National Patient Safety Improvement Programmes

NHS Bradford District and Craven Clinical Commissioning Group

NHS

Managing Deterioration

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

Mel Johnson Y&H PSC Programme Manager
Bev Gallagher Head of Safety and Quality Improvement

Delivered by:
*The***AHSN***Network*
Yorkshire & Humber Patient Safety Collaborative & Bradford and Craven CCG

Led by:
NHS England
NHS Improvement

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

What do we mean by ‘Deterioration’?

Deterioration : ‘when a person you support moves from their normal clinical state to a worse clinical state. This increases their risk of morbidity, organ failure, hospital admission, further disability and even sometimes death.’

To reduce the chances of a poor outcome for the person you support we focus on:

1. **Recognition** – how do we spot early signs that the person you support is deteriorating?
2. **Response** – what actions do we take when we think a person you support has deteriorated?
3. **Communication** – How do we ensure the person you support is part of any decision we make and how do we ask for help from other healthcare staff (e.g. GPs, Ambulance, district nurses)?

Why do we need to spot deterioration early?

- By recognising deterioration earlier we can prevent harm
- Acting early increases the chances of successful treatment and being able to follow person you supports wishes
- We can avoid some hospital admissions which can be upsetting for the person you support

Can Carers Spot the Signs?

There is lots of research that says yes!

One study in 2000 showed that Nursing assistants in care homes spotted signs of illness by an average of 5 days before they were seen in the patients observations.
The study found that nursing assistants were able to spot behavioural and functional status changes in residents. This would also potentially apply to Home Support settings where people you support are visited multiple times daily.

Reference: Boockvar K1, Brodie HD, Lachs M, J Am Geriatr Soc. 2000 Sep;48(9):1086-91. Nursing assistants detect behaviour changes in nursing home residents that precede acute illness: development and validation of an illness warning instrument.

Knowing the person you support

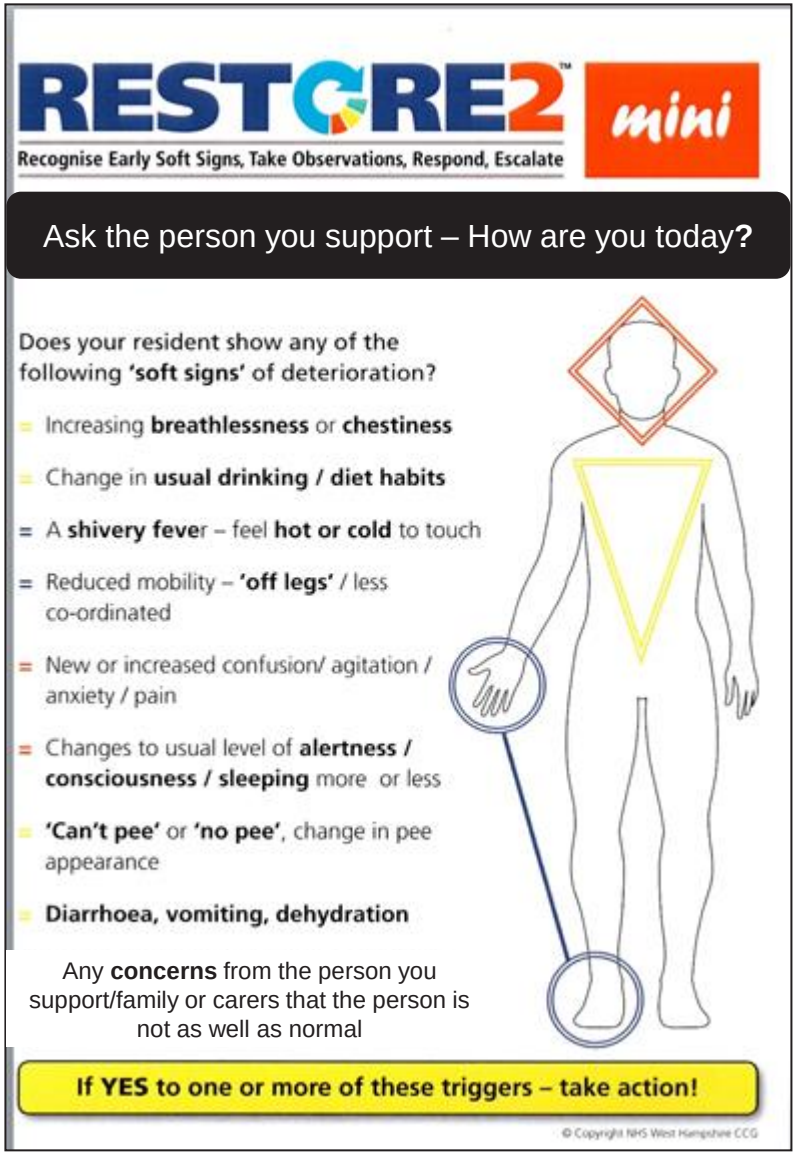
- Important signs can be spotted by everyone who comes into contact with the person you support (care staff, support staff, relatives, person you support themselves).
- Understanding what is normal for the person you support helps you detect changes.
- Good communication in the team is crucial; handover, accurate paperwork and care plans.
- The whole team needs to feel able to speak up if they are worried and feel they will be listened to.
- On their own soft signs may not look significant but looking at all the signs together will help you spot early deterioration.

