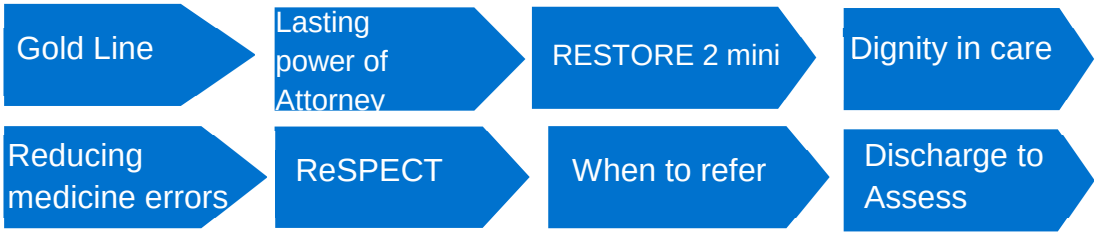
NHS
Bradford District and Craven
Clinical Commissioning Group

Wednesday 29th July 2020 **Care Home Edition 5**

Care@Home newsletter

Supporting people living with frailty and experiencing escalating needs during Covid-19



The Care@Home work stream is leading on the organisation of our COVID-19 response for care homes and the frail elderly at home in Bradford district and Craven.

We are working with key NHS, local authority, VCS and independent sector partners to keep as many of these patients at home as possible and are working directly with care homes to support them in a different way for the next few months.

We are introducing practical pathways for managing people that get sick in care homes, and frail elderly who get sick in their own homes - with covid, or non-covid related illness.

If you have any questions or feedback about this newsletter, or suggestions for articles to include, please contact Walter O'Neill - walter.oneill@bradford.nhs.uk

In this newsletter:

1. Gold Line referral form for care homes

The referral form below can be used to refer people to receive End of Life support through Goldline

The referral form for care homes is available electronically in this link; http://www.airedaledigitalcare.nhs.uk/resources/referral-forms/

The Gold Line – Information for Care Homes

- The Gold Line is a 24/7 support line for all patients and their carers with a GP in Airedale, Bradford, Wharfedale or Craven who are suitable to be part of the Gold Standards Framework (GSF)
- The Gold Line is available 24/7 but for use mainly out of hours when the patient's usual professional support is unavailable.
- Senior nurses skilled in triage, assessment and support answer calls.
- The Gold Line is based in the telehealth hub at Airedale General Hospital; the same nurses also take telemedicine calls from care homes and people in their own home.
- Before a resident is offered details and referred to the Gold Line, their consent will be required to include them on the GSF and share information recorded on SystmOne with appropriate professionals.
- If you ring the Gold Line the team will be able to access the patient SystmOne electronic health record (with consent or in patients best interests if lack capacity).
- The hub will arrange admission to hospital where necessary, but we hope to support more people to stay at home when safe to do so

1. **Who is the Gold Line for?**
   All patients who have a GP in the AWC and Bradford CCGs and who are on, or suitable for the GSF (i.e. all patients with life limiting illnesses who may be considered to be in the last year of life). Patients on chemotherapy need to call the oncology helpline before the Gold Line unless they have been fast tracked as being in last few days of life.

2. **How do Care Home teams refer a resident for the Gold Line service?**
   Speak to the GP or district nurse, agree the details then complete the information overleaf and email to the Gold Line team at digital.carehub@nhs.net or post to Gold Line, Digital Care Hub (A22), Airedale NHS Foundation Trust, Skipton Road, Keighley, West Yorkshire, BD20 6TD

You should explain to the resident and their family about the GSF. A discussion might include:

- Explaining that the resident has serious health problems that may limit their life expectancy
- Although their medical condition is not reversible, we want to provide control of symptoms and support to them and their families, aiming to provide the best quality of life possible
- We want to plan their care in line with their wishes
- Ask the resident if they have any views themselves about what they would want from the future (or has this been recorded previously)
- The resident may wish to ask about prognosis or have other questions, if the person speaking to them doesn't know the answers to these, ask the GP for help
- As a way to help coordinate care and to respect their wishes, we are going to suggest that the resident is placed on a special framework-called the Gold Standards Framework

Key Information: PLEASE COMPLETE AS MUCH AS POSSIBLE- discuss with GP/district nurse, if needed

1. Primary Palliative Care Diagnosis: Choose an item.

2. Confirm that care home has had discussion with GP and GP agrees resident suitable for GSF: (the resident cannot be placed on GSF or registered with Gold line without this)

Yes ☐ No ☐ Name of GP discussed with: Click here to enter text.

3. Confirm that the resident has given consent as below: (NB. If resident lacks capacity to give consent, this needs to be discussed with family/relevant others)

a) To be placed on the Gold Standards Framework ☐ - Consent given ☐

b) For Palliative Care teams to view/contribute to their SystmOne electronic record ☐ - Consent given ☐

4. GSF information leaflet given to resident and /or family? Yes ☐ No ☐ (see End of Life Resource Folder)

5. Gold Line Information leaflet given to resident and / or family? Yes ☐ No ☐ (see End of Life Resource Folder)

6. GSF status: Blue ☐ Green ☐ Yellow ☐ Red ☐ (please discuss with GP and refer to guidance overleaf)

Advance Care Planning. The resident should be involved in all advance care planning discussions if they have capacity to do so. In residents who lack capacity, best interest decisions will need to be made in conjunction with family/relevant others.

