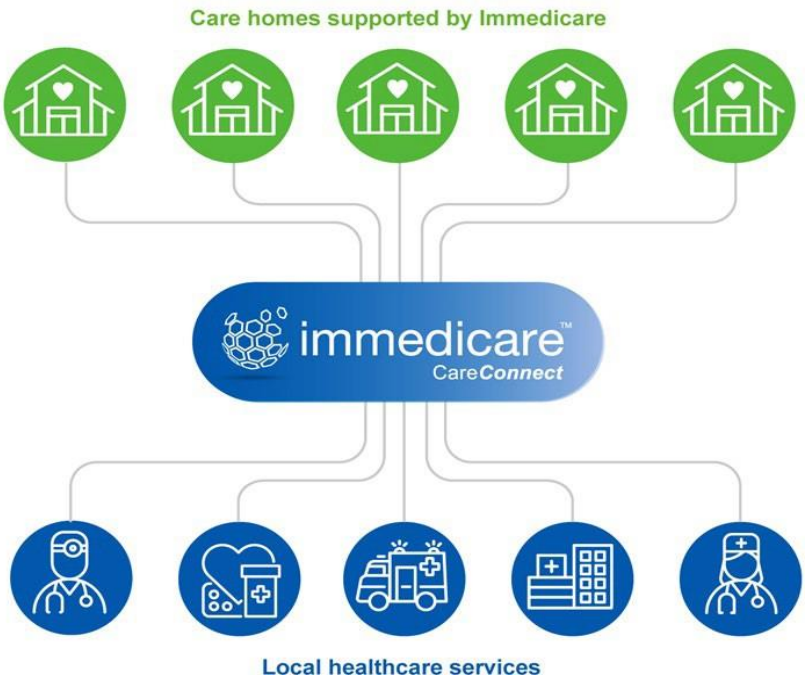
Laptop maintenance

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.

For technical support please call:
0330 088 3312

Care Connect Portal

The Immedicare Care Connect 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 **Care Connect 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.

Telemedicine pathway: Category 3 & 4 999 calls

Immedicare
Here for you

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 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.

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

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?

- ✓ 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/rehabilitation needs.
- ✓ Able to have their health and social care needs met safely within two hours in the home setting.

The UCR service is not for people who are:

1. Under the age of 18 years
2. Acutely unwell or injured, requiring emergency care intervention and an admission into an acute hospital bed.
3. Experiencing a mental health crisis and requires referral/assessment by a specialist mental health team.
4. 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.
- Prescription and/or administration of medication for pain or symptoms relief
- Catheter care to relieve immediate discomfort.
- Medication review
- Social care support (BEST)
- Intravenous (IV) therapy

Virtual Wards

Virtual Wards
Happy Healthy at Home

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.

Resources:

Further information: https://bdcpartnership.co.uk/virtualwards/

Telemedicine virtual training

Immedicare Here for you

Remote virtual training sessions for care homes delivered by Immedicare

Training Features

- Monthly Virtual Training Sessions for registered and non-practitioners
- Post training evaluation available for delegates to submit feedback on the sessions.
- Certificate sent to all delegates who complete a session.
- 12 1-hour monthly sessions on the topics listed.

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

STARTED IN NOVEMBER 2022

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

Topics:

- 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)

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.

Goldline

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 Goldline?

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 Goldline for?

- All patients who have a GP in Bradford district and Carven 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 Goldline unless they have been fast tracked as being in the 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.

Contact details:

Always use your Telemedicine laptop in the first instance.
01535 292 768
digital.carehub@nhs.net
Gold Line, Digital Care Hub, Office block, Building 17, Airedale NHS Foundation Trust, Skipton Road, Keighley, West Yorkshire, BD20 6TD.

Resources:

Further information: https://www.airedale-trust.nhs.uk/service/digital-care-hub/goldline/

Advanced Care Planning

Supporting ReSPECT conversations

What is ReSPECT?

Recommended Summary Plans for Emergency Care and Treatment (ReSPECT)

ReSPECT aims to promote shared decision making between people and clinical teams regarding recommendations for emergency treatment, including Cardiopulmonary Resuscitation (CPR), and treatment escalation, alongside non-clinical preferences such as Preferred Place of Death.

The ReSPECT form allows for recommendations to be summarised and shared across the Bradford district & Craven Health Care Partnership (BD&C HCP) so that the transfer of patients between services does not compromise dignity, quality of care or patient choice.

What can Care Homes do to support the ReSPECT process?

Only those who have completed the relevant training and competencies are able to complete ReSPECT plans, but Care Home staff can support by prompting the conversation, referring to professionals to complete, sharing with health care professionals coming into the Care Home and ensuring plans are regularly reviewed and updated.

Care Homes can play a valuable role in the ReSPECT process by encouraging and initiating conversations when a person is admitted and as part of the Advanced Care Planning process.

What does a ReSPECT conversation involve?

ReSPECT conversation(s) aim firstly to establish shared agreement about the person's important health and care problems and needs, and the ways in which these could change in an emergency. The person's preferences for their future care and treatment in any such emergency are the next key part of the discussion. This is followed by agreeing and recording recommendations that are realistic and could help the person achieve their goals of care.

Should all people in a nursing or residential care home have ReSPECT conversations and a plan?

Ideally most, and possibly all, care home residents should be offered the opportunity to have a ReSPECT conversation and develop a plan.

Residents should not be coerced into having a ReSPECT conversation and/or plan if they make an informed choice not to do so. It is good practice to involve family in a conversation, so they understand the decision-making process. This is essential if the person does not have the mental capacity to make decisions.

When should a ReSPECT plan be reviewed?

ReSPECT plans should be reviewed regularly. Below are some examples of when the opportunity would arise to engage a resident in a ReSPECT conversation (either to develop a new plan or to review one that's in place):

- **When a resident is discharged from hospital (either a new resident or an existing resident returning to the Care Home)**
- **During GP practice ward rounds**
- **At the request of the resident and/or their relative or support network**

If a person lacks capacity to contribute to the ReSPECT process, this must take place with their legal proxy (e.g., Welfare Attorney) if they have one, or otherwise with a close family member or someone from their support network.

How do I ensure other health and care professionals can access the ReSPECT form?

The printed copy should travel with the person if they are admitted to hospital or another care setting. For example, if the resident is transported to hospital in an ambulance, ensure the ReSPECT form is handed to the Paramedic along with the resident's belongings.

Ensure the resident and their relatives or support network have a copy of the most up to date version of the ReSPECT form.

Make sure the printed copy is easily accessible to all care staff within the Care Home.

Advanced Care Planning

Supporting ReSPECT conversations

The Universal Principles of Advanced Care Planning

Below are a set of universal principles that should be adhered to when undertaking any form of Advanced Care Planning. It includes some questions for you to consider when initiating conversations with a resident to either start or review a ReSPECT form:

The person is central to developing and agreeing their advance care plan including deciding who else should be involved in the process.

- ☐ Does the person know they can start or stop conversations about their ACP?
- ☐ Has the person been asked who they would like to include in conversations about their ACP?
- ☐ Does the person know they can change their mind about what is in their ACP?
- ☐ Does the person know their ACP can include their choices about what they would like to happen in the future if they experienced poor health?

The person has personalised conversations about their future care focused on what matters to them and their needs.

- ☐ Does the person know that the conversation will be focused on what matters to them and what good quality of life means to them?

