National Patient Safety Improvement Programmes

Managing Deterioration

NHS Bradford District and Craven Clinical Commissioning Group

NHS

Recognising and Responding to Deterioration in Home Support Services through Restore2 mini and Structured Communication

This workbook has been designed to support your learning from the teaching session. It contains the slides, places for you to make notes, some extra information, tools and links to further reading that you may find helpful. The tools included are examples, clearer copies can be provided upon request. **https://youtu.be/Hwa95LyZOQ4**

We have also included some extra exercises you may wish to complete to help you practice your learning.

Finally there is a brief quiz to check your level of understanding; you may wish to complete this with a senior colleague in your team.

We hope you find the training and workbook helpful.

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Objectives and Aims

To provide you with an overview of the RESTORE2 Mini tool and the necessary skills and knowledge to apply the tool in practice and communicate your concerns

Aims

- To provide an understanding of the advantages of applying the RESTORE2 Mini tool to recognise and react to the deteriorating person you support.
- Train you on the steps and processes of applying the RESTORE2 mini tool in practice.
- Provide a deeper understanding of the clinical signs relating to the prompts contained in the tool.
- To understand why good communication is key to recognising & acting on deterioration.
- Undertake a scenario to ensure that you are comfortable with using the tool and using SBARD to call for help

Contents

Appendices

Using RESTORE2 Mini – Practice scenarios

‘Elsie’

You are Elsie’s regular carer. Your colleague who visited Elsie at lunchtime had made a note in her care plan that Elsie didn’t eat her lunch which is unusual for her.

On your teatime visit to Elsie she appears to be a little more confused than normal (although she has Dementia so is always a little confused). You ask her to describe what is wrong but she is unable to tell you, she appears to be agitated and is moving around in the chair struggling to get comfortable. She is a Type 2 diabetic on tablets and you are worried her blood sugars may drop is she doesn’t eat. You are unable to determine when she last passed urine as she is normally independent to the toilet. She looks flushed and you are concerned she may have a temperature

You check her care plan from that AM, there is nothing especially of concern recorded although it does say that she hasn’t slept well for the past 2 nights and there is no record of when her bowels were last opened.

Exercise:

1. Using RESTORE2 Mini tick which prompts Elise is triggering on.
2. Make a note of when you think the team could have first noticed Elsie becoming unwell
3. Are there any other signs you may have spotted?
4. Complete the SBARD form to communicate your concerns to NHS 111

‘Fred’

You are a night carer. You are doing your 2AM rounds with a colleague and go into Fred’s home to find him on the floor. Fred is 86 and has been having night carers for 7 months so staff know him well.

Fred is awake and appears alert (although he has Dementia so is unable to tell you if he is hurt). He appears more confused than normal although he doesn’t communicate well so it is hard to be sure, you wonder if this could be caused by the shock of the fall. You check his care notes; no one has noted that he had appeared unwell the previous day.

Checking his assessments & care plan you notice that for the past 3 days very little food intake has been recorded, there are some notes to show staff have tried to tempt him with his favourite foods but he refused to eat.

You assess him more closely and notice that his skin appears dry and you wonder if he has become a little dehydrated. You also notice his skin feels clammy to the touch.

There is also a note that he refused to go to the day centre the previous day (although he usually enjoys the music sessions).

Exercise:

1. Using RESTORE2 Mini tick which prompts Fred is triggering on.
2. Make a note of when you think the team could have first noticed Fred becoming unwell
3. Are there any other signs you may have spotted?
4. Complete the SBARD form to communicate your concerns to NHS 111

Using RESTORE2 Mini – A Quiz!

(You may wish to complete this with a colleague so you can discuss your answers)

1. What are the advantages to residents from you spotting deterioration earlier?

   .....

   .....

2. Why are carers in the best position to spot early deterioration?

   .....

   .....

3. Can you think of any clinical reasons why a person you supports mobility may be reduced?

   .....

   .....

