Supporting people in care homes and their own home to stay safe and well this winter - what can we do?

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Overview

- Care Home Context
- System wide support for staff
- Protecting service users and ourselves
- Other developments

Care Home Context

- 227 Residential Homes 4201 residents
- 241 Nursing Homes 9359 residents
- Categories of care

System Wide Support

Education, Training & Development

- Clinical Education Centre
- My Home Life Programme at UU
- QUB module in Care of Older People
- Care Home Clinical Network
- NISCC Learning Zone

Infection Prevention and Control

Essential training:

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Vaccination

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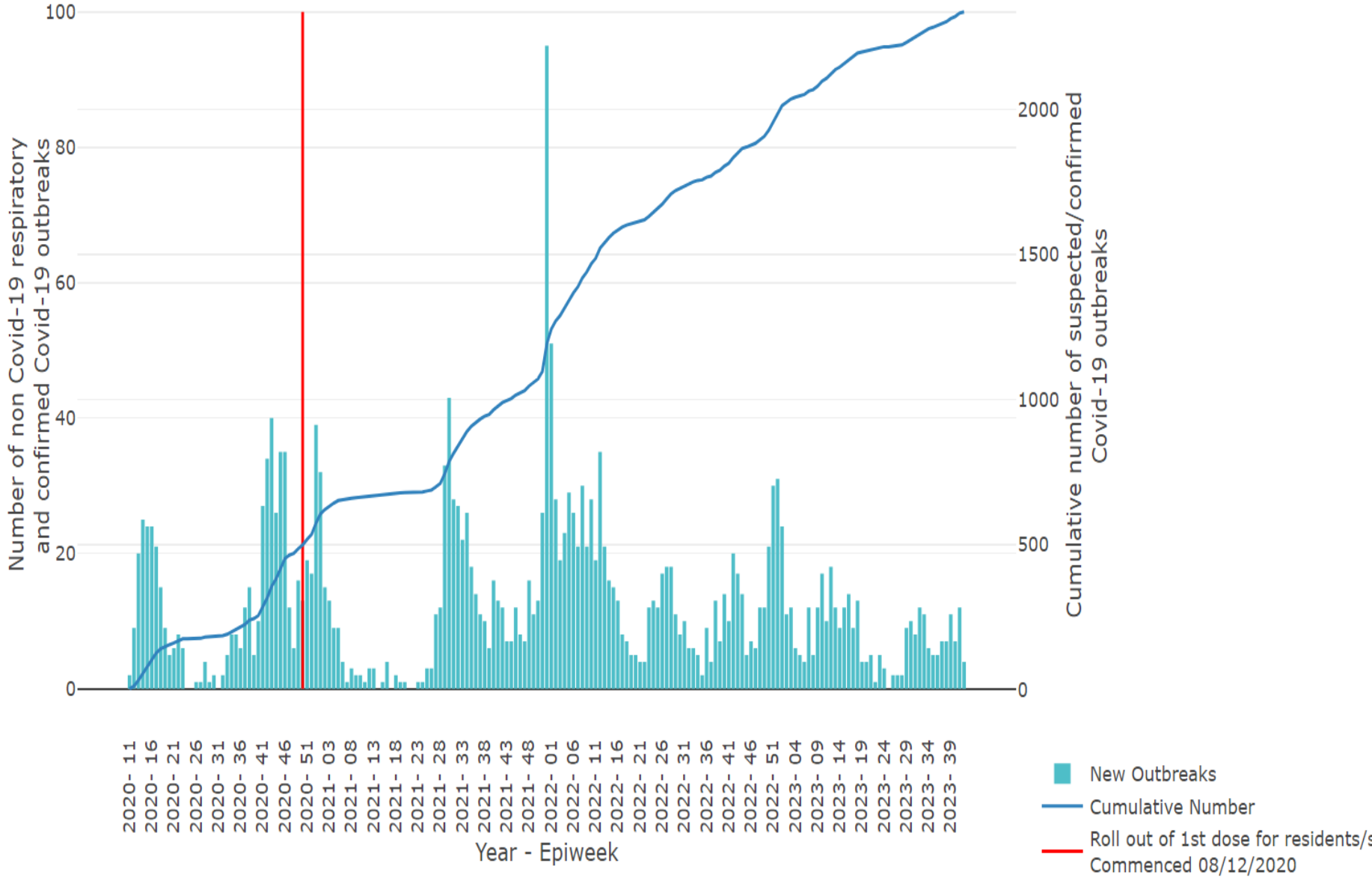

Figure 2.1: Weekly Care Home outbreak totals in Northern Ireland (non COVID-19 respiratory and confirmed COVID-19 outbreaks) as reported to PHA.