1. Does the resident have an advance care plan? Yes ☐ No ☐

Please add any details here (continue overleaf if needed) Click here to enter text.

2. Has anyone discussed the resident's wishes regarding CPR? Yes ☐ No ☐

3. Has a DNACPR form been completed and is it in the resident's care home notes? Yes ☐ No ☐

4. Has anyone talked to the resident about where they would prefer to be if they were in the last days of life?

Care Home ☐ Hospice ☐ Hospital ☐ Not able to express ☐ (give reasons why) Click here to enter text.

Not appropriate to discuss ☐ (give reason why) Click here to enter text.

Best interests decision made ☐ (names of those this discussed with) Click here to enter text.

Details of person completing this form:

Name: Click here to enter text. Role: Click here to enter text. Contact No: Click here to enter text.

For any further advice, or support to fill out the form, please contact our Gold Line Administration Team on 01535 292764

2. Dignity in Care
Social Care Institute for Excellence
Published: June 2020

This practical guide helps to define dignity in care, as well as how best to implement it. It is aimed at care providers, managers and staff who work with adults – especially older adults.

It defines the meaning of real everyday dignity to the lives of people receiving social care, their carers, families and friends, as well as the managers and staff who provide it. In effect, this means all of us. It also shows the links between dignity and key policy issues, and relates to Care Quality Commission (CQC) regulations at each stage

Click on the link below to access the guide;

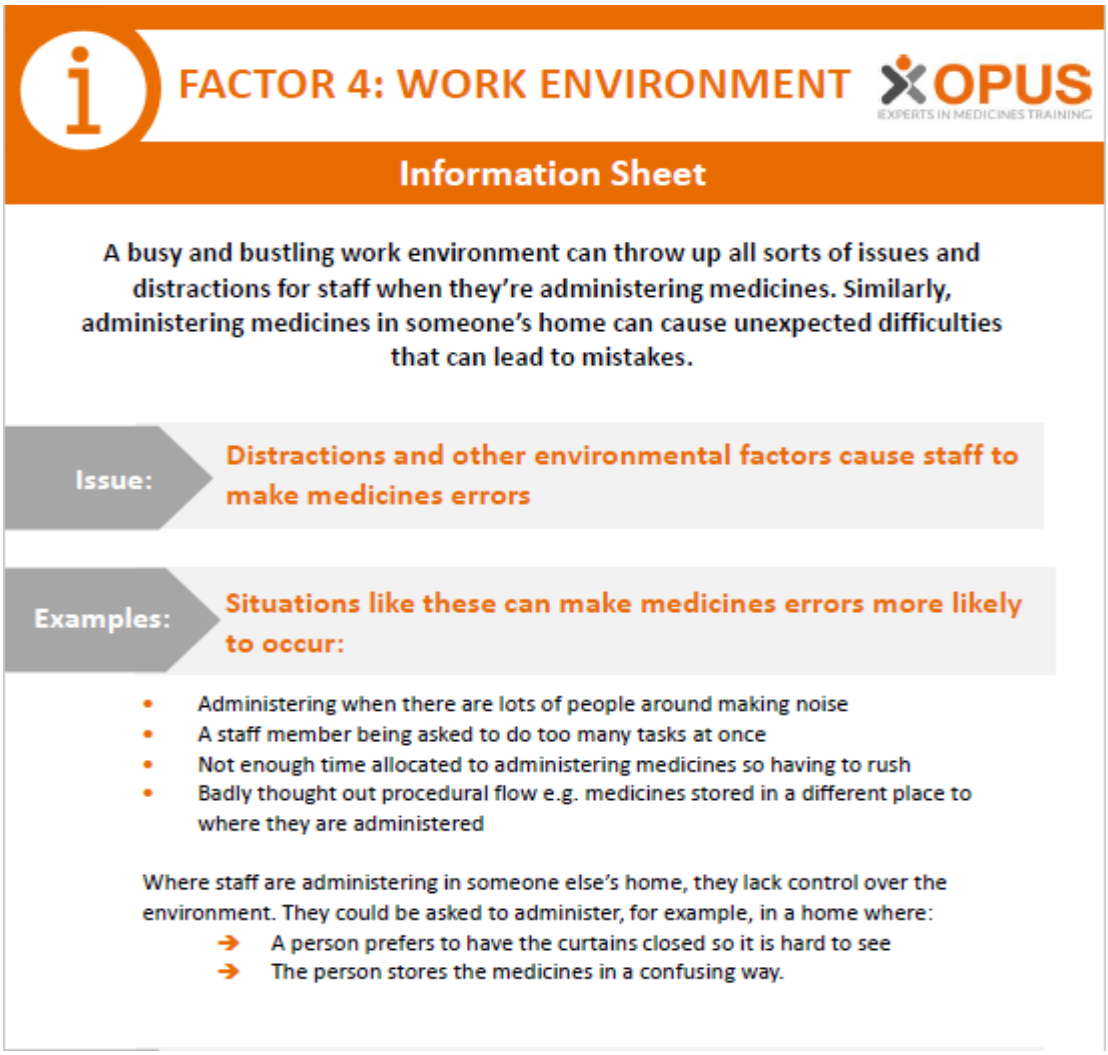
https://www.scie.org.uk/dignity/care?utm_campaign=11670486_SCIELine%2013%20July&utm_medium=email&utm_source=SOCIAL%20CARE%20INSTITUTE%20FOR%20EXCELLENCE%20&utm_sfid=003G000002DRGtVIAX&utm_role=Manager&dm_i=4O5,6Y506,1YQGYT,RYB5S,1

3. Reducing medicines errors

OPUS weekly bulletin to support providers to reduce medicine errors focuses on the Work Environment as a major reason for errors.