RESTORE2 Mini

This tool consists of 8 prompts to help spot early signs of deterioration.

The tool is designed to support your '*Gut Instinct*' and help you explain to colleagues why you are worried so better care decisions can be made.

We will go through the clinical reasons why each of these prompts are included in the tool.



Local Bradford & Craven Tool

RESTORE2 mini

Recognise Early Soft Signs, Take Observations, Respond, Escalate

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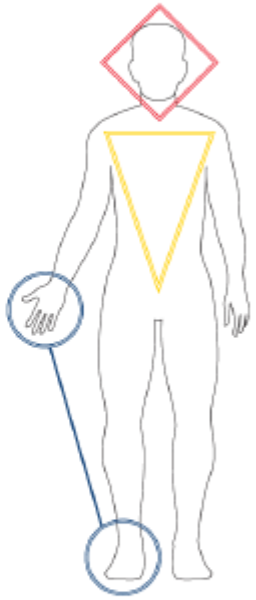
Person you support name:			
Date:		Time:	

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.

RESTORE2_SBARD_tool (Jul2020)

Any Concerns?

- The first and most important sign is that the person you support, family or colleague expresses a concern that they are not as well as normal.

- However small the change, your first step should be to do a full assessment using the RESTORE2 mini tool.

Remember: it may not be a specific sign you notice first, it could be that there is a gut feeling that they are not ‘quite right’, or are acting ‘out of character’.

Joseph, 81

About Joseph

- He has had personal care support at home since the death of his wife two years ago. His daughter visits him weekly with his shopping.
- He has a past medical history of bowel cancer and he had an operation in his 60’s to remove part of his bowel, leaving him with a stoma which he can manage himself.
- He was diagnosed with prostate cancer 5 years ago, which has spread to his hip bone and can cause him some pain on walking although he manages well on his own with a stick.
- He is sometimes a little forgetful but does not have a diagnosis of dementia. He is very sociable, likes his food, chatting with staff who visit and chatting to his neighbours on the phone.

Monday

- Joseph gets up at his usual time but comments to staff on the morning visit that he feels a bit ‘groggy’ and that he didn’t sleep well.
- Whilst staff are making his breakfast, he sits in his chair and watches TV but doesn't chat to staff as he usually would.
- When staff visit in the afternoon he is asleep in his chair. On waking he tells staff that he has been dozing off a few times during the day, which isn’t like Joe but staff put this down to the fact he has had a disturbed night’s sleep.
- He has not had much stoma output today, but he doesn’t mention this to staff
- Joe does not mobilise as much as usual during the day.

