Bradford Home Support Handbook

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Version 04

Review Date: As part of the Home Support Service Improvement Board that takes place every 4-6 weeks.

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 a handbook and clear guidance for Bradford Home Support Providers ensuring that national guidance and good practice can be embedded locally by care providers.

Ensure escalation routes are clearly identified for care providers.

Topics covered in this resource pack:

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

Summary: Suspected Coronavirus Care Pathway

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.**

People may also commonly present with non-respiratory tract symptoms, such as new onset/worsening confusion/sleepy or diarrhea 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

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'). Behavioral interventions may be employed but physical restraint should not be used.

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

Communication with the Council

Please register and update the Capacity Tracker on a regular basis. Any issues, please email the Covid-19 Support Team: Covid19SupportTeam@bradford.gov.uk

Communication with the NHS

- Local Restore2Mini materials are available at this link Restore2Mini (a deterioration and escalation tool) if you have been trained to do so. Where appropriate please ensure that people are offered advance care planning discussions and that their wishes are recorded. The Restore2Mini is an award-winning physical deterioration and escalation package designed specifically for residential and nursing homes. It can also be used in the domiciliary care sector.
- **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
- Complete once weekly CQC tracker, click HERE to view

Isolate and Monitor

Person to be isolated in the household for **10 days**. Use Infection Control Guidance for person using PPE (guidance and how to wear and dispose) - Last updated 26 August 2021.

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

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

Conduct staff audits on Hand Hygiene and auditing the 6 stage hand wash technique used in care

Practice the 5 moments to hand hygiene here

Self-care and home hygiene are very important in reducing the transmission of Covid-19 in the home and wider community. Please download (Stay at Home Guidance), print off, discuss and leave a copy of this document with your service-user.

At each visit it is important to monitor the service-user for signs of deterioration (video). **If you have concerns immediately contact the patient's own GP or 111 and inform your manager.**

What to do in case of an outbreak? An outbreak is defined as two or more people diagnosed with symptoms compatible with Covid-19. If you have one or more new symptomatic people and these are the first new cases for over 28 days:

Contact: The Health Protection Team (Yorkshire and Humber)

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

Email: yorkshirehumberhpt@ukhsa.gov.uk

Phone number: 0113 386 0300

Update: Covid Support Team (get in touch with the team, detail here), IPC, SUS, Capacity Tracker and RIDDOR

How to access Personal Protective Equipment (PPE):

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

Resources and Support for Home Support Staff

- Guidance: provision of home care
- How to work safely in Home Support
- COVID-19 Care Platform
- Bradford Provider Zone
- RIDDOR reporting of COVID-19
- Restore2Mini – Training for Home Support Providers

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

- NHS England state that respiratory disease affects one in five people and is the third biggest cause of death in England (after cancer and cardiovascular disease). Lung cancer, pneumonia and chronic obstructive pulmonary disease (COPD) are the biggest causes of death. It is important that Home Support staff are vigilant in looking out for respiratory diseases, including Covid-19. (NHS England web link)
- Home support staff should always perform a symptom check with a person before commencing the service. Consider that respiratory diseases may be more common in winter months, requiring extra vigilance
- If a person is showing any symptoms of respiratory diseases or there is a deterioration in their health you should report it immediately to your manager. These may include:
    - 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.

  The symptoms of flu are very similar to Covid-19, if you test a service user for Coronavirus and the test is negative you should remain cautious that they could be suffering from a different respiratory disease like the flu. If concerned, contact the UKHSA.
- You must ensure that you are wearing PPE in accordance with the latest guidance for caring for a person who has Covid-19. All Home support staff should be fully trained on donning and doffing of PPE. For support they should speak with a branch manager. For local advice you can contact the Infection Prevention & Control Team (Details Here).