4. Name 2 possible causes of delirium.

   1. ……
   2. ……

5. What signs might you spot that a person you support has a delirium?

   .....

6. Why is it important to observe the colour of urine?

   .....

7. Name 2 clinical signs of dehydration.

   1. ……..
   2. ……..

8. Name 2 common types of infection you see in the people you support.

   1. ……
   2. ……

Appendix 1

RESTORE2 mini

Recognise Early Soft Signs, Take Observations, Respond, Escalate

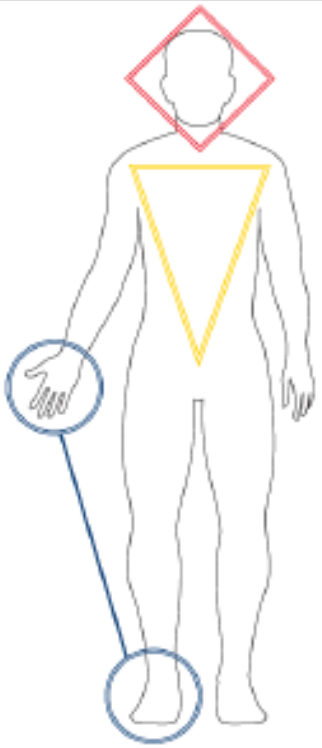
NHS Bradford District and Craven Clinical Commissioning Group

Person you support name:			
Date:		Time:	

Ask the person you support - how are you today?

Does the person show any of the following 'soft signs' of deterioration?

- ☐ = Increasing breathlessness or chestiness?
- ☐ = Change in usual drinking/diet habits?
- ☐ = A shivery fever - feel hot or cold to touch?
- ☐ = Reduced mobility - 'off legs' / less co-ordinated?
- ☐ = New or increased confusion / agitation / anxiety / pain?
- ☐ = Changes to usual level of alertness / consciousness / sleeping more or less?
- ☐ = 'Can't pee' or 'no pee', change in pee appearance?
- ☐ = Diarrhoea, vomiting, dehydration?



Any concerns from the person, family or carers that they are not as well as normal?

If YES to one or more of these triggers - **take action!**

Actions taken:	Person completing			
	Reported to:			
	Date:		Time:	
Person in charge action taken:				
	Date:		Time:	
Outcome for supported person:				

Before calling for help

- **Check Vital Signs (where possible):** e.g. temperature, pulse, etc.
- **Review Records:** recent care notes, medications, other plans of care
- **Have relevant information available when calling:** e.g. care plan, vital signs, advance care plans , DNACPR and RESPECT forms, allergies, medication list

Get your message across

Supported persons name:		**Date of Birth:**	

Raise the alert within your team e.g. to a senior carer, registered nurse or manager.

Report your concerns to a health care professional e.g. nurse / GP / GP Hub / 111 / 999

Using the SBARD Structured Communication Tool. 'Hello my name is', I am calling from .....about.....

S Situation: e.g. what's happened. How are they?

B Background: e.g. what is their normal, how have they changed? Any long term medical conditions e.g. COPD, heart failure, diabetes?

A Assessment: e.g. what have you observed / done? Include signs you spotted from RESTORE2 Mini and any other vital signs if available e.g. temperature

R Recommendation: 'I need you to....'

D Decision: what have you agreed? (including any Treatment Escalation Plan and further observations)

Key prompts/decisions

Name of person			
Service:		**Today's date:**	
Signature:		**Time of call:**	

Don't ignore your 'gut feeling' about what you know and see.

Give any immediate care to keep the person safe and comfortable.