To complete a risk assessment and improve the work environment to reduce medication errors, download the OPUS Work Environment Risk Assessment here;

https://opuspharmserve.us12.list-manage.com/track/click?u=6cf284226bc919caf742b2f72&id=47aa8f5fa0&e=11f8dfc191



FACTOR 4: WORK ENVIRONMENT

OPUS
EXPERTS IN MEDICINES TRAINING

Information Sheet

A busy and bustling work environment can throw up all sorts of issues and distractions for staff when they're administering medicines. Similarly, administering medicines in someone's home can cause unexpected difficulties that can lead to mistakes.

Issue: Distractions and other environmental factors cause staff to make medicines errors

Examples: Situations like these can make medicines errors more likely to occur:

- Administering when there are lots of people around making noise
- A staff member being asked to do too many tasks at once
- Not enough time allocated to administering medicines so having to rush
- Badly thought out procedural flow e.g. medicines stored in a different place to where they are administered

Where staff are administering in someone else's home, they lack control over the environment. They could be asked to administer, for example, in a home where:

- ➔ A person prefers to have the curtains closed so it is hard to see
- ➔ The person stores the medicines in a confusing way.

4. Update of the ReSPECT process

ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment.

"The ReSPECT process is all about thinking ahead with people about realistic care options in a truly person-centred way. Ultimately the process aims to help people understand the care and treatment options that may be available to them in a medical emergency and enables them to make health professionals aware of their preferences"

ReSPECT includes a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

A ReSPECT form is a very specific type of Advance Care Plan (ACP) that summarises the emergency care aspect of a wider Advance or Anticipatory Care planning process. ReSPECT records that information so as to make it accessible rapidly to professionals who need to make immediate decisions about care and treatment in a crisis. Please see the poster below which shows how information is recorded.

ReSPECT creates personalised recommendations for a person's clinical care and treatment in an emergency when they might be unable to communicate this for themselves. It centres on having conversations between a person, their family, and a clinician.

ReSPECT

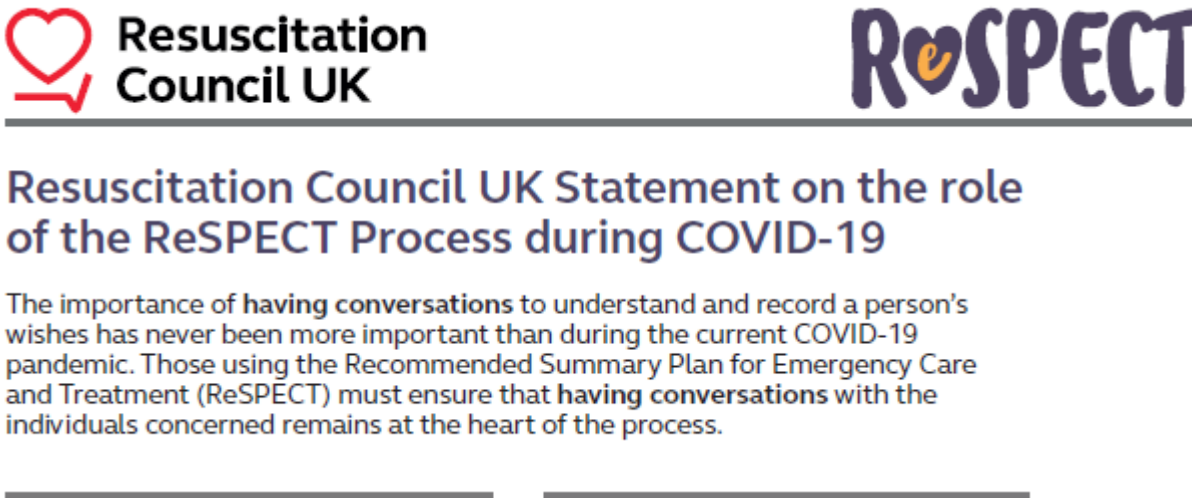
- involves recording a summary of the conversation on a form.
- The ReSPECT form belongs to the patient.
- ReSPECT is a clinical document.
- ReSPECT is NOT just a form and must not be completed in isolation.
- ReSPECT should not be used instead of a DNARCPR form -if this is all that is required
- ReSPECT is NOT an ADRT and is not legally binding

The ReSPECT form cannot, and must not, be filled in without having a conversation with the person and their clinician to inform the decisions recorded on

the form. If the person lacks capacity to contribute to the ReSPECT process, this must take place with their legal proxy (if they have one) or otherwise with a close family member.

ReSPECT is NOT part of a blanket approach to resuscitation and emergency care decisions. All conversations and decisions must be individual to the person involved.