The person agrees the outcomes of their advance care planning conversation through a shared decision-making process in partnership with relevant professionals.

- ☐ Does the person know that the ACP discussion will include their preferences and priorities about their future care based on conversations with other health care professionals about their condition and it's like future course?

The person has the opportunity, and is encouraged, to review and revise their advance care plan.

- ☐ What has the resident been told about how to review and revise their ACP? Do they know that they can request this at any time?

The person has a shareable advance care plan which records what matters to them, and their preferences and decisions about future care and treatment.

- ☐ If the ACP is already in place, is it clear what matters to them, who they regard as most important to them and priorities about their future care and treatment?
- ☐ Is it written from a personal perspective that reflects the person's language?
- ☐ Does it include the person's right to privacy and their preferences for sharing the plan with others, including their family / support network?
- ☐ Do Care Home staff know where to access the ACP and understand the importance of making sure it travels with the resident between care settings?

Anyone involved in advance care planning is able to speak up if they feel that these universal principles are not being followed.

- ☐ Do you as a member of staff feel comfortable and know how to speak up if you have concerns that the universal principles of the ACP have not been followed?

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 can **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.

Arranging Recognition of Life Extinct confirmation for a resident

Recognition of Life Extinct (RoLE)
When one of your residents dies there are several processes which need to take place. One of them is confirming that your resident has died called Recognition of Life Extinct (RoLE). This allows the funeral director to take their body to a chapel of rest, and for the GP to complete the death certificate.

In Bradford, District and Craven place we have recently reviewed the systems and processes around this and tried to simplify it for all concerned by asking Care Homes to use the Telemedicine Service (TMS).

Who can undertake RoLE & how you can support TMS to undertake RoLE virtually
Registered Nurses, such as District Nurses and those working in the TMS can carry out the RoLE process for residents where their death is expected.

An expected death is one where the resident was on the GP's Gold Standards Framework (GSF-palliative care) register and had a ReSPECT form with a DNACPR decision. They do not need to have seen a GP in the last 28 days for death to be expected.

A nurse can carry out the process either over video link with your support to help them, or in person.

Important to note:
1. RoLE is not a mandatory or contractual requirement for Care Home staff to undertake.
2. Care Homes may choose to deliver this task with the support of TMS 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 undertaking RoLE if they don't feel confident and competent to do this.

Call the Telemedicine service 24/7

When a resident in your Care Homes dies, please contact Telemedicine on your laptop. They will assess the residents' details and circumstances to determine if the death is expected or unexpected.

They will advise if you need to ring the GP or 999 (if unexpected) or if they can support you to undertake RoLE virtually (if expected).

If you do not feel comfortable undertaking RoLE, then TMS will arrange for either a Community Nurse or GP to visit the Care Home and carry out the process in person.

In person RoLE will take longer to arrange than via video link as there may not be a nurse available to complete this task straight away.

For the nurse in the TMS to undertake RoLE virtually, they will require you to support them. They will still be the person responsible for undertaking and recording the outcomes of the task but will need you to act as their eyes and ears. To support the nurse in the TMS to carry out RoLE you will need:

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

They will ask you to check if the resident is breathing, if they have a pulse, if they have any eye movement and if their pupils are fixed and dilated.

Nursing Homes may undertake RoLE independently and this can continue however, support is also available for staff working within Nursing Homes from the TMS too if staff feel they would value additional support.

Arranging Recognition of Life Extinct confirmation for a resident

Top Tips for Care Homes

- Check you know which of your residents are on the GSF/Goldline – you may want to discuss this at your next GP ward round.
- Check you can find each residents ReSPECT form and DNACPR decision quickly in an emergency.
- Speak to your District Nurses to make sure that your residents who are at the end of life are on their caseload (not all your residents will be) – this means they can support you as you care for your resident and carry out RoLE if needed.
- Check you know how to use the TMS laptop – putting it on a table at the end of the bed is often easiest. For any technical support please call 0330 088 3312.
- Check you have all the equipment needed to support the TMS nurse as they carry out RoLE.
- It's advised that Care Homes hold a paper record which documents the steps taken i.e., date / time contacted TMS, if RoLE was undertaken virtually or if arrangements for a District Nurse were being made.
- Contact the TMS if you would like some training or support to help you feel confident – but remember this is not mandatory and if you are not able to help them, they will arrange an in-person RoLE.

Common Worries

I don't know what to do.

- The TMS nurse will guide you through the process step by step. There is also information in the Care Home Handbook
- The TMS is happy to provide training on what to do before you help them carry out RoLE for real.

Common Worries

What if I get it wrong/get in trouble

- The TMS nurse is the person taking responsibility for confirming RoLE they are the ones confirming the resident has died and not you.
- The TMS nurse will check the records to make sure death is expected and ask you what happened.
- RoLE confirmation by nurses, both over video and in person, is recognised as safe practice across England.

I'm too upset to do this today.

- We know that it is a difficult and upsetting time for everyone in a Care Home when a resident dies. You may be dealing with distressed relatives and other residents, as well as being upset yourself. If when you talk to TMS you can't help them with RoLE that day please don't worry, they can arrange for a nurse or GP to visit to confirm death.

The District Nurse is here but says they can't do it.

- Not all District Nurses have completed their training to confirm RoLE, and the Healthcare Assistants working with the District Nurses are unable to do this. This doesn't mean that the TMS can't help – please call them and they will organise RoLE.

Shouldn't I call an ambulance?

- If the resident does not have a DNACPR decision you need to start CPR and call 999
- You shouldn't call 999 for an expected death as this will mean paramedics are taken away from dealing with more urgent calls. Call the TMS and they will arrange RoLE confirmation.
- If your resident is suddenly unwell, and their ReSPECT form or advice from GP/Goldline is to call an ambulance to get help then please do. If the resident dies whilst the ambulance is on its way, or whilst the paramedics are with you, then they will carry out RoLE.

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.

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 duty.

If you become aware of a safeguarding issue than 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 in 'Best interests'

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

The Care Act 2014:

Section 42 (1)

Where a local authority has reasonable cause to suspect 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 enquires 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 an online form:
https://www.saferbradford.co.uk/report-a-concern

Telephone: 01274 431077 (Office hours)

01274 431010 (Out of hours emergency duty)

Email: safeguarding.adults@bradford.gov.uk

Safeguarding Adults Service,
5th Floor Britannia House,
Hall Ings, BD1 1HX.

Infection Prevention and Control

Infection prevention and control platform

During the wintertime 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:
https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-covid-19-supplement

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
https://www.gov.uk/government/publications/covid-19-ppe-guide-for-adult-social-care-services-and-settings

BRADFORD COUNCIL IPC TEAM

CONTACT DETAILS:

MICHAEL HORSLEY 07582 102117

DARREN FLETCHER 07582 102163

JASBINDER SANDHU 07970 833276

Admissions to hospital

It is recognised that there will be times when it will be appropriate for your resident to attend an emergency department or be admitted into hospital.

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.

Good communication is essential when residents are moving between hospital and their usual place of residence.

Without it, people can experience:

- Unmet care and support needs
- Avoid able hospital readmission.
- Unnecessary long stays in hospital which can lead to further deterioration and risk of infection.

What you can do to support the transfer of residents in and out of hospital:

Before admission:

- Please prepare any relevant care plans and ReSPECT documentation, equipment, medication, glasses, dentures, hearing aids etc.
- Please make this information/items easily accessible to the health and care staff involved in the transfer to hospital.