Infection Prevention and Control

Infection prevention and control platform:

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

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

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

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

General information on infection control and respiratory infection can be found in the link below:
Infection prevention and control: quick guide for care workers - GOV.UK (www.gov.uk)

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

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

Donning & Doffing

During support visit:

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

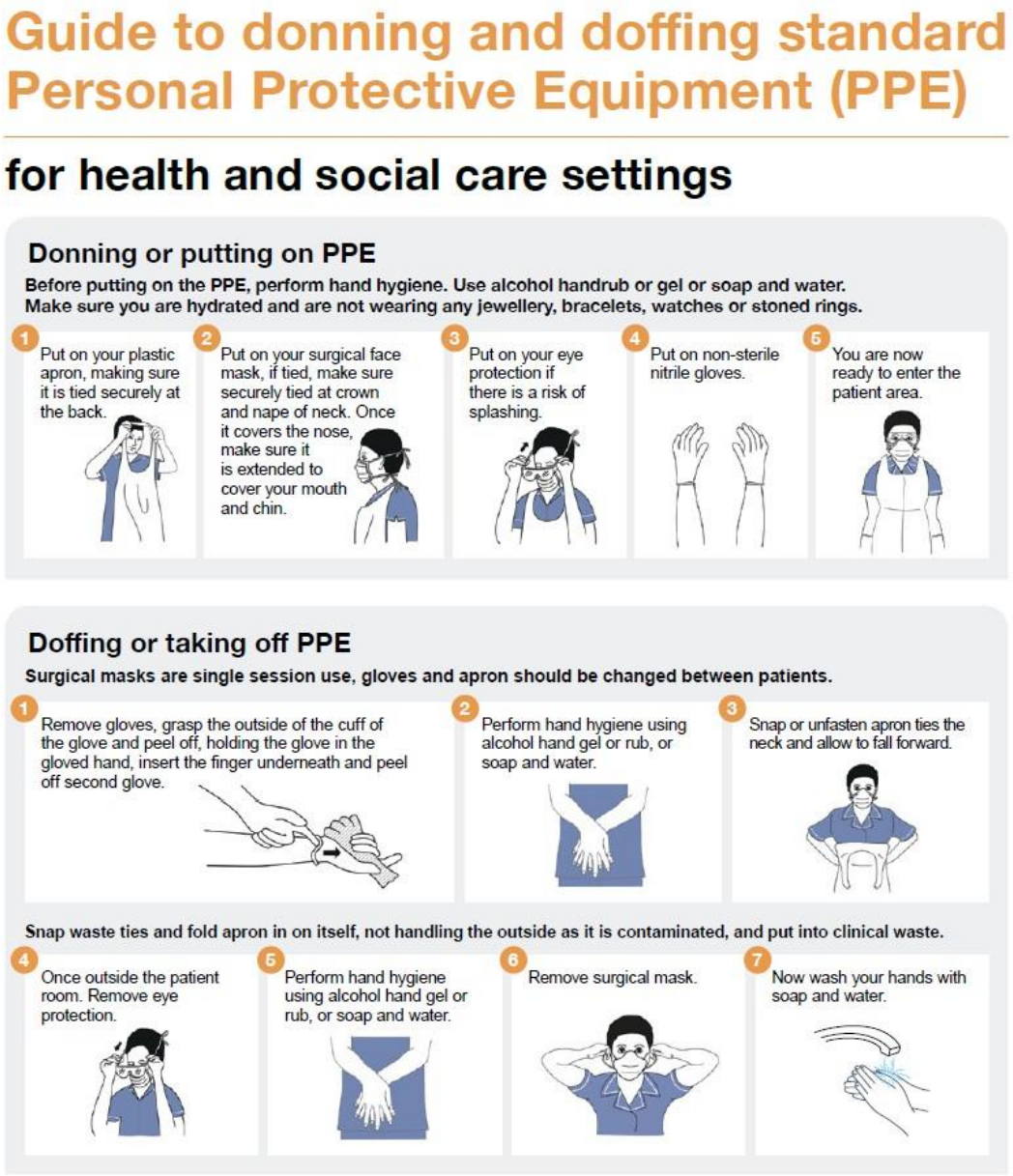
Ensure the correct donning and doffing technique is used (video)

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 willhave contact with more people in different procedures and settings, who are possibly infected. In addition, there are a number of styles of PPEmade by different manufacturers. You will see, for example, not all face masks will look the same.