Bradford District & Craven CCG, with our acute trusts (BTHFT & AFT) and BCCFT plan to roll out ReSPECT over the next few months.



ReSPECT is:

- a process which creates personalised recommendations for a person's clinical care and treatment in an emergency when they might be unable to communicate this for themselves. It centres around having conversations between a person, their family, and a clinician.
- a process that involves recording a summary of the conversation on a form.
- a process where the form belongs to the patient.
- a clinical document.

ReSPECT is NOT:

- just a form and must not be completed in isolation. The form cannot, and must not, be filled in without having a conversation with the person and their clinician to inform the decisions recorded on the form. If the person lacks capacity to contribute to the ReSPECT process, this must take place with their legal proxy (if they have one) or otherwise with a close family member.
- part of a blanket approach to resuscitation and emergency care decisions. All conversations and decisions must be individual to the person involved.
- a DNACPR form.
- legally binding.
- an ADRT.

It is appropriate to have a ReSPECT conversation with residents in a residential/ nursing care home, but this must be done on an individual basis. If a person lacks capacity to make decisions, a discussion should take place with those who know the person best to ensure the ReSPECT plan is as close to what the person would have wanted.

We encourage persons, family members and clinicians to follow the process and continue to engage in conversations around the care and treatments a person would both value and benefit from in an emergency.

Published 23 April 2020

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We encourage persons, family members and clinicians to follow the process and continue to engage in conversations around the care and treatments a person would both value and benefit from in an emergency.

Published 23 April 2020

5. Palliative Care in COVID-19

Key areas to explore when developing holistic urgent care plans for people at risk of severe COVID-19 – these plans may be made in conjunction with health professionals and families

• Ask if the person has ever expressed or formally documented preferences for managing a life threatening condition. This includes whether they have legally appointed a surrogate decision-maker or created a legally binding document specifying treatment preferences (such as an advance decision to refuse treatment)

• Explain the medical treatment escalation plan, including whether cardiopulmonary resuscitation, respiratory support, and other organ support in intensive care are medically appropriate

• Explain that, alongside the treatment escalation plan, there will be a plan in place for symptom management to ensure the patient's comfort whatever the outcome may be

• Ask: **"Knowing what you know now of your situation, is there anything else important to you at this time?"**

• Ask: **"Who should we contact in the event that you are unwell?"** Ensure that their contact details are recorded clearly

Phrases that might be helpful when communicating with people with severe covid-19 and their families and friends:

• Hope-worry statements-**"We are doing all we can. We hope you/your relative will start to respond, but I am worried you/they may continue to deteriorate in spite of our best medical treatments."**

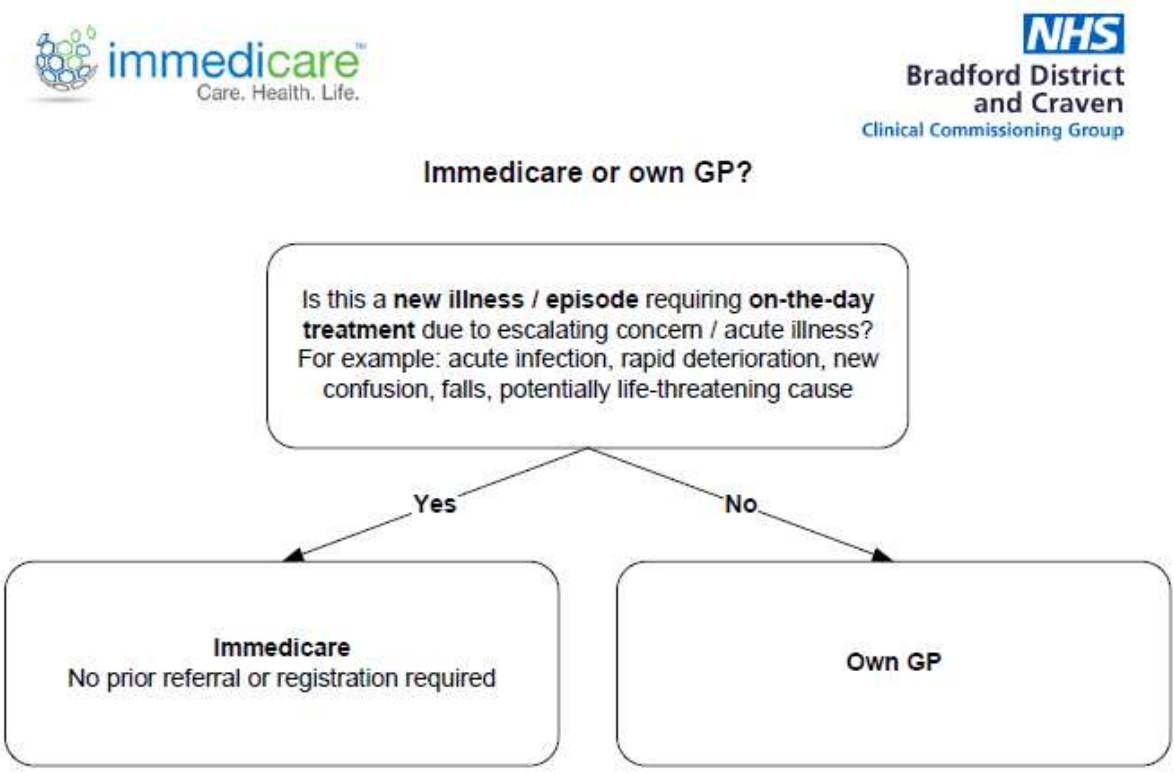
• Sick enough to die-**“I’m afraid there has been a sudden/ongoing deterioration, and you are/your relative is now sick enough to die.”**