AUTUMN / WINTER VACCINATIONS

COVID-19 AND FLU

1) VACCINES ARE TESTED

A COVID-19 vaccine is only approved once it has met strict standards of safety, quality and effectiveness as set out by the independent Medicines and Healthcare products Regulatory Agency (MHRA).

2) TWO VACCINES AT ONE APPOINTMENT

Some people may be offered the flu jab and COVID-19 vaccine at the same appointment. It is safe and effective to receive it in this way.

3) IT'S SAFE FOR PREGNANT WOMEN

The COVID-19 and flu vaccine is the safest and most effective way to help protect you and your baby against the viruses.

4) IT DOESN'T CAUSE INFERTILITY

There are no plausible physiological mechanisms by which any of the COVID-19 vaccines could affect fertility in women or men.

5) SIDE EFFECTS

There are very few people who should not have the vaccine. If you have had a severe reaction to a previous dose of the vaccine you should discuss this with your doctor and make an informed decision.

6) COVID-19 VACCINES ARE SUITABLE FOR RELIGIOUS GROUPS

The vaccines do not contain any components of animal origin and none of the vaccines given contain fetal cells in their ingredients.

7) WHAT IS COMIRNATY OMICRON XBB.1.5 VACCINE?

Pfizer/BioNTech's adapted COVID-19 vaccine (Comirnaty) targets Omicron XBB.1.5 variant. It has been approved MHRA.

If you're eligible for either the flu vaccine, COVID-19 vaccine or both, take up the offer when invited.

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Autumn /winter vaccines - who is eligible

*as defined by green book

How your vaccine will be delivered	COVID-19 vaccine	Flu vaccine
GPs	• 65+ • Age 16 - 64 clinical risk group* • Pregnant women • Age 16 - 64 who are carers* • Age 16 - 64 household contacts of immunosuppressed*	• 65+ • Age 16 - 64 clinical risk group* • Pregnant women • Children 2 – 4 yrs old • 6 months to under 2 years clinical at risk* • Age 16 - 64 who are carers* • Age 16 - 64 close contacts of immunosuppressed*
Community Pharmacy	• Care home residents and staff • Frontline HSC workers • 65+ • Pregnant women • Age 18 - 64 clinical risk group* • Age 18 - 64 carers or household contacts*	• Care home residents and staff • Frontline HSC workers • 65+ • Pregnant women • Age 18 - 64 clinical risk group* • Age 18 - 64 carers or household contacts*
HSC Trusts	• Frontline HSC workers • 6 months - 15 clinical risk group* • Age 12 - 15 who are carers* • Age 12 - 15 household contacts of immunosuppressed*	• Frontline HSC workers • Housebound via home visits
In school		• Children in primaries 1 to year 12

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Enhancing Clinical Care Framework

- Putting residents and loved ones at the heart of decision making
- Designing a system that wraps around the resident to meet their needs.
- Standardisation of Trust inreach teams taking account of local population need and a whole home approach with partnership working between, people living care homes, their loved ones, AHPs and care home staff.

ECCF First Focus Actions

- Preadmission document
- Restore 2/ Mini
- Regional Falls in Care Homes Pathway and Bundle
- Urinary Catheter Passport

RESTORE2™ mini

Recognise Early Soft Signs, Take Observations, Respond, Escalate

Ask your resident – how are you today?

Does your resident show any of the following **'soft signs'** of deterioration?