Appendix 2

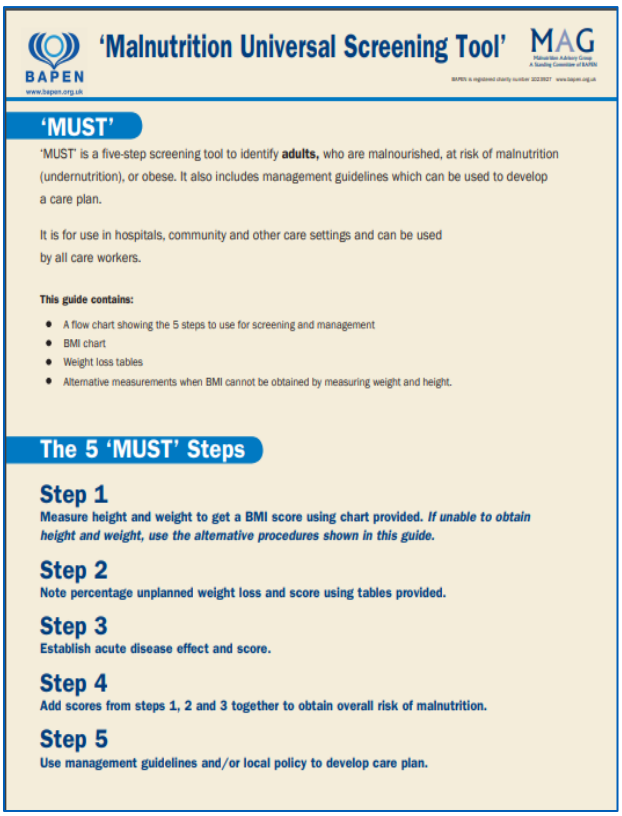
Detecting Malnutrition through Nutritional screening

Screening is the first step in identifying people you support who may be at nutritional risk, and who may benefit from appropriate nutritional support.

MUST is a rapid, simple and general procedure to be used when you first start supporting someone and at regular intervals so that action can be taken and advice provided if needed.

For more information and to download the toolkit for free follow this ink:

https://www.bapen.org.uk/screening-and-must/must



BAPEN

'Malnutrition Universal Screening Tool' MAG

'MUST'

'MUST' is a five-step screening tool to identify **adults,** who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

It is for use in hospitals, community and other care settings and can be used by all care workers.

This guide contains:

- A flow chart showing the 5 steps to use for screening and management
- BMI chart
- Weight loss tables
- Alternative measurements when BMI cannot be obtained by measuring weight and height.

The 5 'MUST' Steps

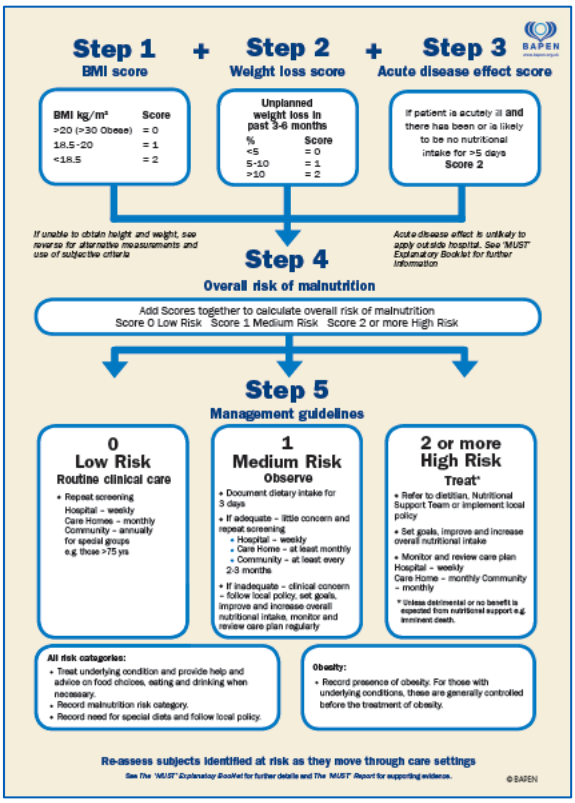
Step 1
Measure height and weight to get a BMI score using chart provided. *If unable to obtain height and weight, use the alternative procedures shown in this guide.*

Step 2
Note percentage unplanned weight loss and score using tables provided.