Removal of (doffing) personal protective equipment (PPE)



Covid-19 and Flu Vaccinations

- Safe and effective vaccines are available for both Covid 19 and Influenza
- There are strict approval processes in place which mean we can be sure of their safety and effectiveness.
- 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 post -natal and breast feeding.

General COVID-19 vaccine information

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

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

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

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

Flu and Covid vaccination advice

Flu vaccine - NHS (www.nhs.uk)

Outbreak guidance

Community Care staff should perform an LFD test if they have any symptoms which could be suspicious of Covid-19. If a number of staff members from the same service are affected at the same time the service should follow the advice below:

- Community - A risk assessment would need to be undertaken to establish whether there is a link between the cases.
- Extra Care - A risk assessment would be undertaken and procedures for a break out would be followed which includes reinstating testing for both residents and staff.
- Stay at Home guidance would be discussed with anyone who tests positive but as this is no longer mandatory it can be difficult to 'enforce' both in community and extra care.
- Keep in mind that during the winter period other respiratory viruses may be circulating such as Influenza or RSV. Concerns relating to an increase in cases of staff with respiratory symptoms can be discussed with the Local Authority Infection Prevention team or with staff in the Health Protection team at UK HSA.

Yorkshire and Humber UKHSA:
Email: yorkshirehumberhpt@ukhsa.gov.uk
Phone number: 0113 386 030

Resources
COVID-19 Infection prevention and control (IPC):
COVID-19: information and advice for health and care professionals - GOV.UK (www.gov.uk)

Testing people and staff

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

Staff are offered priority access to the tests, which is different from a member of the public requesting a test.

Coronavirus (COVID-19) lateral flow testing in adult social care settings: Outlines the COVID-19 testing available for testing staff.

Home Support Providers can access the National Testing Portal or can arrange to order a Home Testing Kit on behalf of their Service User that is presenting symptoms.

The test confirms if someone currently has coronavirus.

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

Testing for influenza is not routinely available except on the advice of your GP or the UK HSA. Please follow the advice below if you think you have influenza.

Resources
Government Testing Guidance

Flu - NHS (www.nhs.uk)

Think

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

Ask

- What is the latest advice on testing?

Symptomatic home care staff or those who test positive should follow national guidance on self-isolation;

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

Admissions into home care

The admission of people into your care from hospital or community settings raises numerous challenges.

- Full guidance here.
- Risk Assessments should be carried out in line with current guidance and recommendations. See example risk assessments and templates (this is a HSE risk assessment)

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:
  - Support 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:
  - Follow the care plan instructions
  - Call community palliative care team if they are already involved and further advice is needed

Supporting your people with learning disabilities

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

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

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

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

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

Resources
End of Life Care: guidance
VIP Hospital Passport
To monitor signs of deterioration – Restore2Mini
Bradford Hospital Visitors guidance
Government guidance on exercise
Protecting extremely vulnerable people: Government guidance
Care staff supporting adults with learning disabilities or autistic adults: Guide

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

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

Additional health support from learning disabilities community team is available here

THINK (Consider using Restore2 Tool)

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

ASK

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

DO

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

Supporting your people with learning disabilities

COMMUNITY RESOURCES

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

- **Mental Health**
  - First Response (Tel: 01274 221 181) will support adults with learning disabilities if primary reason for referral is a mental health issue and the person's learning disability is mild

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

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

  Safeguarding children: airedalesafeguarding.children@nhs.net Tel: 01535 292389
- **Health support for people with LD** who struggle to access mainstream health services:
  - Health Support team based at Waddiloves and also office in Keighley and Craven. Contact Duty team on 01274 497121.