At admission:

- Please provide the admitting team with all the information/equipment as above.

Discharge:

- Please stay connected with the hospital to understand when your resident will be ready to come home.
- Once your resident is medically fit for discharge or if you are taking a new admission from hospital into your Care Home, please complete any assessments and arrange transfer to the Care Home in a timely manner.
- This will help to minimise any risk of harms to your resident, avoid any unnecessary delays and free up a bed for someone with a more urgent need.

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

GP Practices & Care Homes working together.

Weekly home rounds and Multi-Disciplinary Team (MDT) working.

- Each GP practice in our local area is aligned to work with a larger group of GP practices called a Primary Care Network (PCN). The PCN is responsible for delivering a range of service specifications. Some of these specifications for examples the Enhanced Health in Care Homes one in partnership with wider community services like District Nurses, Physiotherapists, Speech, and Language Therapists etc.
- Every Care Home has been aligned to a PCN and will be supported by a GP practice from within that PCN. In most cases there is one GP practice aligned to every Care Home. However, there are occasions due to residents' personal choice that you may receive a service from another GP practice.
- Your Care Home should have been allocated a named Clinical Lead, either a General Practitioner (GP) or a non-GP clinician like an Advanced Nurse Practitioner (ANP) with appropriate experience of working with Care Homes. If you are unsure who your named Clinical Lead is, please ask your GP practice.
- Your GP practice should be carrying out a weekly 'home round'. Depending on the individual need of your Care Home the form of the home round may vary from face-to-face or virtual.
- Some Care Homes send in a list of residents names in advance (48hrs before) to the practice who they think would benefit from a review. It might be beneficial to have a conversation with the Clinical Lead (GP/ANP) or your GP practice to agree how you want to work together in the future and the type of information that would be helpful to be shared as this will help you to make the best use of this time.
- Most Care Homes and Clinical Leads (GP/ANP) have a set day/time for the home round which is good practice and helps both parties to be prepared and have sufficient time allocated to support this. However, effective communication is key as there will be times in busy periods when this might not happen as planned and a degree of flexibility is required by both parties.
- Whether the visit is virtual or in-person, you are encouraged to welcome the clinician and to support them with the home round to promote joint working. One of the ways you can do this is to try and have Care Home staff that are involved directly in the care of the resident available to offer advice and information that may be helpful to the Clinical Lead in determining the resident's future care needs.
- To support the home round to go smoothly, you can support the process by getting residents ready for their visit and located in a private area to ensure confidentiality (this applies both to virtual and in-person consultations/assessments).
- If a resident needs a non-urgent review, you could consider adding them to the next weekly home round list if you feel that they are able to wait until this time to be seen. However, you can discuss this with the Clinical Lead (GP/ANP) if you are unsure.
- Your Clinical Lead (GP/ANP) also works alongside wider community service providers and other relevant partners to establish and coordinate Multi-Disciplinary Team (MDT) meetings/discussions. This will support in the delivery of care and interventions to residents living in your Care Home and delivery of the clinical aspects of the Personalised Care and Support Plans (PCSP). You may be invited to attend the MDT meeting/review and if you are able, it can be helpful to get involved. You may also facilitate MDT meetings within your Care Home and you could ask the GP/ANP to be invited and involved in these too.

GP Practices & Care Homes working together.

Personalised Care and Support plan (PCSP)

- A PCSP is developed following an initial holistic assessment about the person's health and wellbeing needs. The person, or their family, work hand in hand with the health and social care team to complete this assessment that then leads to producing an agreed PCSP.
  - 5 Criteria for developing a PCSP are details below:
    1. *People are central in developing and agreeing their PCSP including deciding who is involved in the process.*
    2. *People have proactive, personalised conversations which focus on what matters to them, paying attention to their needs and wider health and wellbeing.*
    3. *People agree the health and wellbeing outcomes they want to achieve, in partnership with the relevant professionals.*
    4. *Each person has a sharable, PCSP which records what matters to them, their outcomes and how they will be achieved.*
    5. *People are able to formally and informally review their PCSP.*
- The PCSP should be coordinated and developed by the Care Home staff, alongside the resident in partnership with the Clinical Lead (GP/ANP) and Community Provider (where appropriate). This should ideally be completed within 7 working days of admission to the Care Home or within 7 working days of readmission following a hospital episode (unless there is good reason for a different timescale).
- Residents with a Learning Disability (LD), Autism or Severe Mental Illness (SMI) will be required to have an annual heath check completed by the GP practice. It is helpful if you can prepare the resident for this by discussing with them the importance of their health check and helping them to complete their pre-health check questionnaire where applicable and obtaining relevant consent.
- If you have a resident with an Advance Decision to Refuse Treatment (ADRT), Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions, ReSPECT and/or Advanced Care Plan (ACP) this information must be documented in the care notes and paper copies kept within the Care Home to ensure that these wishes are always respected.
- If one of your residents has an admission into hospital that is unplanned, please request your named Clinical Lead (GP/ANP) to review the resident and update their PCSP to reflect any changes in the resident's condition and identify any actions that could be put in place to prevent a further unplanned admission in the future.
- Best practice suggests that as each version of the PCSP is developed or updated, a version should be made available to all parties involved in delivering the care of the resident.

Structured Medication Review (SMR)

- Your GP practice will use appropriate tools to identify and prioritise residents who would benefit from an SMR. Please see the SMR page to see what is involved in an SMR.

Access

- Your GP practice should have provided you with a direct bypass telephone number for use during working hours of 8am to 6.30pm Monday to Friday (excluding public holidays). If you don't have this number, please request this from your Clinical Lead or GP Practice.
- You may find a good way of exchanging communication/information with your GP practice is via an NHS.Net account. This helps as you can send resident identifiable information. However, not all Care Homes will have access to active NHS.Net accounts. You might want to discuss this with your Clinical Lead to understand the best methods of sharing and receiving information.

Structured medication reviews (SMR's)

With increasing age and frailty, people become more sensitive to medicines and side effects, such as confusion, sedation or falls (1). This is why residents living in care homes and other frail people are prioritised by the NHS for structured medication review (SMRs)(2).

SMRs are comprehensive reviews of a patient's medication, taking into consideration all aspects of their health. In a structured medication review clinicians and patients work as equal partners to understand the balance between the benefits and risks of and the alternatives of taking medicines. The conversation being led by the patient's individual needs, preferences, and circumstances. Some care home residents are living with dementia or lack capacity and may need help from a carer who knows them well during structured medication review.

SMR's can take around thirty minutes to complete in some cases.

Problematic polypharmacy is where the potential for harm outweighs any benefits from the medicines. This may include:

- Medicines that are no longer clinically indicated or appropriate or optimised for that person.
- Combination of multiple medicines has the potential to or is actually causing harm to the person.
- Practicalities of using the medicines become unmanageable or are causing harm or distress.

SMRs have **benefits** to people taking multiple medicines and can help:

- Improve quality of care through a better understanding of the medicines a person takes.
- Reduce risk of harm from medicines (e.g. adverse drug events, side effects or hospitalisation).
- Simplify medicines regimes, reducing medicines waste and time taken to administer medicines.

What's involved in highlighting the need for an SMR, and how can carers help?