New or increased confusion/ agitation/ anxiety/ pain

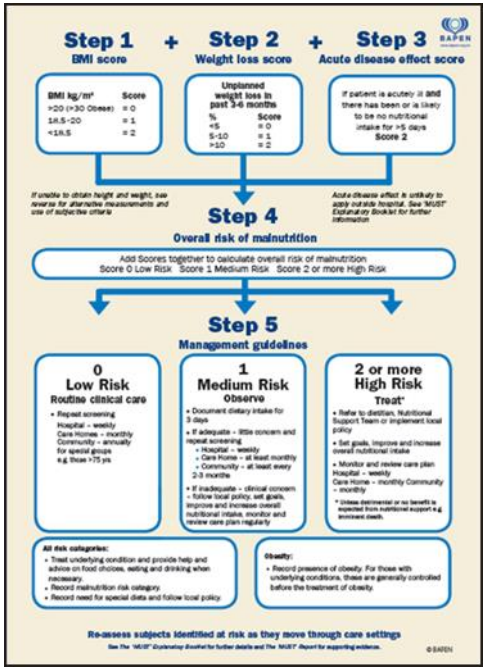
- You may notice the person you support is fidgeting, trying to get out of their chair/bed, looking scared or anxious. The person you support may become more active and aggressive, newly or more confused or nervous, withdrawn and tearful.
- Not all the people you support can tell you they are in pain. You may need to observe for non verbal clues such as: looking uncomfortable, fidgety, agitated or not wanting to move.

Clinical cause: Pain is an important symptom of something not being right e.g. pressure damage, bowel problems, angina.
Agitation can be an important sign of a developing infection, **delirium**, pain, lack of oxygen or problems with medication.

Free toolkit and e learning available via: http://www.yhscn.nhs.uk/mental-health-clinic/Dementia/WYHHCPICS/WYH_ICS_Delirium.php

Change in the usual drinking / diet habits

- Thinking about the person you support, has their normal eating pattern altered? e.g. eating less, avoiding certain foods.
- Has the person you support lost weight? Either through weekly monitoring or you may notice other signs like poorly fitting clothes, jewellery, drawn face.



Tools like MUST are a great help in monitoring and assessing dietary intake.

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

Lack of nutrition can lead to malnutrition with its potentially serious consequences.

Clinical cause: Causes of weight loss include stress, decreased intake due to ageing or can be a result of other changes in the body such as depression, infections and cancers. Lack of appetite can be a sign of lots of underlying medical conditions.

Tuesday

- Joseph had another disturbed night with back pain. He is short-tempered with staff the following morning and doesn't want them to make any breakfast for him.
- He sits in his chair watching TV again. It is a lovely sunny day but Joe shows no interest in sitting in the garden today.
- When walking to the toilet staff notice he seemed a little unsteady on his feet and needed help with his trousers.
- When offered a cup of tea he declines, asking for juice because his mouth is dry.
- Joe finds that he doesn't really fancy the cottage pie his daughter has made for his evening meal. He usually looks forward to this on a Tuesday. He has some soup instead.

Changes to alertness/ consciousness/ sleeping (more or less)

- Have there been any changes to a person you supports sleep pattern (more or less)?
- Whatever the person you supports usual way of communicating, are they are doing this less often or less effectively?
- Does the person you support have less energy?
- Consider their consciousness ‘Think **CAVPU’**

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

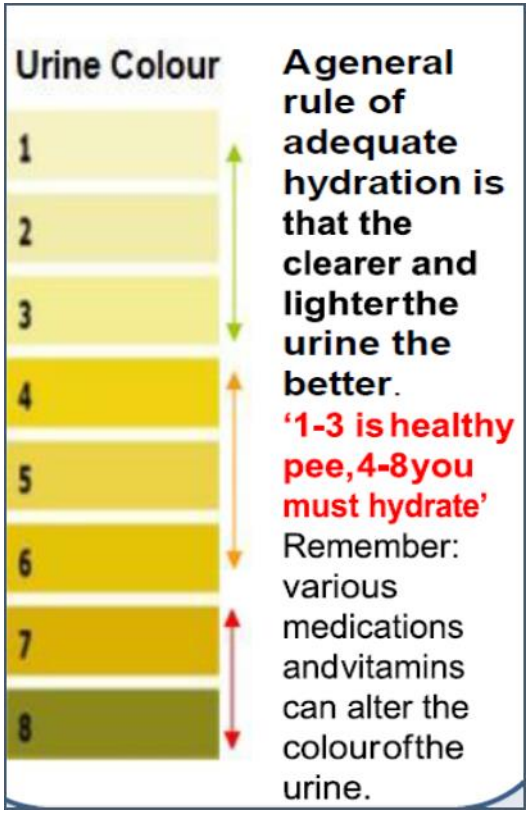
Clinical cause: These symptoms could be a sign of **delirium**