Step 3
Establish acute disease effect and score.

Step 4
Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.

Step 5
Use management guidelines and/or local policy to develop care plan.



Appendix 3

Free toolkit and e learning available via: **https://bit.ly/3eu9ZJL**

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Delirium can be prevented and treated. Delirium is a medical emergency!

Prevent it	Suspect it	Stop it
• Calculate risk • Assess for clinical factors • Daily care plan and actions	• New or worse o Confusion o Drowsiness o Behaviour • Do SQiD, 4AT or CAM	• Treat causes • Explain and reassure • Physical needs

Single Question in Delirium = 'Do you think [patient] has been more confused lately?' Ask a friend or family member

REMEMBER

TIME AND SPACE

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

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

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

Do

- Follow Delirium guidelines
- Re-orientate frequently
- Use calming speech. Involve family/ friends and familiar staff
- Walk to toilet frequently
- Be kind, calm, patient and mindful of emotional needs.

Don't

- Change bed/ward
- Argue/confront
- Catheterise – unless essential
- Restrain – do allow to wander with supervision
- Sedate unless part of treatment plan.

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THINK DELIRIUM

***Prevent* it, *Suspect* it, *Stop* it.**

Information for patients, relatives, carers and staff

What is delirium?

Delirium is a condition where people have increased confusion, changes in thinking and a reduced attention span. Symptoms can develop quickly and often fluctuate during the day.

Delirium is also known as 'acute confusion'. It is treatable - but if it is undetected then it can be a life-threatening condition.

How common is delirium?

It is quite common - it affects around 1 in 10 patients in hospital. It can affect anyone of any age. Delirium is more common for people in certain situations, for example, if they need intensive care, have a hip fracture, or have had surgery to their arteries or veins. It is also more likely to affect older people being treated for a medical condition.

Who gets delirium?

It can happen to anyone but there are some things that put a person at higher risk of it. These include:

- Older age
- Sensory impairment
- A diagnosis of dementia
- Having a lot of other health problems
- Being in hospital with a broken hip or serious illness.

What are the symptoms of delirium?

People are affected in different ways but people with delirium can:

- become restless, agitated or aggressive
- be withdrawn, quiet or more sleepy
- be less aware of what is going on around them or where they are
- struggle to think clearly
- find it hard to concentrate, for example keeping track of a conversation
- hear or see things that aren't there
- have vivid dreams.
- be more confused at certain times of day, especially evenings and night time
- feel an urge to wander around
- suddenly not be able to control their bladder or bowel movements.

If someone has dementia, the symptoms of delirium can sometimes be mistaken for the dementia getting worse, but it is important to recognise and treat delirium in its own right.

What causes delirium?

Delirium has many causes. Often more than one thing causes it to develop. Some causes are:

- Infection (e.g. urine or chest infection)
- Dehydration or malnutrition - not eating or drinking enough
- Pain
- Medicines (e.g. codeine, morphine, diazepam)
- Constipation
- Being unable to pass urine
- Problems that need surgery
- Being in an unfamiliar place
- Alcohol use or withdrawal.

How is delirium diagnosed?

Delirium is diagnosed by identifying that the symptoms of it are present,

and can't be explained in other ways. In this hospital we screen patients over 65 years old for possible delirium by asking a relative or carer if the patient has become more confused more recently.

If delirium is suspected, tests will be carried out to look for possible causes. For example blood tests, urine tests, a heart tracing (ECG) and X-rays. If you notice symptoms of delirium please let a doctor or nurse know immediately. You may wish to show them this leaflet to help to explain your concerns.

Is a brain scan needed?

Brain scans don't usually help to find a cause for delirium so they are not generally needed. In some situations a brain scan may be helpful, for example, after a head injury.

How is delirium prevented and treated?

There is evidence that delirium can be prevented by targeting the potential causes. For example, avoiding unnecessary urinary catheterisation to reduce risk of infection, avoiding constipation and encouraging good food and fluid intake. Any drugs that may be contributing to delirium should be reviewed. Ward and bed moves should be avoided wherever possible.