- Observations: for side effects of medicines that may be causing problems for the resident i.e. changes in behaviour, confusion, constipation, dehydration, dizziness, drowsiness, discomfort, falls etc.
- Discussion: find out how the patient is feeling, any changes?
- Request review: discussion with appropriate clinical staff, i.e. G.P, practice pharmacist, advanced clinical practitioner, on your observations and information from the discussion with the patient and/or carer staff.

How often should an SMR take place?

SMR's are most often carried out within a twelve-month period. More frequent reviews may be needed, for example after hospital admission or falls.

The medication review will involve the pharmacist or GP gathering information from clinical records. During the SMR the pharmacist or GP will check with the resident whether:

- They are taking the medicine in the correct way.
- They can take medication without difficulties.
- The medicine is treating any conditions properly.
- The medicine and the dose is still right.
- The medicine is not causing any problematic side effects.
- Any blood tests or monitoring needed to ensure medication is not impacting on other areas of health.
- They are taking any other medicines, such as those bought in a pharmacy or supermarket.

This will ensure that medicines are working well for your residents. It is important that the resident, and/or family or carers are involved in all the discussions about medicines.

Reference:
Prescribing in the elderly | Medicines guidance | BNF | NICE
NHS England » Structured medication reviews and medicines optimisation

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.

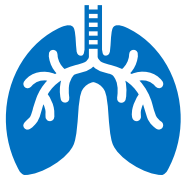
There are simple things you can do to help **relieve coughing.** *e.g.,* drinking honey & lemon in warm water, sucking cough drops/hard sweets, elevating the head when sleeping and avoiding smoking.

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. Remember **respiratory disease** is the biggest cause of death, so flu & covid boosters are important to reduce people's risks. Learning from Lives and Deaths - people with a learning disability and autistic people (LeDeR) - King's College London (kcl.ac.uk)

When the person accesses the community, 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.

Resources

- VIP Hospital Passport
- To monitor signs of deterioration – RESTORE2 mini (identifying deterioration and use of RESTORE2 mini)
- Bradford Hospital Visitors guidance - please be aware that most hospitals let people with learning disabilities have additional support during admissions as a reasonable adjustment.
- Government guidance on exercise
- Protecting extremely vulnerable people: Government guidance

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 the Learning disabilities liaison teams who are based in hospital Safeguarding teams. These are available in BTHFT or Leeds hospitals.

For Airedale please also contact the Safeguarding team (see contact detail on the next page)

You can also contact the Learning Disability Health Support Team at Waddiloves if appropriate.

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, are they urinating as normal, etc.
- Does the person need extra help to remain safe and protected?

ASK

- Is there a change in the person's normal presentation.

DO

- Do ensure baseline health information is available for all your service users including weight, BP, pulse, sats levels etc.
- Ensure all staff are aware of what is normal for that person so they can pick up changes easily.

Supporting your people with learning disabilities

COMMUNITY RESOURCES

Social Care Referrals – for Care Act assessments, respite services, daytime activities:

- Bradford social care – either Access point 01274 435400 or Community team learning disabilities CTLD.Frontdoorteam@bradford.gov.uk
- North Yorkshire Adult Social care- 0300 131 2131.

Mental Health

- First Response (Tel: 0800 952 1181) 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.

Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DOLS)

The Mental Capacity Act has not changed during Covid.

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:

Bradford:
MCA Service

DoLS Referrals

North Yorkshire:

Send us an email using our online form

Resources

MCA and DoLS COVID 19 guidance and summary

Supporting people with memory problems & dementia

Dementia is not an inevitable part of ageing and is not a disease in its own right. It is an umbrella term. It describes the symptoms that occur when the brain is affected by certain diseases or conditions that cause the gradual death of brain cells. This leads to progressive cognitive decline. How fast cognitive decline progresses will vary from person to person and may depend on which type of dementia they have. Symptoms include:

- loss of memory
- changes in behaviour and mood
- problems with communication and reasoning skills.

Research has shown that between 75% and 89% of care home residents have dementia, and that many of these residents are undiagnosed (Lithgow, Jackson, & Browne, 2012; Stewart et al., 2014). A dementia diagnosis will aid the understanding of care workers, family members and friends, leading to better support of the person with dementia. It can lead to more appropriate care and support, may give the person with dementia the opportunity to plan for the future and depending on the type and stage of dementia specific treatments or interventions may be available.

Behaviours that care staff may find challenging are usually due to inability of people to communicate their needs or as a symptom of distress. See Supporting residents who are showing distressed behaviour.

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.

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.

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.

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

THINK

- Does my person have a memory problem and if they do they have a diagnosis of dementia?
- 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 what you are doing.
- 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
- Know how to access the Digital Care Hub and Care Home Liaison Team if you need extra support.

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. OR you may want to communicate with your practice via a DeAR - GP™ Dementia Assessment Referral https://healthinnovationnetwork.com/wp-content/uploads/2022/09/1-Dementia-Assessment-Referral-DeAR-GP.pdf

Resources

- Alzheimers Society- why-person-with-dementia-might-be-walking
- SCIE Difficult Situations
- SCIE Supporting people with dementia
- Meeting the needs of people with dementia living in care homes video

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.

Resources

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

Supporting residents who are showing distressed behaviour

As dementia progresses, people can sometimes present with distressed behaviours such as anxiety, agitation, aggression, shouting, crying, walking with purpose (previously called wandering), sexual disinhibition, sleep disturbance and withdrawal and apathy. These are often referred to as challenging behaviours or sometimes 'behavioural & psychological symptoms of dementia' (BPSD) but challenging is how we feel and distressed is how the person is feeling and if we consider it in this way, it is easier to understand and help the person.

Distress can be due to one problem or a combination of issues.

- Physical causes such as pain, thirst, hunger, needing the toilet, infections, delirium, issues with vision, hearing or medication.
- Environmental causes or over or under stimulation, new places, being too hot or cold or being unable to find the toilet or their room.
- Difficulty understanding the words due to inability to communicate, poor hearing or vision, unable to recognize objects and being unable to tell you what they want.
- Previous problems in their lives and lack of knowledge of carers of their personal preferences such as being touched etc.
- Underlying mental health problems like anxiety, bereavement, or previous trauma.

Antipsychotic medication does not help distress, walking, shouting or withdrawal & increases the risk of death, stroke, drowsiness & falls.

Think

- I may find this behaviour challenging but it is a sign of distress.
- What may be causing the distress?
- What do I know about this person and their life that could help explain the distress?

Ask

- Start with simple things such as thirst, hunger, pain, too hot or too cold and a need to go to the toilet.
- Ask other staff and family if they know of any triggers for distress.

Do

- Review care plans & documents that tell you more about them and their lives.
- Consider potential causes of distress before resorting to medication.
- Call the Telemedicine service on your Immedicare laptop.
- Request a review with the GP who may be able to refer you to the Care Home Liaison Team.
- Take time out when you find it hard.
- Consider CLEAR training for all staff in your home.

Supporting residents who are showing distressed behaviour

How can you reduce the risk of distress?

- Dementia Friendly Environments
- Knowing the person and their life story & triggers & sharing that with other staff
- Routines
- Ensuring glasses are worn, teeth fit, and hearing aids are worn.
- Orientation and giving information.
- Time to care (never an easy one!)
- Regular routines for hydration, food, toileting, pain relief
- Think about unnecessary interventions.
- Knowing when to walk away and try again later.
- Considering the risk of pain and triggers that cause distress & plan for them.
- Considering your own emotions and distress

How you can manage distress when it happens

- Think and ask about a cause.
- Look for signs of a cause.
- Try and stay calm and maintain eye contact.
- Explain what is happening and who you are.
- Reduce environmental overstimulation.
- Distraction –Music, movies, photos, talking.
- Music or gentle hand holding.
- Offer a cup of tea or food.
- Consider a change of scene.
- Consider giving some space +/- coming back later if it is safe to leave.