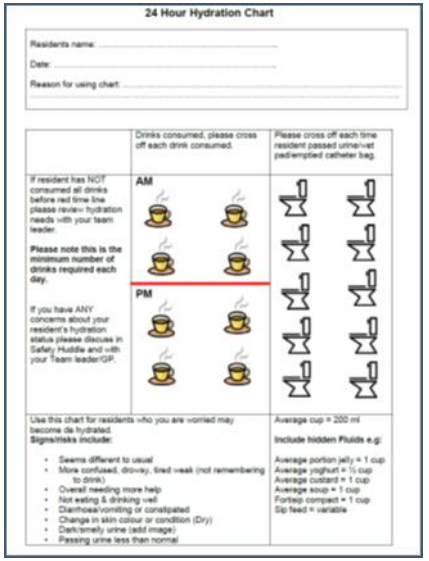
Wednesday

- Joe is really not feeling himself today. He is tired and doesn't have the energy to eat or drink much.
- He decides to mention his low stoma output to carers, and when they ask about his waterworks he realises it has been darker and more smelly than usual.
- Carers dip his urine which is all clear.
- Joe asks for extra paracetamol during the day and before bed for his backache. Embarrassingly, he forgets the name of several carers who visit him during the day. He goes to bed early.

‘Can’t pee’ or ‘no pee’, change in pee appearance

- Sometimes difficult to spot until the person you support becomes dehydrated which can have serious health consequences.
- Key is monitoring; consider using a simple hydration chart. Also observe the colour of urine.





Clinical cause: this can be a sign that the person you support has a UTI or their kidneys are not functioning well

Thursday

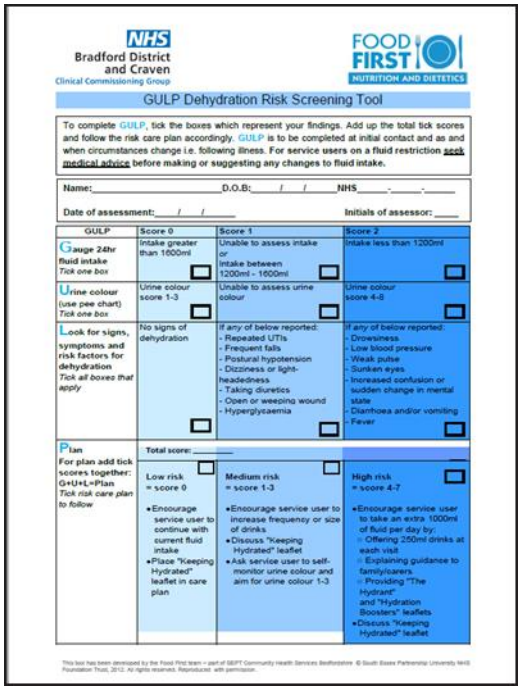
- Joe’s daughter Maggie is visiting today. He always looks forward to the visits, but today he seems to have forgotten, because the carers have to remind him this morning.
- He is eating and drinking less, and Maggie notices that his mouth and skin seem dry and his clothes appear looser than normal
- He falls asleep during her visit, which is troubling for Maggie. She talks to carers.
- Carers inform her of Joe’s sluggish bowels and say they think it is because of the increase in pain medication at night. They reassure Maggie that they are giving him laxatives and keeping an eye on things.

Diarrhoea, vomiting, dehydration

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.

Signs of dehydration:

- Increased thirst,
- tiredness,
- dizziness,
- headache,
- dark/decreased urine,
- sticky/dry mouth,
- irritability



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FOOD FIRST NUTRITION AND DIETETICS

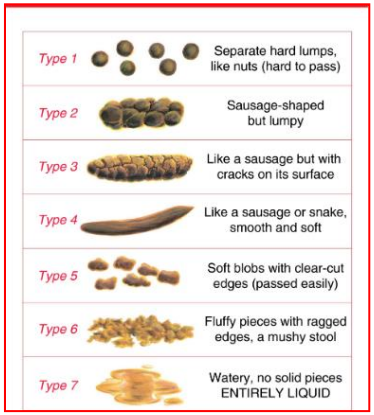
GULP Dehydration Risk Screening Tool

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



Clinical cause: Changes to bowel patterns can be a sign of infections, underlying medical conditions such as thyroid disorders or IBS, medications such as laxatives and antibiotics and more worrying conditions such as cancer.