• Advance care planning-**“We are hoping for the best, but it would be wise to start planning for the worst. Knowing the full picture now, what is important to you/your loved ones at this time?”**

• Comfort and reassurance-**“We are doing all we can, and, whichever path this takes, we will do our best to ensure you are/your relative is comfortable.”**

• Supportive or empathic statements-**“I’m so sorry that we’re talking about your loved one by phone and not face-to-face.” “This must be such a difficult thing to hear by phone.” “We are constantly checking your loved one, and we will ensure they get what they need.”**

7.Who to Call – Immedicare or GP?’



Examples of when to advise Immedicare *

- Acute infection needing on-the-day treatment due to escalating need
- Deteriorating patient where immediate decision is required by assessing clinician
- Fall requiring review
- New symptoms requiring immediate advice.

Examples of when a call can be handled by the GP surgery *

- Simple prescription requests e.g. food supplements, aperients, emollients
- Ongoing long term condition management
- Ongoing treatment of current illness requiring tweaking of medication or clarity on treatment plan
- Routine medication requests

* **Please note these are not exhaustive examples.**

- If the patient is displaying a deterioration that requires on-the-day treatment and advice, the home should contact Immedicare.
- Any ongoing episodes of care or prescription tweaks should be reviewed by the patient's own GP.
- Immedicare does not replace responsibility of the surgery for care home patients between the hours of 8am-6pm.

V1.1 27.02.20

8. Restore2mini, vital signs monitoring and structured communication tools care home training

The COVID-19 pandemic raised particular challenges for care home residents, their families and staff that look after them, this includes the fact that COVID- 19 often presents atypically in this cohort of people.

Care home staff, who have an in depth knowledge of their residents are well-placed to instinctively recognise these subtle signs of deterioration.

As part of the Care@Home offer to support people living with frailty in care homes with escalating needs we support the implementation of Restore2mini - a recognised consistent approach to recognise and respond to deterioration and support residents to get the right care.

Restore2 provides a platform to recognise and respond to deterioration, vital signs monitoring and a structured communication tool to enhance communication between professionals.

RESTORE2™ mini

Recognise Early Soft Signs, Take Observations, Respond, Escalate

NHS Bradford District and Craven Clinical Commissioning Group

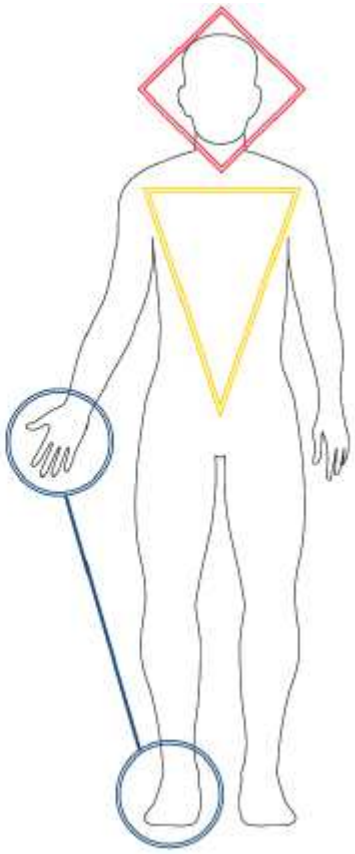
Resident Name:			
Date:		Time:	

Ask your resident - how are you today?

Does your resident 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 resident / family or carers that the person is not as well as normal?



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

Actions taken:	Name:			
	Reported to:			
	Date:		Time:	
Person in charge action taken:				
	Date:		Time:	
Outcome for resident:				

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

Key prompts/decisions

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. Immedicare Digital Hub / GP / 111 / 999 **using the SBARD Structured Communication Tool.**

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.

RESTORE - TRAINING AVAILABLE – see details below

Delivered by:
Yorkshire and Humber
Patient Safety Collaborative & Bradford & Craven CCG
TheAHSNNetwork

Led by:
NHS England
NHS Improvement

National Patient Safety Improvement Programmes
Managing Deterioration

NHS
Bradford District and Craven
Clinical Commissioning Group

NHS

Recognising and Responding to Deterioration in Care Home Residents through Restore2mini, vital signs and Structured Communication

Module 1 Dates: 28th July 14.00 pm
29th July 13.30 pm
3rd Aug 13.30 pm

Virtual training sessions via Zoom – log in details will be provided once registered.

To book a place, please contact Bradford & Craven CCG: Elaine.Phelps@bradford.nhs.uk
Dates and times for Modules 2 and 3 will be released shortly

9. Bradford COVID – 19 testing for admission to a care home from a person's own home or transfer from one care home to another

Individuals from the community OR transferring from another care facility must be tested prior to admission* to a care home setting AND will require isolation for a 14 day period following admission.

Referrals can be made by professionals involved or proposed admitting care home to BMDC Safe and Sound Team on: 01274 434994 and results will be fed back by the referrer.