How can relatives and carers help someone with delirium?

- keep calm and speak in short, easy to understand sentences
- remind them where they are and why they are there
- reassure, don't argue or disagree
- don't argue with them

- remind them of the date and time, and make sure they can see a clock and calendar if possible
- make sure they have their usual glasses and hearing aids and use them
- encourage them to eat and drink - bring them food /drinks they like if this helps
- bring in some familiar photos or objects from home
- limit the number of visitors and reduce noise as much as possible - stimulating the person too much can make things worse

If someone has delirium and is behaving aggressively, what will help?

We aim to treat the symptoms that cause delirium because these can contribute to aggressive behaviour. It can help if relatives and carers can come in and sit with the patient to help calm them down. You might be invited to do this. If the person is very aggressive and may be a risk to themselves or others then they might be prescribed some medicine for a short time to help calm them down. This type of medicine is called a sedative. This is a last resort and will only be used:

- so that essential tests can be done
- to give essential treatments
- to protect the patient or others from harm

If this type of medicine is needed the lowest possible dose will be given for the shortest possible time.

How long does delirium take to get better?

Once the cause of the delirium is found and treated, most people start to improve within a few days. For a small number of people, delirium may take weeks, or occasionally even months, to get better. People who also have dementia are more likely to take longer to get better.

Some people who have delirium might continue to have symptoms. This might be a sign of early dementia. If so, the person's GP will be asked to refer the patient to the memory clinic for a full assessment.

If a person has had one episode of delirium they are more likely to have another one in the future.

This leaflet has been produced to give you general information about delirium. If you have any other questions please do not hesitate to discuss this with a member of the healthcare team who has been caring for your friend or relative.

For more information about delirium:

National Institute for Health and Care Excellence (NICE) information for people with delirium, carers and those at risk of delirium.

http://www.nice.org.uk/guidance/CG103/InformationForPublic

Royal College of Psychiatrists information leaflet:

http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/delirium.aspx

Original Authors: Dr A Clegg (Consultant Geriatrician), Dr A Illsley (Geriatric medicine registrar

Appendix 4

CAVPU

Changes to a person you supports consciousness is an important indicator that they are unwell. It can be hard to spot in a person who is normally confused but consider if there have been any changes to their sleep pattern (more or less), or perhaps focussing on the way they normally communicate, are they are doing this less often or less effectively?

Clinical assessments use the CAVPU scale as a way to measure changes.

Level of Consciousness	
C	(New or Increased) **C**onfusion
A	**A**lert 'can answer questions sensibly'
V	Responds to **V**erbal commands/questions
P	Responds to a **P**ressure or **P**ain stimulus
U	**U**nresponsive to any stimulus

Appendix 5

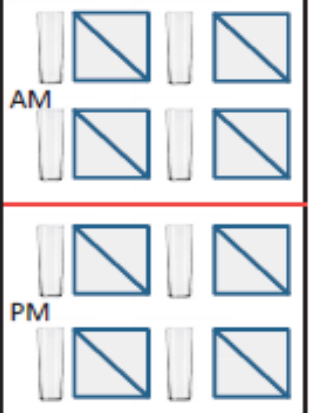
Hydration Matters

It is very important to monitor how much people you support are drinking, older people can become dehydrated very quickly, this affects their kidney function and can cause permanent damage.
The following is an example of a simple Hydration chart that can be adapted for use.

24 Hour Hydration Chart

WPG812

This chart is **NOT** to be used if strict input and output monitoring is required.
If you think your patient may be dehydrated use the jug with a RED lid.

Date	Drinks consumed, please cross off each drink consumed, time and sign	Passed urine/wet pad/emptied catheter bag. Please cross off 1 toilet every time patient passes urine or catheter bag is emptied
If patients have NOT consumed all drinks before red time line please review patient's hydration needs with a senior nurse and/or doctor and consider a strict fluid input/output chart. Please note this is the minimum number of drinks required each day. If you have **ANY** concerns about your patient's hydration status, please discuss it with the Nurse in charge or the Medical team.		