= Increasing **breathlessness, chestiness** or **cough/sputum**

= Change in **usual drinking / diet habits**

= A **shivery fever** – feel **hot or cold** to touch

= Reduced mobility – **'off legs'** / less co-ordinated or **muscle pain**

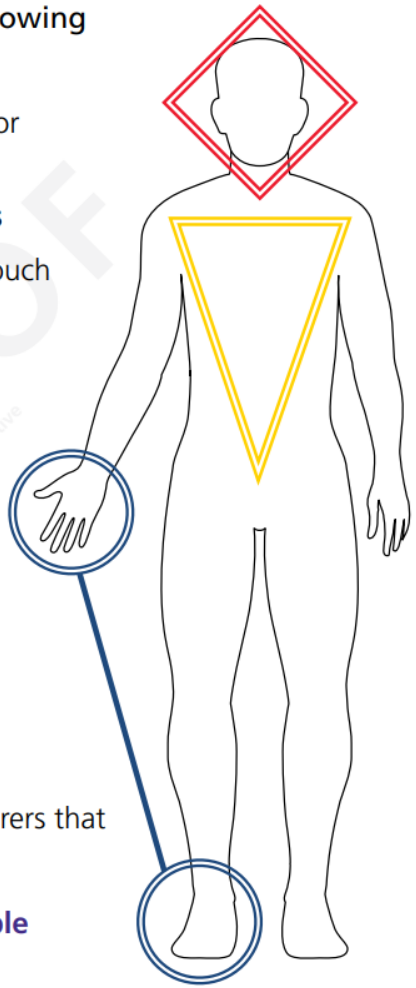
= New or increased confusion / agitation / anxiety / pain

= Changes to usual level of **alertness / consciousness / sleeping** more or less

= **Extreme tiredness** or **dizziness**

= **'Can't pee'** or **'no pee'**, change in pee appearance

= **Diarrhoea, vomiting, dehydration**



Any **concerns** from the client / family or carers that the person is not as well as normal.

If purple signs are present, think possible COVID-19.

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

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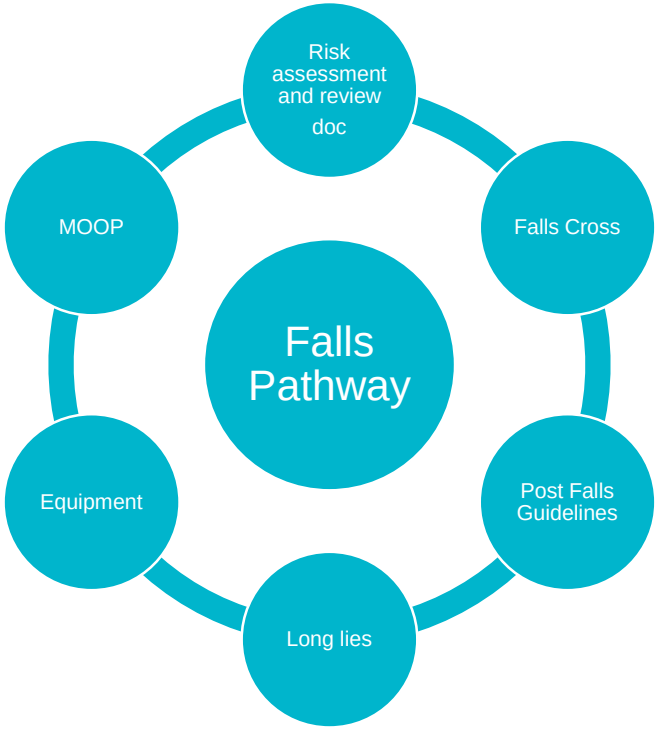
Falls Pathway and Bundle Products



Post-falls guideline

Ensure the environment is free from hazard. Ask the resident what happened.
Proceed to assess the resident and follow actions in the appropriate colour pathway below.
Consent and capacity or the resident's wishes must be factored into decision-making.
Also refer to **Treatment Escalation Plan/Advance Care Plan** where available.
Registered Health Care Professionals (HCPs) should continue to use their clinical judgement and decision-making skills as appropriate when using these guidelines.

Green Pathway

No obvious injury / unwitnessed fall with no evidence of loss of consciousness
No bruising
No obvious head injury
No new pain
Mobility unaffected
No wounds or bleeding
No limb deformity

Green Pathway Actions

Assist resident to a place of safety and comfort if it is safe (using hoist/handling aid if required)
Complete 'Post-falls assessment tool' and observation charts: **Form A, B and C** (Inc. vital signs in nursing home environment)
Inform GP and named worker
Document all actions

Amber Pathway

Minor injury / minor head injury with or without single antiplatelet therapy:
- Signs of bruising
- Minor wounds to skin including face
- On single antiplatelet therapy
- New pain

Amber Pathway Actions

Administer first aid and prescribed pain relief as required
Assist resident to a safe and comfortable place if it is safe to do so (using hoist/handling aid if required)
Complete 'Post-falls assessment tool' and observation charts: **Form A, B and C** (Inc. vital signs in nursing home environment)
Inform GP/DUC via phone