For more information on specific responsibilities and scenarios to include emergency admissions by exception to a home without prior testing please see COVID testing for admissions to a care home pathway below

Moving forward responsibility for ongoing updates will sit with the Local Authority IPC team

Specific responsibilities for each pathway are demonstrated below:

Admission from community 'own home' to a care home

BDCFT Community Nursing Team Responsibilities

- For all individuals known or not known, symptomatic or asymptomatic, the COVID-19 Home Visiting Team (C19HVT) (HomeTeamCovid19@bdct.nhs.uk) will carry out the test on referral from LA Safe and Sound

BDCFT Infection Prevention Team Responsibilities

- Provide advice and guidance on IPC, PPE and isolation/cohorting
- Review test results recorded on ICE and advise the LA Bradford Hub at LACovidtestresults@bradford.gov.uk with plan of care for admission / further isolation

Local Authority Responsibilities

Refer any test requests made via Safe and Sound to the **COVID-19 Home Visiting Team** (C19HVT)

- Bradford Hub AIAs will record and manage testing using the LACovidtestresults@bradford.gov.uk email address, forwarding test request form with person's details to HomeTeamCovid19@bdct.nhs.uk
- When results are received back at Bradford Hub AIAs will log results and input onto the LA module of SystmOne and inform the referrer by phone of the outcome. A progress note will be input to SystmOne with the name of the person informed and the date.
- COVID-19 positive test in 'own home' if the person requires a care setting and the proposed home cannot take due to Covid 19 positive status refer to LA Access Point on: **01274 435400** for LA accommodation for isolation/cohorting
- COVID-19 positive test to an Independent Care Home – if appropriate isolation/cohorting is not available with the care home a referral should be made to the LA Access Team on **01274 435400** to request that the LA secure alternative accommodation and care

Care Home Responsibilities

- Arrange COVID-19 testing via Safe and Sound on **01274 434994** prior to admission, or after admission for emergency admissions (by exception only)
- For any new admissions, instigate a 14-day isolation period. If unable to meet this requirement discuss this with the LA assessment team
- COVID-19 positive test to a COVID-19 positive home – care homes must confirm with the LA that they are able to admit and accommodate these individuals through effective isolation/cohorting

Immedicare Responsibilities

- Provide enhanced surveillance of COVID-19 positive residents until the end of the 14 days isolation/cohorting period (those that continue to be unwell will continue to be monitored)

Transferring from one care home to another

BDCFT Community Nursing Team Responsibilities

- For all individuals known or not known to community nursing teams, who are symptomatic or asymptomatic, the **COVID-19 Home Visiting Team** (C19HVT) will carry out the test. A test referral will be made from the LACovidtestresults@bradford.gov.uk AIA to the C19HVT
- The COVID-19 Home Visiting Team will transfer the swabs to hospital for testing

BDCFT Infection Prevention Team Responsibilities

- Provide advice and guidance on IPC, PPE and isolation/cohorting
- Review test results recorded on ICE and advise the LA Assessment Team on LACovidtestresults@bradford.gov.uk who will inform the referrer and agree plan of care for admission / further isolation