Use hydration chart for patients who do not need a fluid balance chart but you want to ensure they drink enough e.g. have:	**Remember to include:**
Risk of dehydration Dementia/confusion A disability so unable to feed themselves Thickened fluids etc.	Average portion jelly = 1 cup Average yoghurt = ⅓ cup Average custard = 1 cup Average soup = 1 cup Fortisip compact = 1 cup Average cup = 200 ml Sip feed = variable

If your patient does not have any of the factors listed but you are concerned about their hydration status then commence a hydration chart.

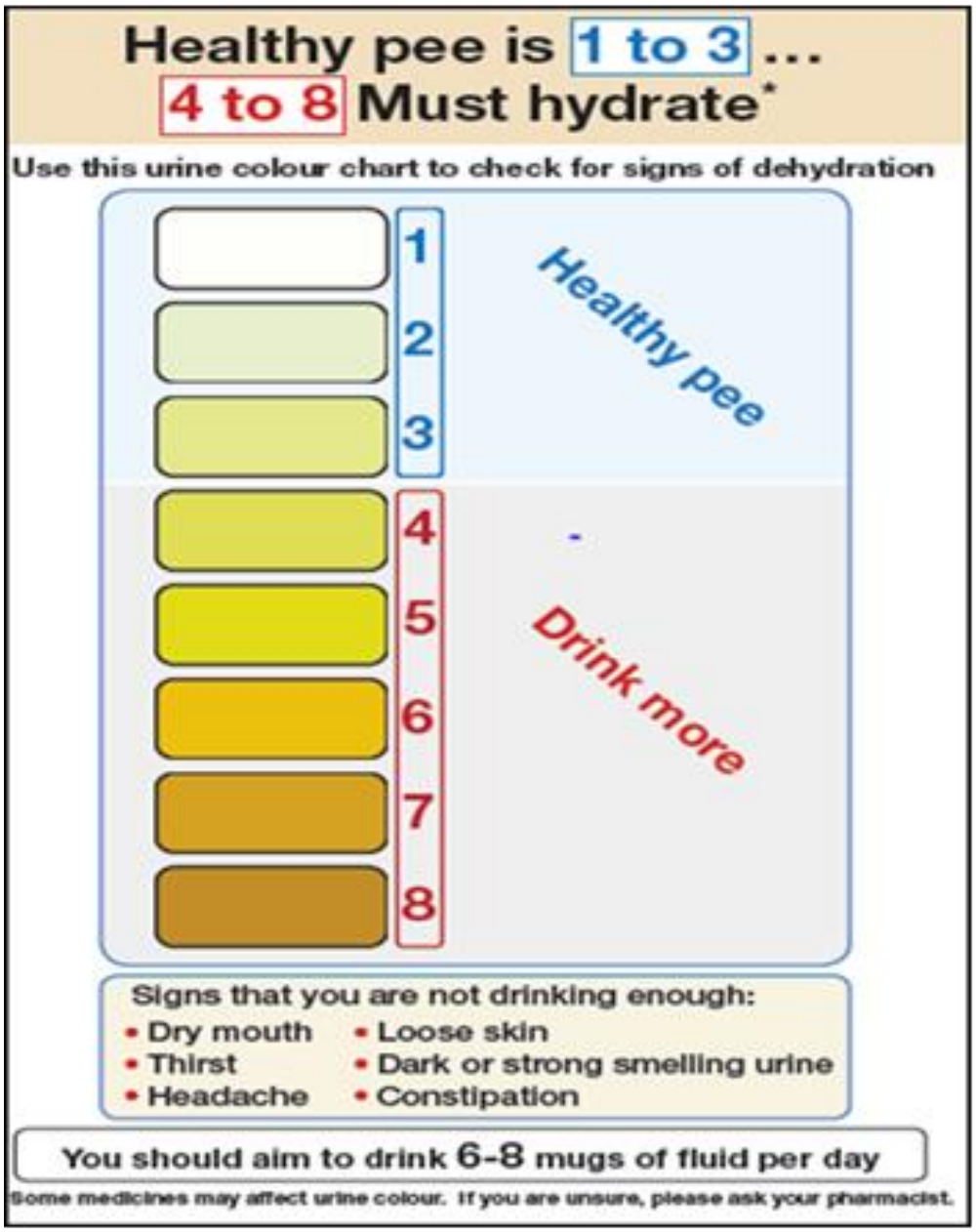
If the decision not to start a hydration or 24 hour fluid balance chart is taken, this must be documented in the patient's notes and the reason why.