Red Pathway

Significant head injury/other moderate/significant injury, dual antiplatelet therapy, triple therapy or anticoagulant therapy.
Unwitnessed falls where loss of consciousness and head injury cannot be ruled out.
- Actual / suspected collapse
- Airway or breathing problems
- Loss of consciousness or unresponsive
- Acute confusion
- Actual / suspected head injury to resident on dual antiplatelet therapy, triple therapy or anti-coagulant therapy
- Head injury or trauma (other than shallow injuries on the surface of the face)
- New onset of intense pain
- Bleeding or extensive bruising
- Acute loss of mobility or movement in limbs

Red Pathway Actions

Call 999 for Ambulance
Registered HCPs should continue to also use your clinical decision making.
Complete Forms A, B and C (Inc. vital signs in nursing home environment) Consider impact on resident lying on floor for more than 1 hour (long lie waiting on ambulance 'Resident experiences a long lie' poster for further info). NIAS will have a clinician call back to assess or dispatch a vehicle (meet paramedics at door and escort to resident, have your records and monitoring available). NIAS clinicians will then decide whether the resident is to remain in the home or to **transfer the resident to ED (prepare appropriate documentation for transfer)**

If the resident's condition deteriorates at all, ring 999

In all cases, review all relevant falls risk/checklists and ensure any learning is communicated, documented and implemented with consent and agreement of resident.

If resident is admitted for greater than 24 hrs, then complete relevant risk assessments on return to care home.
If resident is assessed and discharged back to care home, continue to complete Forms A, B and C

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Form A Post-fall assessment and management tool

Name of resident		H&C number	
Date of fall		Time of fall	
Location of fall		Name/designation of person completing form	

Tick/comments

Level of consciousness	Responsive as usual	
	Less responsive than usual	
	Unresponsive or unconscious	
Pain or discomfort	No evidence of new pain or discomfort	
	Showing signs of new pain or complaining of new pain	
	Where is the pain?	
Injury or wounds (See body map)	No evidence of injury, bleeding or wounds	
	Evidence of swelling, bruising, bleeding or deformity/shortening/rotation of limb	
	Where is the injury or wound/s?	
Movement and mobility	Able to move all limbs as usual for the resident and has no new pain on movement	
	Able to move limbs but has new pain on movement	
	Unable to move limbs as usual for the resident or there is a major change in mobility	
Observations, including neurological observations (in nursing homes only)		

Heart Rate		Blood Pressure Lying (if possible record both)		Blood sugar		Respiratory rate	
Oxygen saturations		Standing		Neuro Obs GCS score		Temperature	

Conclusion of assessment (24hrs post fall)

		Tick
No obvious injury sustained	Assisted resident to a comfortable place	
	Completed falls assessment tool, body map & 24 hr observation chart	
	Informed relatives, named worker & GP + RQIA-if appropriate	
	Completed all relevant paperwork	
Minor Injury sustained	Assisted resident to a comfortable place	
	Administered First Aid	
	Completed falls assessment tool, body Map & 24 hr observation chart	
	Informed relatives, named worker & GP + RQIA-if appropriate	
	Completed all relevant paperwork	
Serious injury sustained	NIAS called – Time: Remained in Home Transferred to ED	
	Completed falls assessment tools body map & observation chart	
	Informed relatives, named worker, GP and RQIA	
	Completed all relevant paperwork	

Print Name		**Signature**	
Date & Time		**Designation**	

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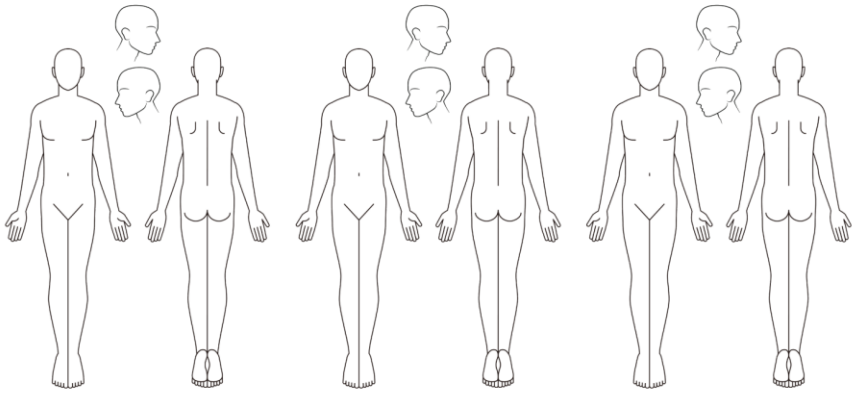
Form B: Body map