Friday

- This morning, carers find Joseph in the bathroom in a mess. His stoma has started working and is passing loose watery stools.
- He has obviously tried to change the bag, but has not managed this and has soiled his clothes and the bathroom. He seems muddled and upset as to what he should be doing.
- Joseph wants to rest in his chair today. When staff visit at lunchtime he picks at his food and leaves drinks unfinished.
- In the evening staff visit earlier than usual and help him to bed because he has been falling asleep in his chair throughout the day.

Increasing signs of breathlessness or chestiness

For some people you support breathlessness may be normal (COPD, Asthma, Heart Failure) you are looking for any changes to their condition where breathlessness is not normal for them.

Increased breathlessness is one of the earliest signs of severe illness.

Chest problems are common in people you support, the common signs to look out for are:

- breathlessness or rapid and shallow breathing,
- wheezing/ noisy breathing,
- a persistent cough,
- coughing up yellow or green phlegm (thick mucus), or blood,
- chest pain or tightness,
- a rapid heartbeat,
- a high temperature (fever),
- skin colour changes (paler/bluish).

Clinical cause: lung conditions such as COPD or cancers, heart conditions including abnormal heart rhythms, anxiety and being unfit and or overweight.

A shivery fever – feels hot or cold to touch

As well as potentially having a high temperature, there are other indicators that you may notice in the person you support earlier such as them feeling tired or fatigued, having a headache or feeling sick or vomiting.

Clinical cause: Fever is most likely to be due to an infection, most commonly you will see infections from Chest, Urine, Stomach (Gastroenteritis) and skin (cellulitis, ulcers). However fevers can also be caused by virus, heat exhaustion & certain inflammatory conditions such as rheumatoid arthritis or a malignant tumour.

Saturday morning

- Joe has significantly deteriorated overnight. He mobilised to the bathroom during the night without his stick and says he fell for the first time. Luckily, he does not seem to have significantly injured himself, and denies hitting his head. The night sitter helped him back to bed but noted he seemed disorientated and unsteady on his feet and that his skin is dry and he appears pale.
- This morning, Joe was unable to get out of bed. He has had an accident and wet himself overnight. He is complaining of back and tummy ache. He is confused, asking for his wife Barbara.

Reduced Mobility- ‘off legs’ / less co-ordinated

- More dependent, asking for help, needing two staff to help with transfers, needing more help for activities of daily living.

Clinical cause: May be early signs of an acute illness such as UTI, dehydration, malnutrition, chest infection.

Softer Signs & COVID

The following indicated how the symptoms of COVID relate to the softer signs you have learnt about. If you suspect COVID you must tell your manager immediately.

COVID Symptom	Linked Softer Sign
Dry cough.	Increased breathlessness or chestiness
Tiredness, delirium	Changes to usual level of alertness
Aches and pains, headache	New or increased pain
Sore throat	Increased breathlessness or chestiness
Diarrhoea	Diarrhoea, vomiting, dehydration
Loss of taste or smell.	Change in usual drinking/diet habits
Rash on skin, or discolouration of fingers or toes.	Shivery fever
Difficulty breathing or shortness of breath.	Increasing breathlessness
Loss of speech or movement	Reduced mobility
Chest pain or pressure.	New pain

When did you first notice Joe was deteriorating?

- Monday – Reduced mobility, changes to his daily routine
- Tuesday – Poor sleep, low in mood, loss of appetite, reduced mobility, dehydration
- Wednesday – Tired, poor appetite, changes to bowels, reduced pee, increased pain, new confusion
- Thursday- Forgetfulness, poor appetite, weight loss, tired, changed bowel habits
- Friday – Diarrhoea, increased confusion, loss of appetite, sleepy
- Saturday – Fall, disoriented, unsteady, pale, incontinent, increased pain, very confused.