MCA / DoLS

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

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

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

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

For further advice, email:
MCA Service
DoLS Referrals

Resources

MCA and DoLS COVID 19 guidance and summary

Supporting your people with dementia

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

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

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

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

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

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

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

THINK

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

ASK

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

DO

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

Consider

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

Resources

- SCIE Supporting people with dementia
- Communication cards can help to talk about COVID-19
- HIN activities resources during COVID-19
- Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) COVID 19 guidance and summary
- British Geriatric Society short guide dementia and COVID-19

Supporting people who are more confused than normal

Delirium is a sudden change or worsening of mental state and behaviour. It can cause confusion, poor concentration, sleepiness, memory loss, paranoia, agitation and reduced appetite and mobility.

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 the GP let them know you are concerned.

Delirium in people with learning disabilities may indicate a deterioration in theperson's physical or mental health. Please contact the individual's 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 for advice and guidance
- Why is my person more confused than usual?

DO

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

Prevent it, Suspect it, Stop it.

Resources

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

Managing falls

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

To help prevent falls:

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

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

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

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

THINK

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

ASK

- **Dietetics:** Bradford or Airedale, Wharfedale and Craven
- **Community Therapy services (preventing deconditioning):** Craven/Bingley/Keighley/Ilkley or Bradford North, South & Central
- ACS Access Team for an Assessment of personal care needs for a Falls Pendant ACS.Access@bradford.gov.uk
- OT Moving & Handling for equipment needs assessment OT-Moving&Handling@bradford.gov.uk
- GP or community team for clinical advice and support
- Follow advice on NHS website on when to ring 999

DO

- Complete a multifactorial falls assessment
- 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
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

Mouth care is vital to prevent or reduce soreness. Good mouth care is thought to reduce the inflammation associated with COVID infection

If the person is conscious

Person sits upright with good head support, or lies on one side with head supported by pillows.

Frequent sips of cold water (every 30 minutes is ideal), unless unable to swallow or sit upright.

Use person's usual small, soft toothbrush (manual, not electric) with a smear of usual toothpaste or just water.

Toothpaste should be non-foaming and should not contain Sodium Lauryl Sulphate (SLS).

If the person becomes distressed

Encourage them to hold and feel the toothbrush, perhaps brushing their hand with it, to reassure that it won't hurt.

A wipe of toothpaste over lips can be a reminder / prompt of what is being suggested.

Try putting your hand over the person's hand and gently guiding the toothbrush together (hand over hand technique).

Distraction may help.

Try to involve someone the person knows and trusts.

Medications

Seek clinical advice on suitable types of gel or mouthwash.

Mouth moisturising gels should be slowly massaged in to avoid leaving a sticky layer.

Mouth ulcers

Medications may be prescribed.

Ensure dentures are regularly cleaned (see below) and toothbrush is changed.

Dentures

Clean dentures twice daily with a toothbrush and water.

Remove dentures at night and soak in a cleansing solution for 20 minutes. Recommended soaking solutions are:

- Dilute sodium hypochlorite solution for plastic dentures
- Chlorhexidine solution for dentures with metal parts

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.

Tooth brushing
Establishing good tooth brushing routines are important to help stop the progression of gum disease and prevent dental decay. Home support staff 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.

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
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.
Home support staff should encourage clients 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
Denture care is very important and residents should be provided with daily oral care for full or partial dentures.
Home support 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 frequent or long-term 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.
Also, certain medications may impact on a resident's saliva flow with reduced saliva flow increasing the risk of dental decay. Additional oral health support may be required.

Mouth Care Assessments

Completing a mouth care assessment is important to identify residents that are at risk of developing problems with their health and highlighting additional support required.

A mouth care assessment and plan should be completed for every resident. 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 resident's 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
- Learning difficulties
- Nil-by-mouth
- Palliative care
- Refusing food or drink
- Severe mental health
- Stroke
- Unable to communicate
- Uncontrolled diabetes

Assisting residents with mouth care

Following the completion of a resident's mouth care plan, varying levels of assistance will 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 tooth brushing or denture care.
- Staff should always provide reassurance when carrying out tooth brushing.