Patients should be assessed every shift as a minimum

Adapted from documentation provided by Bedford Hospital

As well as monitoring how much people you support are drinking, you can also look for signs of dehydration, the colour of pee is a good indicator. It should be considered alongside the other signs that someone is not drinking enough:

- Dry Mouth
- Thirst
- Constipation
- Loose skin
- Headache



Training Package : Dehydration & Benefits of Hydration

What is Dehydration?

- *'the loss of water or body fluids from an individual'* (World Health Organisation 2002)
- Dehydration can affect both our physical and mental health
- It can affect your mood and feelings as well as your body

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Bradford City CCG
Bradford Districts CCG

CQC: Regulation 14: Meeting nutritional and hydration needs

- People who use services have adequate nutrition and hydration to sustain life and good health and reduce the risks of malnutrition and dehydration while they receive care and treatment.
- Providers must make sure that people have enough to eat and drink to meet their nutrition and hydration needs and receive the support they need to do so.

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Common causes of dehydration

- The elderly have a reduced thirst so may not know when they are thirsty
- Unable to communicate (cannot say when they are thirsty)
- Pre-existing medical conditions e.g. diabetes, stroke.
- Dementia
- Cognitive impairment
- Medications e.g. diuretics
- Dysphagia/swallowing difficulties
- Fear of incontinence due to drinking
- Mobility and dexterity issues

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What are the benefits of good hydration?

- Good hydration improves cognitive function
- Reduced risk of constipation
- Promotes skin health and reduces risk of pressure ulcers and aids wound healing
- Reduces risk of UTI's - Good hydration maintains healthy urinary tract and prevents infections

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What are the benefits of good hydration?

- Avoids postural hypotension (low blood pressure)
- Kidney stones- reduces risk of stones forming
- Reduces risk of falls- (dehydration identified as a risk to falling)
- Reduces risk of hospital admission and improves clinical outcomes
- Diabetes- blood sugar levels (high sugar level control leads to increased urine output)

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Signs and symptoms that can indicate a person may be dehydrated

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Let's Talk Hydration Levels

Bradford Teaching Hospitals NHS
NHS Foundation Trust

Signs of how hydrated your patient is!

1 2 3	Hydrated	If the colour of your patient's urine matches 1, 2 or 3, it can be used as an indication that they are hydrated.
4 5 6	Dehydrated	If the colour of your patient's urine matches 4, 5 or 6, they need to drink more. Update their care plan to ensure regular drinks are offered and drunk. Ensure staff assist the patient to drink for the 24/48 hours and monitor colour of urine to see improvement.
7 8	Severely Dehydrated	If the colour of your patient's urine matches 7 or 8 – **it may be an indication that your patient is dehydrated.** ➢ Review Fluid intake ➢ Commence fluid chart ➢ Observe for other signs of deterioration ➢ Contact the doctor if necessary

Healthy pee is 1-3; 4-8 you must hydrate!