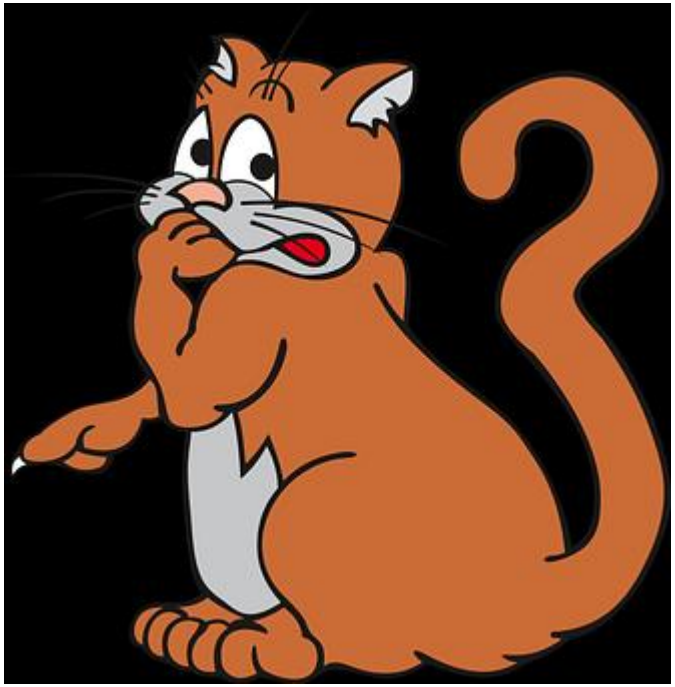
When would you have called for help?

What happened to Joe?

- His carers called 111 on Saturday am and following ambulance assessment he was admitted to hospital
- He was admitted to an elderly medical ward where he was found to have high calcium. This had probably been caused by his prostate cancer affecting his bones.
- High calcium has symptoms of dehydration, constipation, confusion and bony aches. It can be fatal if not treated quickly.
- He was very sick on admission and ended up staying 2 weeks in hospital, developing a chest infection on day 5
- He returned to his home on day 14 and took 3 months to fully recover his strength.

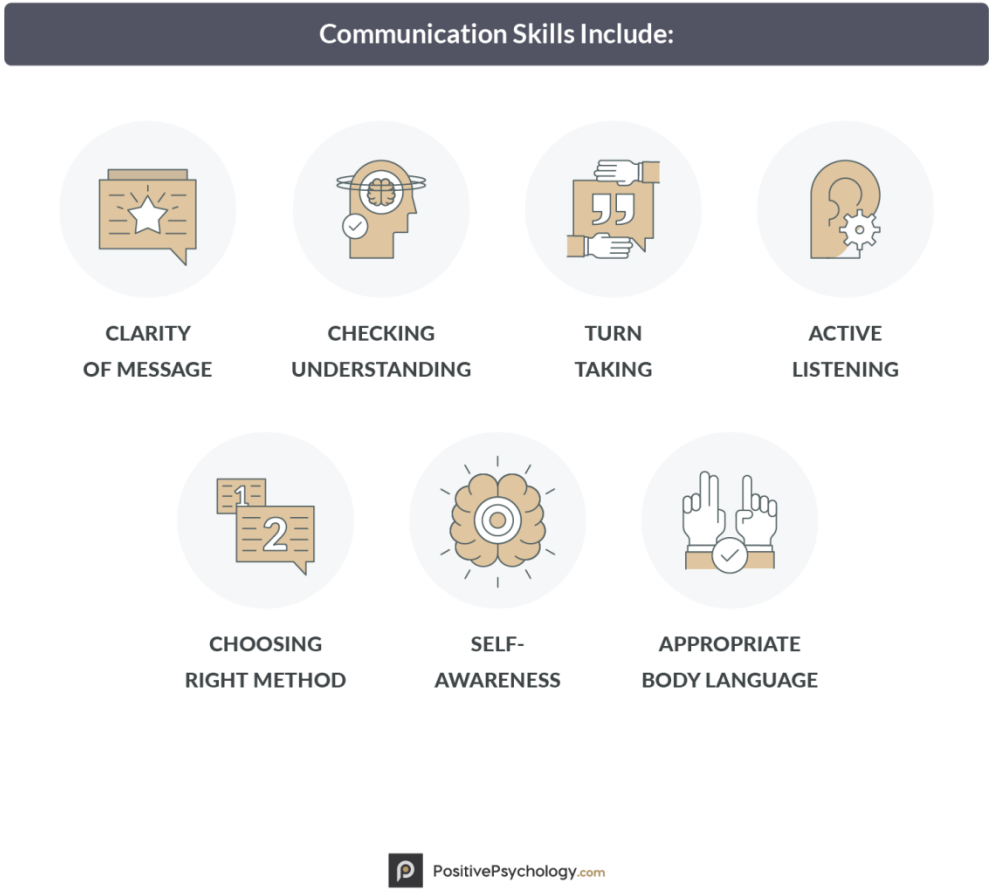
Could this outcome have been avoided?