For more information, visit: https://www.bdct.nhs.uk/services/community-dental-care.
https://mouthcarematters.hee.nhs.uk/links-resources/mouth-care-matters-resources-2/

Nutrition Support Guidance

Standards 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 nutritional care plan in place and actioned and ongoing monitoring**
- **All residents at risk of malnutrition supported by using a 'food first' approach**. This means offering a fortified menu to increase calories and protein 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 high energy snacks or nourishing drinks
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*** *between meals and before bedtime.*

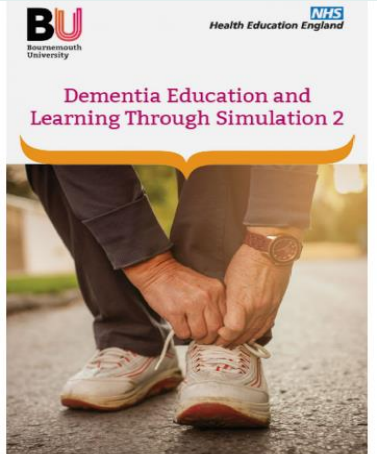
✓ ***Avoid*** *'diet', 'light', 'low fat' options.*

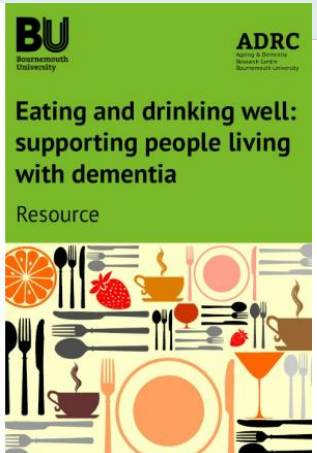
Further national support and guidance, including nutrition care plans, can be found here if you need support now:

Managing Malnutrition: Care Homes: Care Homes Fact Sheet: The Pathway: Making Malnutrition Matter (malnutritionpathway.co.uk)

The 'MUST' Itself (bapen.org.uk)

Update: Bradford District & Craven have a new Nutrition Support Team in development that will be working with care homes and communities, to provide training on screening, prevention and treatment for individuals at risk of malnutrition. Contact details to follow soon.





Podiatry Services

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

Suitable referrals for Podiatry that residents may present with:

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

Who and when to refer to Podiatry:

Any person with Diabetes that develops a new foot wound that needs debriding (except a pressure wound). The referral should be made within 24 hours.
Any other person that develops foot wound (except a pressure wound) that needs debriding.
An ingrowing toe nail 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.

How to contact Podiatry:

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

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

Airedale and Bradford Community Therapy Services

Support and advice for people 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?
You 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

ACS Access Team for an Assessment of physical needs
ACS.Access@bradford.gov.uk
OT Moving & Handling for equipment needs assessment
OT-Moving&Handling@bradford.gov.uk

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

Speech and Language Therapy

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

What issues might be presenting?

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

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

People where there is**:**

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

Questions to ask before referring:

- Has the person 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 person also been referred to a dietician?
- Are these swallowing/ communication issues new or has there been gradual onset?

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

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

GPs can refer the patient via **SystmOne**

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

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

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

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

Using technology to work with health and care professionals

To combat every day challenges facing adult social care, the sector has evolved in new and innovative ways that may require the use of technology - this is particularly relevant to Home Support.
Through utilising digital tools, you can ensure you can continue toaccess 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 - 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 providers, NHS England have put together an advice page for your consideration.

- Please consider taking these opportunities to enhance connectivity 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.
- The use of electronic rostering and care record systems,
- Using Apps for advice, support, training as well as team meetings/supervisions/appraisals.
- Enabling service users to contact their family members.

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 and use this telephone Helpline
- Ask your Local Authority/ICB/AHSN for support adopting new technology.