Note: Some foods, Vitamins and some medication can change the colour of urine.
Also be aware patient maybe on a fluid restriction for an underlying condition

Adapted from Milton Keynes Hospital NHS Trust - 2018

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Tools for assessing and recognising dehydration

- GULP dehydration screening tool

https://eput.nhs.uk/wp-content/uploads/2014/07/GULP-Dehydration-risk-screening-tool.pdf

- Recognising dehydration

https://www.infectionpreventioncontrol.co.uk/content/uploads/2016/10/Advice-Bulletin-Care-Homes-02-2016.10.pdf

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Think about choices – what would people like to drink?

- Hot and cold
- Different flavours
- Colourful options
- Fruit infused water
- Ice
- Squash
- Fruit Juice
- Nourishing milk drinks

- Different types of cups – find out what residents like
- Try something new ***'flavour of the week/month'***

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FOOD FIRST
NUTRITION AND DIETETICS

GULP Dehydration Risk Screening Tool

To complete GULP, tick the boxes which represent your findings. Add up the total tick scores and follow the risk care plan accordingly. GULP is to be completed at initial contact and as and when circumstances change i.e. following illness. **For service users on a fluid restriction seek medical advice before making or suggesting any changes to fluid intake.**

Name:_____ **D.O.B:** ____/____/_____ **NHS** _____-_____-_____

Date of assessment: ____/____/_____ **Initials of assessor:** _____

GULP	Score 0	Score 1	Score 2
Gauge 24hr fluid intake *Tick one box*	Intake greater than 1600ml ☐	Unable to assess intake *or* Intake between 1200ml - 1600ml ☐	Intake less than 1200ml ☐
Urine colour (use pee chart) *Tick one box*	Urine colour score 1-3 ☐	Unable to assess urine colour ☐	Urine colour score 4-8 ☐
Look for signs, symptoms and risk factors for dehydration *Tick all boxes that apply*	No signs of dehydration ☐	If *any* of below reported: - Repeated UTIs - Frequent falls - Postural hypotension - Dizziness or light-headedness - Taking diuretics - Open or weeping wound - Hyperglycaemia ☐	If *any* of below reported: - Drowsiness - Low blood pressure - Weak pulse - Sunken eyes - Increased confusion or sudden change in mental state - Diarrhoea and/or vomiting - Fever ☐
Plan **For plan add tick scores together: G+U+L=Plan** *Tick risk care plan to follow*	**Total score:** _____		
	☐ **Low risk** **= score 0** • Encourage service user to continue with current fluid intake • Place "Keeping Hydrated" leaflet in care plan	☐ **Medium risk** **= score 1-3** • Encourage service user to increase frequency or size of drinks • Discuss "Keeping Hydrated" leaflet • Ask service user to self-monitor urine colour and aim for urine colour 1-3	☐ **High risk** **= score 4-7** • Encourage service user to take an extra 1000ml of fluid per day by: ○ Offering 250ml drinks at each visit ○ Explaining guidance to family/carers ○ Providing "The Hydrant" and "Hydration Boosters" leaflets • Discuss "Keeping Hydrated" leaflet

Appendix 6

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

First published: Lewis SJ, Heaton KW (1997) Stool form scale as a useful guide to intestinal transit time. Scandinavian Jorunal of Gastroenterology 32: 920–4

Loose stools can very quickly lead to dehydration even if the person you support is drinking normally.

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

Appendix 7

Chinese whispers exercise

This is a fun exercise that you can do with colleagues to demonstrate how difficult it can be to pass on a simple message

- Line up into 1 or 2 lines of colleagues (you will need at least 5 colleagues per line)
- Give the first person the message (below) on a piece of paper, ask them to read it and not to show anyone else then to whisper exactly what it says to the person next to them
- Each person then whispers what they hear to the next person in line
- The person at the end writes down exactly what they heard and feeds back to the rest of the group

To sum up ask colleagues to consider how misunderstandings happen sometimes when you think you have been clear in the message you have been given.

Ask colleagues to consider how they could improve and be clearer when they pass on any information

Message 1 - “Never let your inferior do you a favour, it will be extremely costly.”

Message 2 - “Morality like art, means drawing a line in someplace”