Communicating your concerns



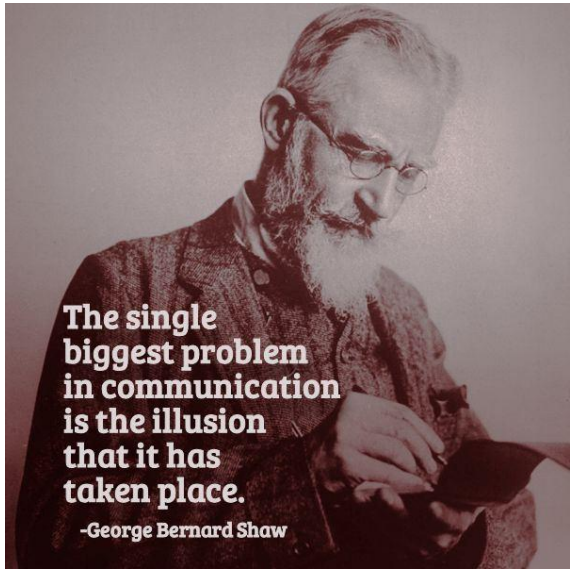
Becoming a ‘good communicator’

We are not all great communicators all the time BUT there are skills we can learn to make us better.



Improving team communication

- Consider how does the team communicate with each other (face to face, via technology, paper records)
- Does the critical information always get shared especially when handing over to colleagues?
- Who is involved in discussions about a person you supports wellbeing?
- How do you know if the message was understood as intended?



Structured communication tools

Can be helpful to:

- Help team members give the correct information
- Ensuring all colleagues get a chance to speak
- Ensure the important information is prioritised
- Maintain the focus of the discussion
- Helps ensure key information isn't forgotten
- Give newer/junior members of the team confidence to join in discussions.

When are these tools useful?

- Handovers
- Getting help – inside and outside the team
- Team meetings

SBARD

- SBARD is an easy to use, structured form of communication that enables information to be transferred accurately between individuals.
- Originally developed by the United States military for communication on nuclear submarines.
- Standardised prompt questions in five sections to ensure that staff are sharing concise and focused information. It allows staff to communicate assertively and effectively, reducing the need for repetition and the likelihood for errors.
- It helps staff anticipate the information needed by colleagues and encourages assessment skills.

- SBARD can be used in any setting but can be particularly effective in reducing the barrier to effective communication across different care settings and between different types of staff i.e. when you are calling for help to colleagues outside the team.

The use of SBARD prevents the unreliable process of 'hinting and hoping' that the other person understands.

Situation

- Identify yourself and the team/address you are calling from
- Identify the person you support by name and the reason for your communication
- Describe your concern.

What you say needs to grab the attention of the listener.

E.g. Hello, this is Mel from care at home. I am ringing about Bob Smith one of the people we support. I have just arrived at his home and he is on the floor following a fall and I am worried he may have a head injury.

Background

- Give the reason for your visit.
- Inform the receiver of the information of the person you supports background: significant medical history, admitting diagnosis, date of admission, current medications, allergies, DNACPR status.

For this part in the process you need to have collected information from the persons care notes.

E.g. Bob has a history of dementia, previous falls , he is tablet controlled diabetic and is on blood pressure tablets. He has a DNACPR in place but is still for active treatment.

Assessment

- The triggers from RESTORE2 Mini. Add any other indicators e.g. Blood Sugars if taken.
- Your impressions about what is wrong, any functional changes & other concerns.

e.g. – Bob has a blood sugar of 3.6, he appears flushed and I think he may have a temperature. He has been incontinent of urine and it is strong smelling. Although he has dementia he is usually mobile independently but is unable to get up. He definitely appears to be more confused than normal.

Recommendation

What would you like to happen by the end of the conversation.

- Any advice that is given on the phone needs to be repeated back to ensure accuracy & understanding.
- Explain what you need – be specific about request and time frame.
- Make suggestions.

e.g. – I would like an ambulance crew to come out and assess Bob, we are worried about moving him from the floor as he may be injured so we need a crew to come out in the next hour as we are also worried about pressure damage. We will stay with him and monitor for signs of distress. Is there anything else you can recommend while we wait for the crew to arrive?