MDTs and virtual consultations

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

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

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

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

Supporting people's health and well-being

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

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

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

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

THINK

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

ASK

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

DO

- Use the NHS live well resources
- Adult Services Access Point - 01274 435400
- Make activities fun and engaging

Resources

Physical activity for adults and older adults poster
Simple set of exercises to stay active - video and a poster
Later life training you tube exercises including chair based exercises
Relatives & People's Association helpline
At a Loss tips to help someone bereaved at this time here
Cruse – what to say when someone is grieving here.
Long-terms effect of coronavirus (long COVID)

Talking to relatives

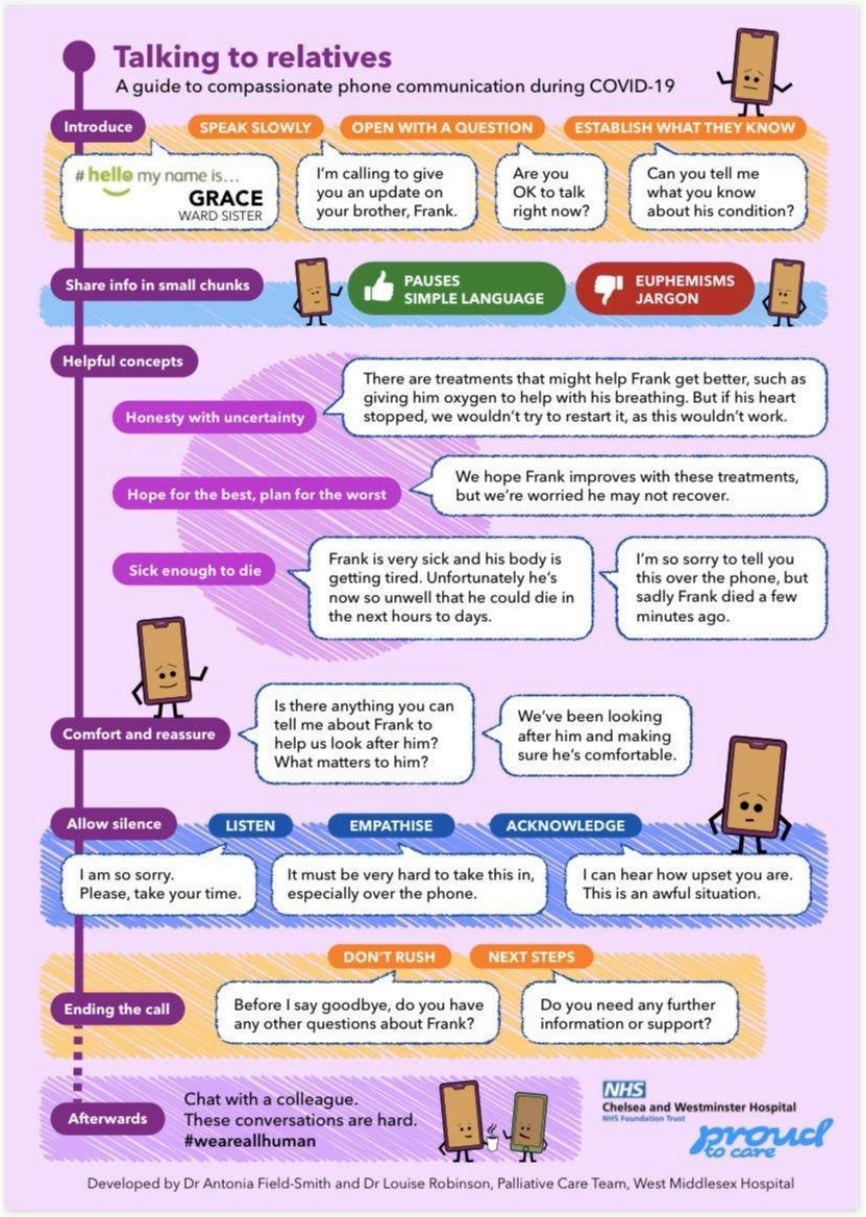
Conversations with relatives about health issues can be challenging.