Resources

- 'This is me': Copies can be found at (https://www.alzheimers.org.uk/get-support/publications-factsheets/this-is-me)
- Dementia Friendly Care Home Environments: (https://www.scie.org.uk/dementia/supporting-people-with-dementia/dementia-friendly-environments/video-environment-care-home.asp)
- The Alzheimer's Society best practice guide to optimise the treatment and care of the behavioural and psychological symptoms of dementia.(Optimising treatment and care for behavioural and psychological symptoms of dementia: A best practice guide. Full colour version (alzheimers.org.uk))
- Alzheimer's Societies information on drugs used to relieve behavioural and psychological symptoms in dementia.(https://www.alzheimers.org.uk/about-dementia/treatments/drugs/antipsychotic-drugs)
- Social Care Institute for Excellence (SCIE) has a dementia gateway for people who work with people with dementia (http://www.scie.org.uk/publications/dementia/index.asp)
- Dementia UK is a charity: (http://www.dementiauk.org)
- Antipsychotic-Prescribing-Toolkit-for-Dementia.pdf (england.nhs.uk)
- Pain assessment tool (2021_Pain-and-dementia-leaflet_online.pdf (dementiauk.org)
- Eating and Drinking support (https://www.dementiauk.org/get-support/health-issues-and-advice/eating-and-drinking/)
- Information on CLEAR (but would be delivered by BDCFT) https://www.northerntrust.hscni.net/services/dementia-services/clear/clear-dementia-care-training/
- Bradford local Guidance on Distress and the use of Antipsychotics: See Chapter 4
- BCA's Dementia Care home quality workshop resource: BCA Doc

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

- 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
- Dietetics: Bradford or Airedale, Wharfedale and Craven
- Community Therapy services (preventing deconditioning): Craven/Bingley/Keighley/Ilkley or Bradford North, South & Central

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.

Resources
For more information on mouth care matters visit:

https://mouthcarematters.hee.nhs.uk/links-resources/mouth-care-matters-resources-2/

Mouth Care

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 – Bradford District Care Trust.

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.

FREE Oral Health training (Funded until March 2024)
The Bradford Community Dental Service are providing evidence based Oral Health Training for Care Homes includes resources and is aimed at the Care Home Manager, Deputy, or other Senior staff members. The programme will enhance your offer to residents, meet the requirements of the CQC and is endorsed by Bradford Admiral Nurses. The training is online, using Microsoft Teams. To book please email elisha.mistry@bdct.nhs.uk

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 Workshop 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 toenail where there is hyper granulation tissue present at the side of the nail that is in growing.
- 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

We provide foot health services in many locations across Bradford, Airedale, Wharfedale and Craven.

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 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

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.

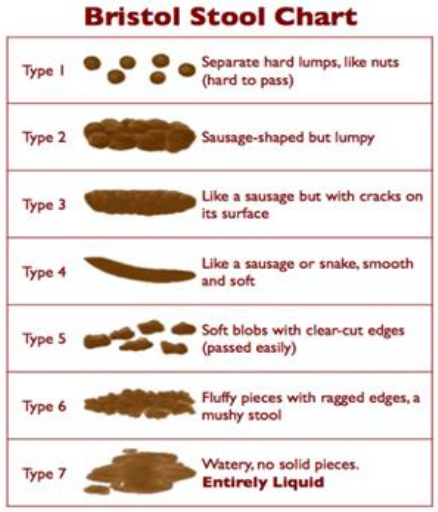
People with dementia and other cognitive difficulties

- **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

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

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)

Tissue Viability Service

What is a pressure ulcer?

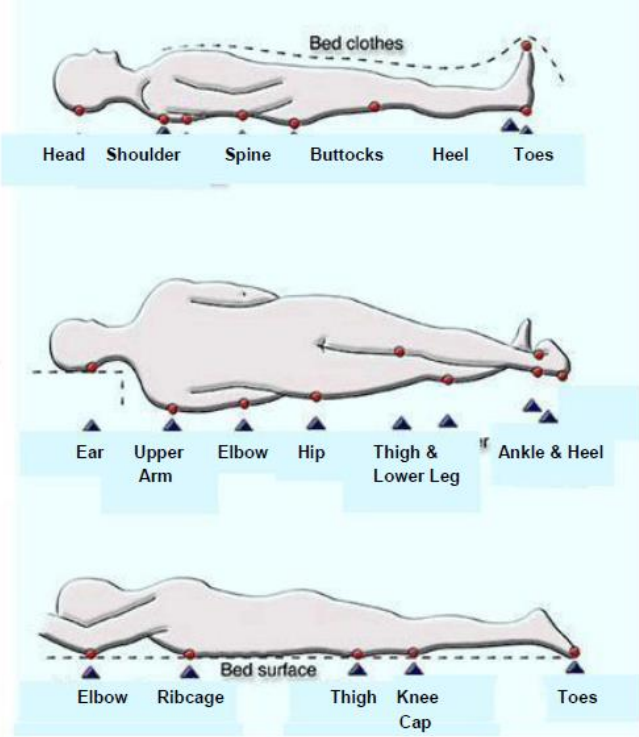
A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure. The damage can be present as intact skin or an open ulcer and may be painful" NHS Improvements (2018).

Skin inspections

Early identification of skin changes is essential in the prevention of pressure ulcer development and deterioration, and regular skin inspection is a core element of the SSKIN bundle.

Pressure ulcers are caused by a combination of:

- Pressure from the weight of the body pressing against a hard surface, damaging the blood supply that keeps the skin healthy.
- Shearing – this may occur if patients slide down or are dragged up the bed or chair causing damage to the deeper layers of the skin.



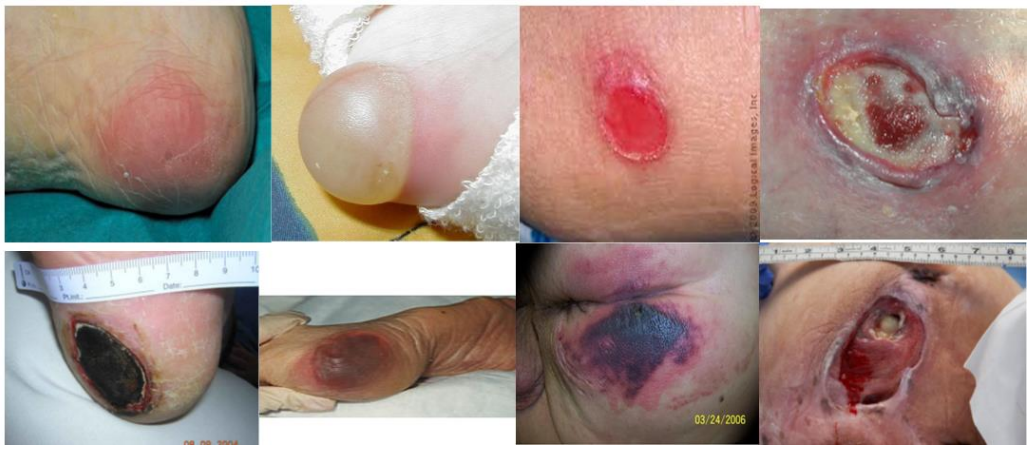
Tissue Viability Service

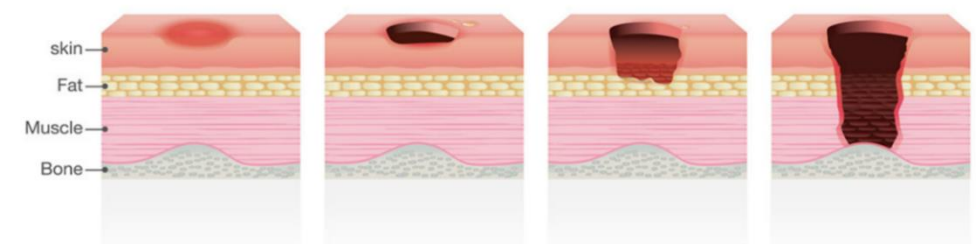
Early symptoms of a pressure ulcer include:

- Part of the skin becoming discoloured, people with pale skin tend to get red patches, while people with dark skin tend to get purple or blue patches.
- Discoloured patches not turning white when pressed.
- A patch of skin that feels warm, spongy, or hard.
- Pain or itchiness in the affected area.

Later symptoms include:

- An open ulcer or blister.
- A deep ulcer that reaches the deeper layers of the skin.
- A very deep ulcer that may reach muscle, bone or tendon.





Who is at risk?

Anyone can get a pressure ulcer, but the following things can make this more likely to happen:

- Extremes of age, especially being over 70
- Reduced mobility, being confined to bed.
- Inability to move parts of the body.
- Incontinence
- Poor diet and fluid intake, obesity or under being weight.
- Medical conditions that affect blood supply, make skin more fragile or cause movement problems.

If you are looking after someone either in a care setting or their own home and you identify any early skin changes, it is important that you take action to prevent further deterioration. You **MUST** take the following action:

- Offload the area using the techniques below.
- Increase the frequency of repositioning and ensure this is clearly documented.
- Ensure all moving and handling techniques are reducing the risk of shearing forces, use full length slide sheets.
- Ensure bedding is crease free, clothing does not have thick seams and footwear is well fitting.
- Inform the senior member on duty and refer to the DN Team for support and reassessment/equipment review.

You **MUST** get medical advice immediately if:

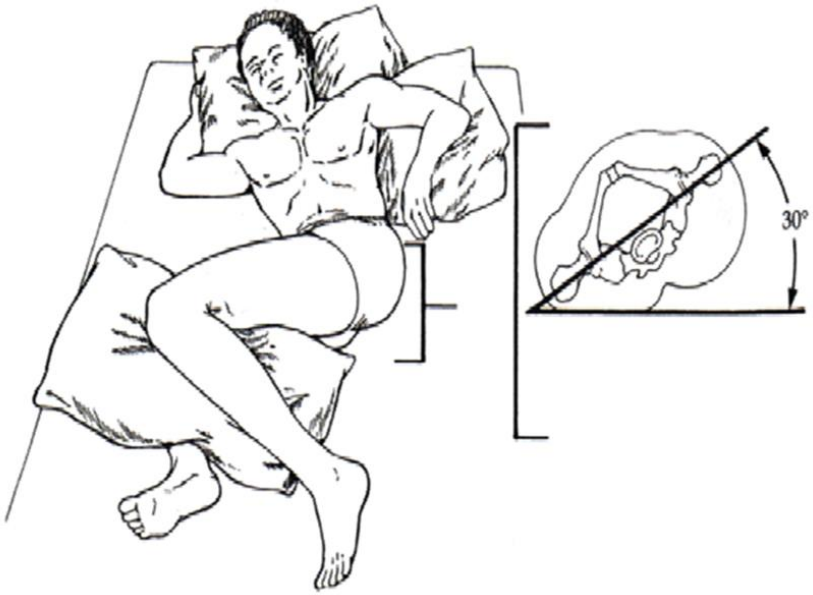
- There is red, hot, swollen skin.
- Pus leaking from the pressure ulcer.
- Severe or worsening pain
- A high temperature

These symptoms could indicate that there is a serious infection that needs treatment.

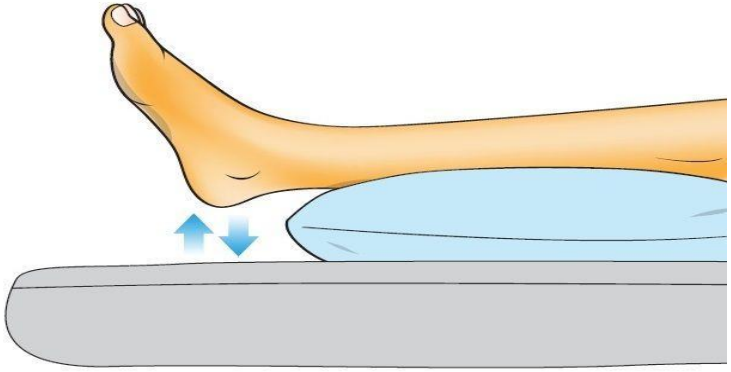
Tissue Viability Service

Offloading techniques

30-degree tilt



Offloading



Incontinence and moisture

Moisture damage can occur to the skin by prolonged contact of moisture to the skins surface. This can be in the form of sweat/wound leakage/urine & faeces.

These factors will make the skin more vulnerable to pressure, friction & shear.

Why do urine & faeces damage skin?

Urea in urine

Enzymes in Faeces

↓

Alters PH, encourages bacteria

=

Skin damage - Red or broken skin

Aim to keep the skin clean, dry, and moisturised:

Cleanse skin regularly/avoid soap.

Appropriate use of continence products.

Regularly apply moisturiser/barrier cream.

Evaluate skin condition at each contact.

Tissue Viability Service

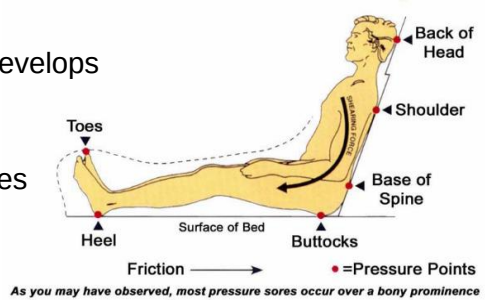
Pressure ulcer Prevention Training

Face to face training offered to all care providers in the Bradford, Airedale, Wharfedale & Craven district.

Would your care home staff benefit from pressure ulcer training?
Do you have new starters joining your team?
If yes to any of these questions, then please do not hesitate to get in touch via the email below.