Decision

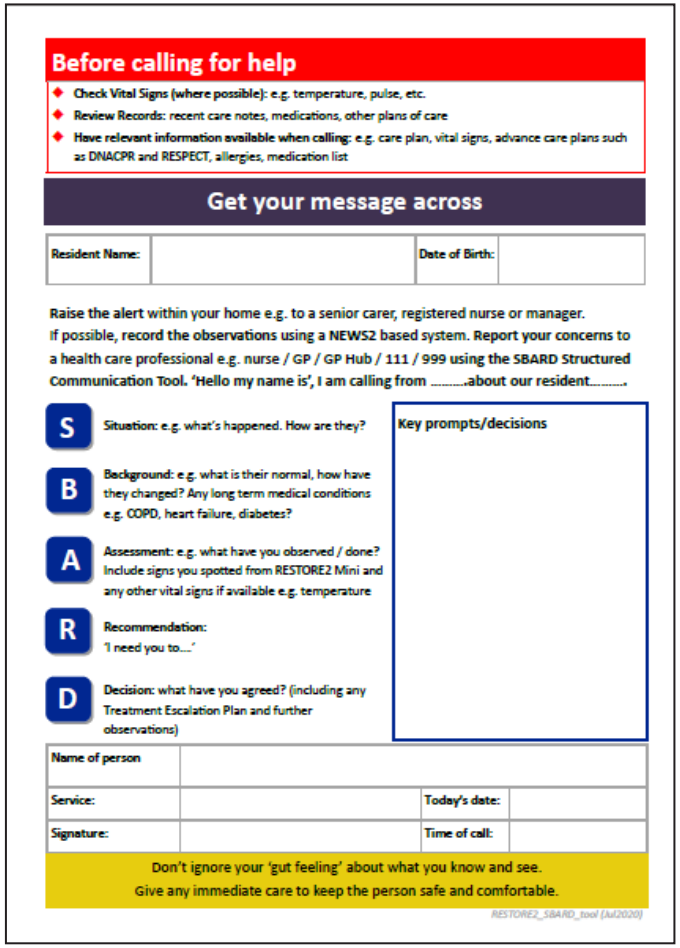
What you have agreed will happen next

- Times and specific actions need to be captured
- Agree a ‘Plan B’ If ‘Plan A’ doesn’t work out.

- e.g. – So we have agreed you will send an ambulance crew to assess Bob, to come to this address in the next hour. My colleague and I will stay with him and monitor for signs of distress. If he declines any further we will call 999.

Escalating your concerns

- If you are worried pick up a tool
- Assess the condition of the person you support using RESTORE 2 Mini
- Use the information + anything else you have noticed to escalate these concerns (following your organisations process).
- SBARD is a great tool for getting across critical information.
- There are many opportunities for information to get lost or become inaccurate and using structured communication tools like SBARD can help.



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 such as DNACPR and RESPECT, allergies, medication list

Get your message across

Resident Name:		Date of Birth:	

Raise the alert within your home e.g. to a senior carer, registered nurse or manager. If possible, record the observations using a NEWS2 based system. 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 our resident.....

		Key prompts/decisions
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)	

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.

RESTORE2_SBARD_tool (Jul2020)

Key messages

- Using RESTORE2 Mini to recognise when someone is becoming ill can lead to early interventions and stop the situation getting worse.
- Everyone has a responsibility to notice these changes and crucially to tell someone!
- If the team works well together these early signs are more likely to be spotted and get acted upon.
- Carers are in the best position to do this as you have the skills and knowledge to use these tools effectively.
- There are many opportunities for information to get lost or become inaccurate. Using structured communication tools like SBARD can help you get your message across clearly so the person listening understands why you are worried so appropriate help can be given.

What Next?

- Discuss your learning with colleagues, are there any questions you need help with?
- How would you use RESTORE2 Mini in your team, would it be a paper form to complete or do you have an electronic system?
- Test new ideas out, perhaps you could use the form for any person you support that you are worried about for a day, discuss with colleagues how it went and what you learnt?
- Practice using SBARD, there are scenarios available in your workbook.
- Think about how you will make sure all your colleagues get the training?
- Practical considerations: where will you store the forms so they can be grabbed easily, how will you tell each other of your concerns.
- Use your workbooks to remind yourselves what you have learnt and make notes of any questions you have.

Questions?

Contact for further support/information/access to other module contents and materials:

Bev Gallagher – Bev.Gallagher@bradford.nhs.uk

Lauren Ward – Lauren.Ward@bradford.nhs.uk