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

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

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

Resources using Covid-19 as an example:
Real Talk [evidence based advice about difficult conversations]
Health Education England [materials and films] to support staff through difficult conversations arising from COVID-19.
[How we are keeping you safe and how to help us keep you safe]



Advance Care Planning ‘My future wishes’

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

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

Some people will also have an Emergency Care Plan or ReSPECT documents detailing their wishes in an emergency. ReSPECT will be continued to be rolled out in 2021.

People can start their own plan with family or staff support. That initiated work is then checked, edited and signed off by an appropriate health care professional making it visible to all appropriate users including Urgent Care Services.

THINK

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

ASK

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

DO

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

Resources

Further Information about ReSPECT click here

Short 2 minute Video on ReSPECT

One-hour recorded training session, delivered by the education hub leads from St Gemma’s Hospice in Leeds and Wakefield Hospice:

https://vimeo.com/421448975

- 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

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 home and be made as comfortable as possible when they are dying.

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

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

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

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

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 ReSPECT which details resuscitation discussions?

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

ASK

- The family and person if they want to connect using technology
- The GP or palliative care team or Gold Line (if people have already been referred to the service)
- GPs/Gold Line and Palliative Care Team are available for urgent support

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 staff well-being

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

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

- Consider and acknowledge how you are feeling, 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. It can help to focus on what we can control rather than what we cannot
- Acknowledge that what you and your team are doing matters. You are doing a great job!
- Choose an action that signals the end of your shift and try to rest and recharge when you are home

TO SPEAK TO SOMEONE:

- Our Frontline support for **healthcare workers** to talk by text, **text FRONTLINE to 85258** any time. To talk by phone for free, **call 0800 069 6222** from 7am to 11pm if you're in England, or **call 116 123** any time if you're elsewhere in the UK. Support for **social care workers** to talk by text, **text FRONTLINE to 85258** any time. To talk by phone, **call 0300 131 7000** from 7am to 11pm if you're in England, or **call 116 123** any time if you're elsewhere in the UK.
- Visit **Bereavement Support Online** or call the free confidential bereavement support line (Hospice UK), on **0300 303 4434,** 8am – 8pm
- **NHS Psychological therapy (IAPT):** Search here to find out how to get access to NHS psychological therapy (IAPT)
- **Finances:** The Money Helper Service work to improve people financial wellbeing across the UK. Add +44 7701 342 744 to your WhatsApp and send the Money Helper Service's national support team a message for help with sorting out your debts, credit questions and pensions guidance. Chat to one of the Money Helper Service team via their online portal

See next slide for more resources

Staff mental health and emotional 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:

- **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**
- **Recovering from COVID– 19 Support for staff - Primary Care Wellbeing Service**
- **The Cellar Trust Training and Website Link**

FURTHER RESOURCES:

- Building your own resilience, health and wellbeing website is a resource from Skills for Care
- **Reflective debrief after a death:** Support carers to take time grieving and reflecting together about the person that has passed away, what happened leading up to the death, what went well, and what didn't go so well, what could have been done differently, and what needs to change as a result of the reflection. Resource from 'What's Best for Lily' by UCL Partners. Find out how to do this by downloading resources here.
- For access to more tips, free guides, assessments and signposted resources, visit Good Thinking

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

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

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

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

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

Please can we ask:

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

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

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

Change Log last update: 12/04/2023

Details of change(s) & the page heading	Name & Date
Added Nutrition Support Guidance for People in Residential Care page	Matty Clark, Louise Keighley – 29/03/23
Added additional mouth care pages to the Mouth Care section	Matty Clark, Lou Bilenko, Sharon Walker – 12/04/23
Updated CRT contact details on ‘Airedale and Bradford Community Therapy Services’ & ‘Managing Falls’	Kate Hilditch- 15/09/23

Glossary

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