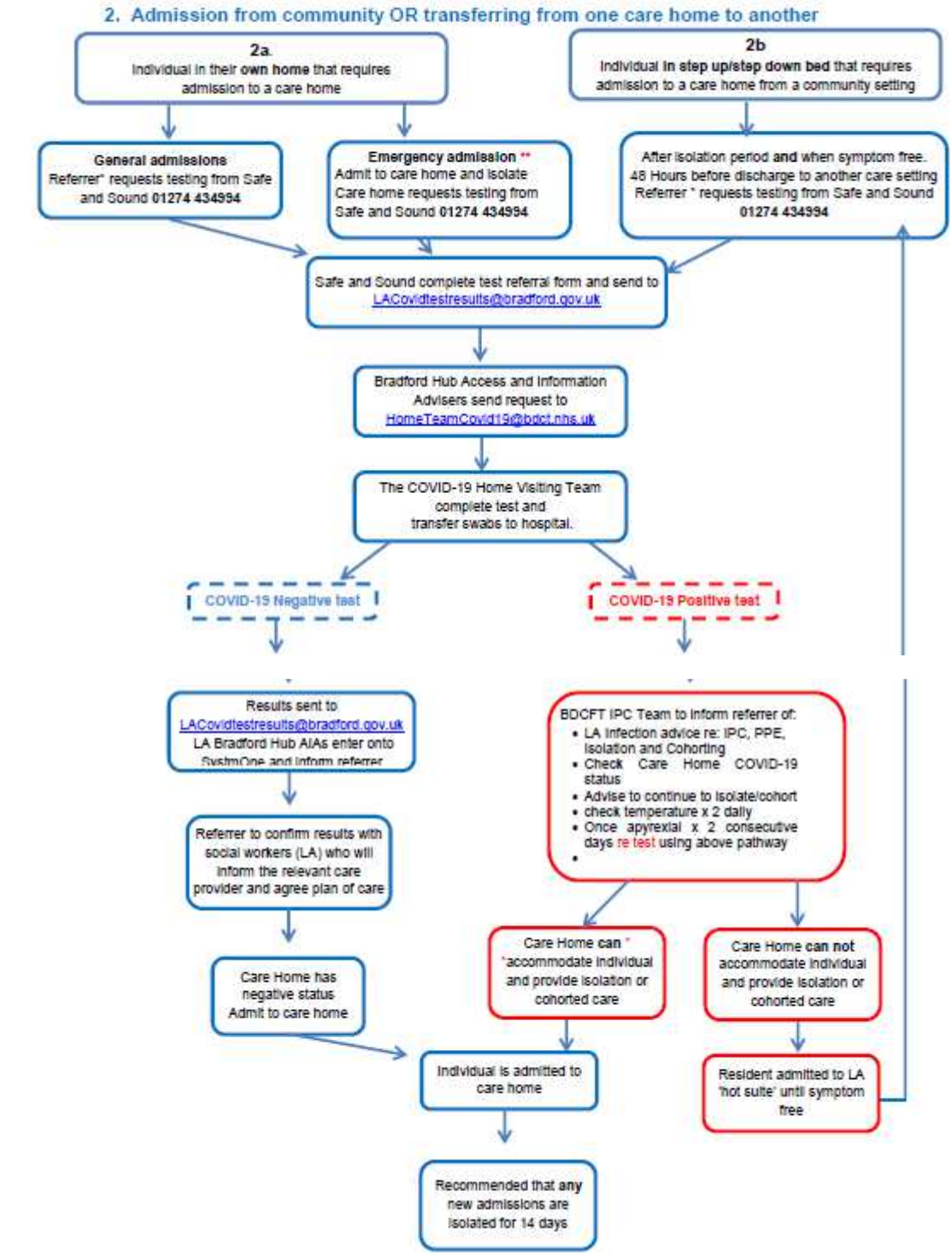
Local Authority Responsibilities

- When symptom free, if being transferred from a LA short term bed after isolation period, the LA is responsible for contacting the COVID-19 Home Visiting Team to complete test at least 48 Hours before discharge to another care setting
- If being transferred from one independent care home (ICH) to another, the LA is responsible for contacting the Safe and Sound **01274 434994** o on behalf of the ICH.
- If COVID-19 negative status, the LA contacts the care home to arrange discharge. (if home is infection free)
- If COVID-19 positive status, the social worker (LA) will inform the relevant care provider (and Immedicare) of date and time of all COVID-19 tests and continued COVID-19 positive status and will advise staff to continue to isolate/cohort, check temperature x 2 daily. Once apyrexial on 2 consecutive days, resident should be retested via The COVID-19 Home Visiting Team.

Immedicare Responsibilities

- Immedicare will provide enhanced surveillance of COVID-19 positive residents until the end of the 14 days isolation/cohorting period (those that continue to be unwell will continue to be monitored)

COVID testing for admissions to a care home pathway



* Referrer may be care home / social care staff, community nursing and therapy staff in care settings
** Any emergency admission(by exception) to a home without prior testing would need to be treated as COVID positive and the home would need to confirm that they would be able to provide effective isolation.

Updated process 20/07/2020 BMDC

10. Care@Home - Discharge to Assess (D2A) - now available to patients admitted to a care home from the community

Put simply, discharge to assess (D2A) is about supporting people to leave hospital (or step up from the community), when safe and appropriate to do so, and continuing their care and assessment out of hospital in the care home. They can then be assessed for their longer-term needs in the right place.

Care@Home have set up a D2A model for all admissions to Care Homes from the hospital and the community, where they will have a one off assessment by the Super Rota team (mainly Care of the Elderly & Rehab consultants and GPwSI in COE).

This doctor will review the records, including medication, PMHx and the reasons around the admission and develop an action plan for measures that need to be put in place. Some of these actions will be undertaken by the Digital Care Hub (referrals to OPMH, Physiotherapy dietetics, medication reviews, and some escalation plans etc.) and some actions will be passed back to practices to undertake around ACP and DNAR discussions, changing medications etc.

Most people will then be discharged back to primary care for on-going review in the 'weekly check ins' .Some patients with on-going issues that require a more frequent review will be stepped up to the Super Rota until they are stable enough to be discharged. We hope the new system will enable patients to access the support required as soon as possible after discharge.

Discharge to Assess (D2A)

D2A is now available to people admitted to care homes from the community to a care home.
We would like all care homes or GPs to let us know of the new admissions from the community by phoning **01535 292768** so we can arrange the review.

The present D2A service is running until the end of September

11. Lasting Power of Attorney and advanced care planning

Click on the link below for information about making a Lasting Power of Attorney while observing guidance on social distancing, self-isolating and shielding.

Making and registering an LPA during the coronavirus outbreak

12. Training and education resources

Leeds Community Healthcare NHS Trust is providing free live care home training (with an opportunity for questions and answers) on: COVID-19 Infection Prevention and Control - How to protect care home staff and residents wellbeing.

Session dates

- **Thursday 9th July – 2-3pm**
- **Tuesday 21st July – 2-3pm**
- **Tuesday 11th August – 2.30-3.30pm**
- **Tuesday 25th Aug – 2.30-3.30pm**

Join any of the sessions via zoom link: https://echo.zoom.us/j/94916461139
Meeting ID: 949 1646 1139

To join a session via Zoom you'll need access to a PC with camera and microphone; or laptop; or Smart Phone
For further IT support contact janec@st-gemma.co.uk

The Gold Standards Framework (GSF) Care Homes Training Programme

An Invitation to join the GSF Care Homes Programme.
designed to help you provide the best care for all your residents,
right up until the end of life, empower your staff,
transform the culture of care and significantly reduce hospital admissions and deaths

The GSF Care Homes Programme used by over 3000 care homes since 2004, is the most well recognised way to achieve long-term, effective sustainable change for care homes - the 'gold standard' of care.