Name of resident		DOB		H&C number	

- Complete immediately post-fall then after 1 hour and 24 hours
- If deterioration, please copy this sheet and repeat as necessary
- Completion guidance – insert arrows and relevant codes. If required, draw in diameters of bruising/wounds

Use codes below to indicate injury on body map

A = Abrasion
BL = Bleeding
B = Bruising
BU = Burns
D = Deformity
F = Fracture
L = Laceration
P = Pain
S = Swelling
T = Tenderness



Immediately post-fall **1 hour post-fall** **24 hours post-fall**

Signature: _____ Signature: _____ Signature: _____
Date/time: _____ Date/time: _____ Date/time: _____

Any additional information should be recorded in the resident's notes

Form C 24-hour post-fall observation chart

Name of resident		DOB		H&C number	

1. Complete checks as per recommended frequency - wake the resident up to do the checks if head injury/ suspected head injury
2. Insert tick (√) if completed, (NA) if not applicable, (S) if sleeping or relevant code into each section
3. Areas shaded do not require completion unless clinically indicated
4. Please note that the frequency of observations may increase/ decrease depending on the AVPU/ NEWS/ GCS score, if resident deteriorates seek further advice

		Unless you have to wake the resident, do not wake for these checks				**Head Injury/Suspected Head injury/ reduced loss of consciousness**			
Date	**Time**	**Pain assessed**	**Offered toilet**	**Items/call bell within reach**	**Wounds/bruising (See body map)**	**Residential** A-Alert V-Responds only to voice P-Responds only to pain U-Unconscious	**Nursing** CNS obs (insert GCS score)	**Comments** including any changes in capacity (see page 2 for info)	**Signature/ Designation**
	ASAP								
	½ hour later								
	½ hour later							This is a 'long lie' see long lies factsheet	
	½ hour later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								
	1 hr later								

Troubleshooting Guide

THE ENHANCING CLINICAL CARE FRAMEWORK FOR ADULTS LIVING IN CARE HOMES

Blockage of catheter

Catheter previously draining
- Mechanical obstruction
- Check for kinked tubing
- Is the bag valve occluded
- Is the drainage bag below the level of the bladder
- Does the drainage bag need to be emptied

Newly inserted catheter does not drain urine
- Check that the catheter is correctly positioned in the bladder
- Is the catheter selected the appropriate length (Standard/female)

Blockage of catheter

Due to encrustation /debris
- Look at catheter history for blockages
- If recurrent catheter blockage occurs, the nature of the blockage can sometimes be ascertained by external examination of the catheter or if necessary catheter dissection
- Discuss findings with Continence Nurse Specialist

Catheter is bypassing

Bladder spasm/irritation
- Fluid intake: How much is the patient drinking: What type of fluids is the patient drinking
- Is the patient constipated
- Does the patient have a catheter associated urinary tract infection: If the patient is symptomatic consider sending CSU and discuss with GP. Do not test urine routinely with dipsticks
- Consider reducing Charriere size
- Consider catheter material irritation
- Discuss with GP commencing an anticholinergic
- In females: consider atrophic vaginitis and commence treatment with a vaginal hormonal therapy if not contra indicated

Non deflating balloon

If the catheter balloon fails to deflate
- Remove the syringe and try a different one
- Leave the syringe attached for 15-20 minutes
- Check if the patient has a kinked catheter or is constipated
- Pressure of debris, encrustation or foreign material can prevent deflation. The catheter can be 'milked' along its length by rolling it between thumb and fore finger to unblock or remove any obstruction. A few mls of sterile water added to the valve may clear the obstruction
- Use a syringe and needle to aspirate the inflation arm just above the valve
- Do not attempt to burst the balloon by over inflating
- Do not cut the catheter material during removal

Haematuria
- Small blood stained particles seen in debris in the inlet tube or drainage bag are a common occurrence in most urinary drainage systems and may be the result of infection or trauma.
- Increase fluid intake
- Observe the colour of the urine: eg blood stained particles only: the urine is rose: the urine is dark red: If appropriate empty the leg bag and ask the patient to drink well for 2 hours and then observe colour of urine
- If the urine is rose or dark red discuss same with GP

Thank you for listening

Discussion / Questions