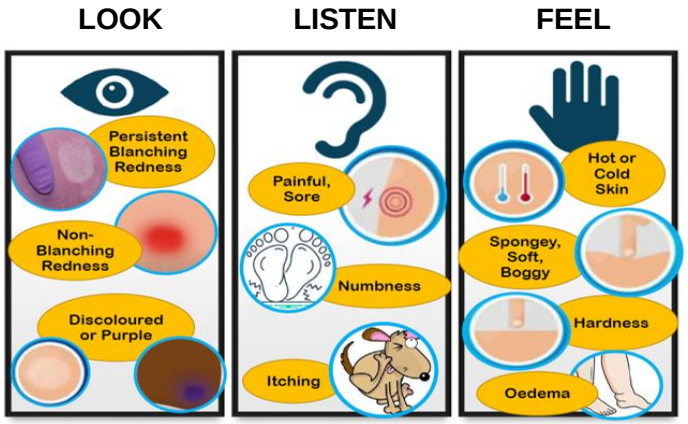
The training covers:

- What a pressure ulcer is and how it develops
- Risks and causes
- Categorising pressure ulcers
- Prevention and management strategies
- Correct use of equipment
- Documentation and responsibility



As you may have observed, most pressure sores occur over a bony prominence

For more information please contact: pressureulcerteam@bdct.nhs.uk



Virtual training accessible to all care providers via Microsoft Teams

Daily sessions available Monday -Friday, evening, and early morning sessions also available to allow all staff to access.

Pressure ulcer prevention training supports knowledge around all aspects of pressure ulcer prevention, including patient assessment and how to identify those most at risk, early detection of skin changes, offloading techniques to prevent deterioration and the correct use of pressure relieving equipment.

All requests to access training sessions should be by return of email to pressureulcerteam@bdct.nhs.uk

Contact:

You can contact the **Tissue Viability team on 01274 221168** from 8.00am-5.00pm Monday -Friday, excluding bank holidays.

If you need to speak to a nurse urgently but do not need treatment in A&E, you can call the Single Point of Contact Duty Nurse on 01274 256131 any time.

Further resources:

https://www.bdct.nhs.uk/services/tissue-viability-service/

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

Equipment, Walking aids & Wheelchairs

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 safe 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 swallowing or communication difficulties.

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).
- 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?

Q. Is SALT the right service for your concern?

WE ARE UNABLE TO ACCEPT REFERRALS FOR THE FOLLOWING REASONS:	Contact
• Difficulties swallowing tablets only	GP / Pharmacist
• Low appetite or food/drink refusal with no concerns of swallowing difficulty	GP / Dietitian
• Food pipe related swallowing problems only (oesophageal dysmotility, achalasia)	GP / Gastroenterology
• Difficulties chewing food due to condition of teeth / dentures only	GP / Dentist
• Difficulties due to dry mouth / excess saliva / oral thrush only	GP / Prescriber

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 293641.
GPs can refer the patient via **SystmOne**

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

Referral forms are available on the Airedale or on Bradford Care Trust's website and can be emailed securely to the appropriate services:
Bradford: admin.services@bdct.nhs.uk / 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. See the next page for steps you can take to support your resident awaiting an assessment.

Speech and Language Therapy

Things you can do to support people whist they wait for a dysphasia assessment:

Feeding Safely Routines:

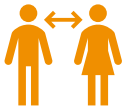
Conscious Level – no-one should be given food or drink if unconscious or semiconscious. Alternative nutritional and hydration options should be discussed with the responsible clinician.

Distraction - reduce distractions at mealtimes to facilitate concentration and awareness.

Time - allow adequate time to support the individual to eat and drink.

Positioning – people should sit upright for all snacks, meals and drinks. People should remain sitting upright for at least 30 minutes after a meal to avoid reflux.

Oral Hygiene - Ensure the mouth is clean and free from residue at the end of the meal. Encourage a 'clearing swallow' or 'saliva swallow' to assist in clearing residue from the mouth. Cleaning teeth and the mouth at intervals during the day is advocated.



Position yourself – at eye level so that you may observe signs of aspiration as well as being able to provide verbal prompts and encouragement. Positioning yourself above eye level or sitting at the side of individuals to assist with eating and drinking may have a negative impact on the individual's ability to swallow safely as they may change their posture.

Utensils – ensure you have the correct utensils identified for the individual.

Dentition – dentures, if worn, should fit well. Be aware that some individuals prefer to eat without their dentures and softening the diet may help.

Glasses– Swallowing requires multisensory stimulation. Food should be visually appetising in its presentation and smell appealing to stimulate the appetite.

Hearing aids- Ensuring that the individual can hear the guidance and advice being given e.g., when prompted to slow down.

Modifying Diet – Ensure the correct consistencies of food and drink are prescribed for the individual with dysphagia.

Independence – Individuals should be encouraged to feed and drink themselves to encourage and maintain functional independence.

Portion size - people who are frail or lack stamina should be given small portions which require less energy to eat (e.g. softer and/or more moist foods). These small portions of food or drink should be given at more frequent intervals in the day. The Dietician should be asked to advise if a patient/client is losing weight.

Size of mouthful - It should be sufficient to stimulate chewing and swallowing but it is important to avoid overlarge mouthfuls.

Other professionals can support you:

The roles of the **physiotherapist** in managing any associated respiratory condition, the **dietitian** in managing nutritional and hydration support, the **occupational therapist** in postural and feeding equipment, the **nurse** in overseeing safe feeding practice, the **dentist** in denture fitting, and the medical staff in monitoring and managing general health all need to be stipulated and agreed in local care plans for dysphagia management.

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

BEEP EXERCISE REFERRAL

Beat the heat

Keep your residents hydrated and avoid dehydration and acute kidney injury during hot weather.

In the hot weather it's 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.

During hot weather we can see increased 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.

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 Telemedicine or
Your GP practice at the weekly check in,
who may consider reducing or stopping certain

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)

Summary: Suspected Coronavirus care pathway-Residential & Nursing

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.

Communication with the NHS

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

Recognising & Responding to Deterioration – Module 1 – Softer Signs (includes RESTORE2 MINI) Module 2 – Measuring Vital Signs; Module 3 – Keeping Residents Safe Through Good

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

- No more PCR testing required & no more whole home testing at all (LFD or PCR)
- Record temperatures twice a day, including asymptomatic residents. Monitor oxygen
- saturations and observe for signs of deterioration.
- Care Home is to only swab the first 5 symptomatic Residents via LFD swabs, and only do subsequent LFD swabs if the resident is entitled to Covid 19 Antiviral medication. This would be confirmed via GP or similar Healthcare professional.
- No longer required to take daily LFD tests from day 5.
- Staff & residents who are symptomatic after the first 5 are swabbed don't need to swab and should be determined after Covid 19 positive based off symptoms & the knowledge there is Covid 19 present in the home or service.
- Isolation is just for 5 days for residents & staff should stay off work for 5 days.
- Isolation (residents) and return to work (staff) should only end if the individual is feeling better and is no longer feverish or have a temperature in the last 48 hours (day 4 & 5). If none are achieved isolation should continue & staff remain off work until fever gone or clear for 48 hours & recovered sufficiently. The fever is the main one to look out for.
- No longer require a follow up negative swab to come out of isolation or return to work.
- Admission from the Acute trust require a LFD swab 48 hours prior to admission. If positive the home decides whether they take the admission. If admitted; the care home continues the isolation from when the swab confirmed positive of Covid 19 and not from when they were admitted to the home.
- Admission from the community no longer requires a swab for Covid 19 at all.

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

Resources and Support for Care Home Staff

- https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-covid-19-supplement

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.