Programme - in line with current best practice, learning from Vanguards, helps you attain the Enhanced Care in Care Homes (EHCH) model in practice, enhancing primary care support and working with GP's, MDT and in-reach support. It promotes independence and high quality integrated care in final days, as well as workforce training and development leading to more confident team.

1. **4 days of training** - over 6 months with progress to accreditation within 9 - 12 months
2. **Affordable** - depends on the size of the home - Average cost for training programme £995+VAT
3. **Simple** - focussed on 7 key tasks, progressing to Accreditation and Quality Hallmark Award
4. **Outcome focussed** - evidence of impact, audits, audits, outcomes, systematic care, all as evidence for CQC inspections
5. **Digital-ready** - helps get you ready for better IT record sharing for integrated care

"The GSF programme represents incredibly good value, builds on 15 years of success involving thousands of care homes, where it has been shown to be transformational, not only for staff but for relatives and residents. GSF helps demystify dying, and encourages everyone to play their part, so staff morale improves and turnover decreases. In enabling better quality care, with better outcomes recognised by CQC, this helps differentiate quality homes from others, making them stand out in this vital area of care."

Prof Martin Green OBE, CEO Care England

The Gold Standards Framework (GSF) Care Homes Training Programme

What do we hope to achieve with GSF?

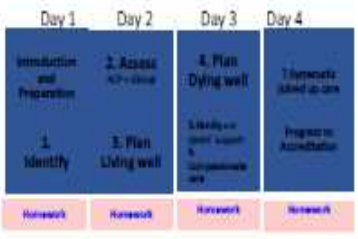
1. Better quality of care experienced by all people nearing the end of life

3. Better outcomes for people *living well and dying well where they choose*

2. Better communication + coordination, systems, teamwork

4. Better outcomes for health systems, *better use of limited resources, reducing over- hospitalisation.*

GSF Care Homes Programme



Accredited and Re-accredited teams recognised with the well-regarded GSF Quality Hallmark Award

As the most widely used end of life care improvement programme for frontline staff, GSF has been at the forefront of the national momentum of best practice since 2004. **GSF Care Homes Training Programme and Accreditation is recognised by:-** Skills For Care as an Excellent Provider, Care England, National Care Forum, National Care Association and Registered Nursing Home Association **and by Care Quality Commission. Many GSF homes receive outstanding and excellent CQC reports**

The Evidence:

- **Spread** - more than 3,000 care homes GSF trained with hundreds GSF accredited (many reaccredited 2, 3 and 4 times)
- **Impact - CCGs** - Significant reductions in hospital admissions and deaths in GSF homes, with home deaths increased, leading to significant cost-savings to CCGs e.g., £1.4m/CCG
- **Impact** - residents and staff improved quality of care, culture change and positive feedback from relatives
- **Communication - 95% GP practices** use at least basic GSF, most with a GSF/Pall Care Register including care homes residents

What teams from GSF Accredited Care Homes say...

"I really think it was GSF that helped us get the outstanding rating. *All the principles you implement when doing GSF are principles that help you to get an outstanding inspection from CQC Inspectors mentioned that our care for people who are dying is like a hospice".* Kineton Manor Nursing Home rated outstanding by CQC.

"GSF has improved what we do immensely, and we've noticed a major reduction in hospital admissions. In fact, hospitals and hospices are now referring patients to us to look after at the end of their lives." Denese McPhee, Manager, Church View NH.

"One of the overwhelming outcomes of GSF for us has been the significant culture shift across the whole home. The trepidation and angst,.... has now gone – Advance Care Planning is now embedded in the fabric of the whole organisation." Owner, Melrose Care Home, GSF Care Home of the Year.

Reduced hospital deaths, more dying at home in 1st, 2nd, 3rd time accredited care homes

Reduced charges leading to greater affordability. Average cost for training programme £995+VAT to include all staff for 2 years, with 10% reduction when booked with accreditation.

Join the national momentum of best practice and become a gold home. Contact the National GSF Centre on carehomes@gsfcentre.co.uk | 0207 7893 740 | www.goldstandardsframework.org.uk

Educational resources for Continence Awareness and Management

The BDCFT Continence Service work closely with Essity (Tena) using their products and resources.

Essity is delighted to support the continuing professional development of Healthcare Professionals and Care Home Staff members through e-learning at TENA Academy.

Accessed via www.tenanet.co.uk learners can self- register for 7 modules exploring various aspects of incontinence which can be studied at each learners own pace , and accessed at any time.

A certificate of learning is available following the completion of each module.

Ongoing support Information regarding TENA products, training and services is available from Essity's local Account Contracts Manager- Sharon Jackson on 07342087176.

Please click on the link below to access the information leaflet relating to Tena Academy.

https://zerodrive.pitcher.com/50f341a6a6773bd4e39a93624063c07d