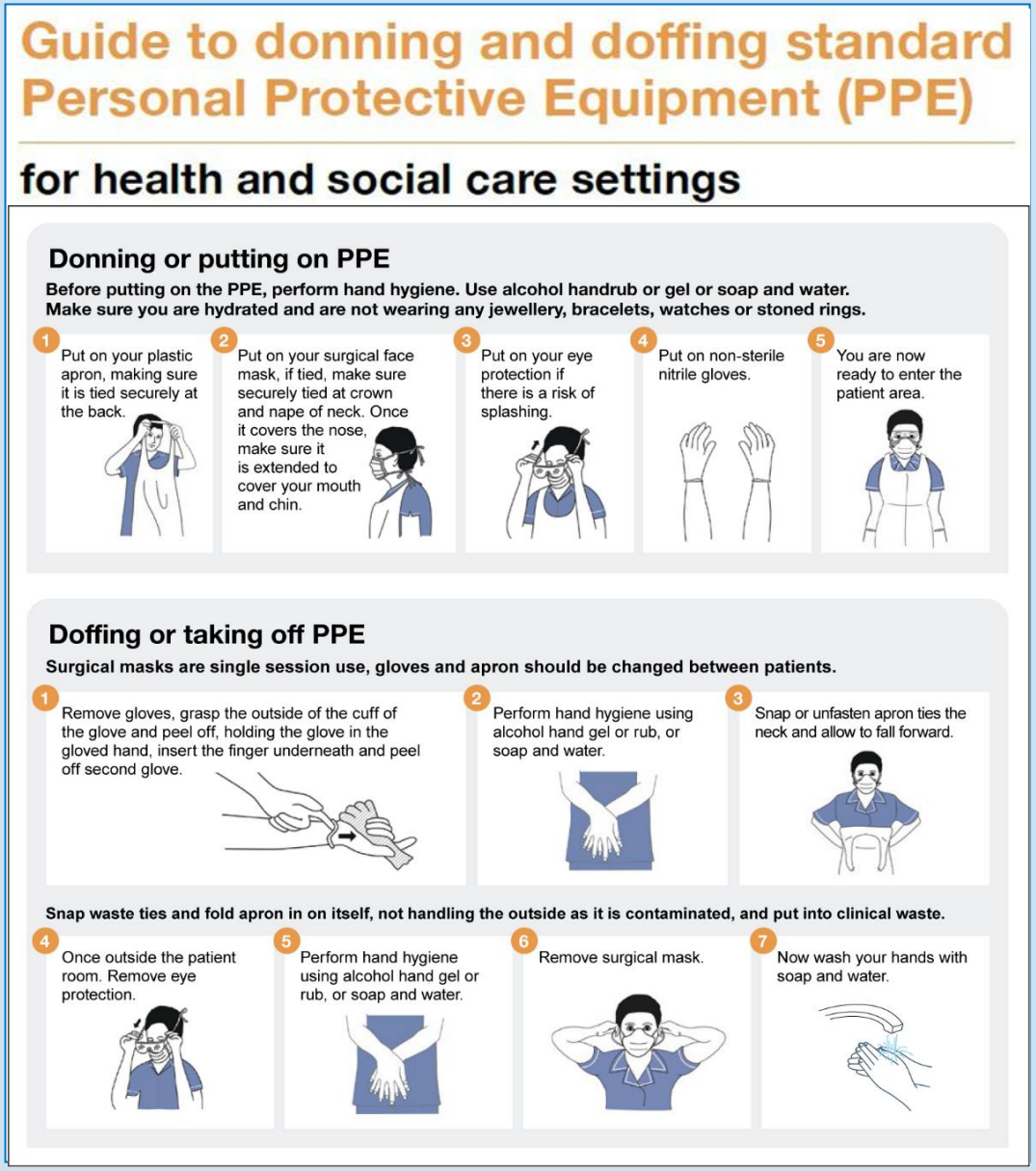
Why are people wearing different PPE?

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 vaccination advice: https://www.nhs.uk/conditions/vaccinations/flu-influenza-vaccine/

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.

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
- https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-covid-19-supplement

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 kit s - 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

During a suspected outbreak, there is no longer a need to test the whole home to identify Covid-19 cases.

The care home should undertake a risk assessment as soon as possible to determine if there is an outbreak and if control measures are needed. The provider should inform the HPT or other local partner of a suspected outbreak. However, they are not required to wait for advice from the HPT (or other relevant local partner) if they feel they are able to initiate the risk assessment independently.

The risk assessment can be undertaken directly by the care home provider using the expertise of relevant care home staff. Further support is also available from the local HPT (or other local partner according to local protocols) at the care home's request.

Linked asymptomatic cases are no longer defined as outbreaks.

If 2 or more linked care home residents develop symptoms of a respiratory infection within 14 days of each other, the first 5 residents with symptoms should take a COVID-19 LFD test, whether or not they are eligible for COVID-19 treatments. After this, only residents who are eligible for COVID-19 treatments should take an LFD test if they become symptomatic.

If an outbreak is identified, care homes should revert to the guidance for management of single cases 5 days after the last positive or symptomatic case.

Further LFD testing in an outbreak should only be done following an HPT risk assessment and on HPT advice in relation to specific concerns.

Refer to the section on Outbreaks in care homes (link below) for further information:

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

Using technology to work with health and care professionals

The COVID-19 pandemic changed the way we access services. We now have more digital options available, and many healthcare services can now be accessed using digital tools.

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 ICB 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/ICB/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 ANHSFT 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 How to use Telemedicine
- **Zoom** must only be used for meetings and not for discussing any patient confidential information.

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 supporting 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 Bradford District and Craven talking therapies: https://www.bdctalkingtherapies.nhs.uk/**
- **Finances:** If you are financially affected you can contact Money helper for advice **call 0800 138 1677**, from www.moneyadviceservice.org.uk.
- **Cost of living support in Bradford district https://costoflivingbradford.co.uk/**

Staff mental health and well-being

EVIDENCE-BASED APPS AND PERSONALISED ONLINE TOOLS:

- **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**
- **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**

Glossary

AGP Aerosol Generating Procedures	**ICB** Integrated Care Board (formerly CCG)
AHSN Academic Health Service Network	**ICE** Requesting Pathology / Microbiology Tests IT System
AIA Access Information Adviser	**IDDSI** International Dysphagia Diet Standardisation Initiative
ANHSFT Airedale NHS Foundation Trust	**IPC** Infection Prevention Control
BDCFT Bradford District Care NHS Foundation Trust	**LA** Local Authority
BTHFT Braford Teaching Hospitals NHS Foundation Trust	**LD** Learning Disabilities
BRI Bradford Royal Infirmary	**LeDeR** Learning Disability Mortality (Death) Review Programme
CCG Clinical Commissioning Group	**Mb** Megabytes
CCT Collaborative Care Teams	**MCA** Mental Capacity Act
COPD Chronic Obstructive Pulmonary Disease	**MDT** Multi-Disciplinary team
COVID-19 Coronavirus Disease 2019	**NHS** National Health Service
CTLD Community Team Learning Disabilities	**NHSE** National health Service England
DNACPR Do Not Attempt Cardio-Pulmonary Resuscitation	**NHSX** A Joint unit driving the digital transformation of care
DoLS Deprivation of Liberty Safeguards	**PHE** Public Health England
EoL End of Life	**PPE** Personal Protective Equipment
EVW Elderly Virtual Ward	**ReSPECT** Recommended Summary Plan for Emergency Care and Treatment.
GP General Practitioner	**RIDDOR** Reporting of Injuries, Diseases and Dangerous Occurrences Regulation 2013
HSE Health and Safety executive	**RNVoEAD** Registered Nurse Verification of expected adult death

Glossary

SALT Speech and Language 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	
VOED Verification of Expected Death	

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