One Gloucestershire
Transforming Care, Transforming Communities

Care Home Toolkit

Best Practice Interventions and Tools for Care Homes

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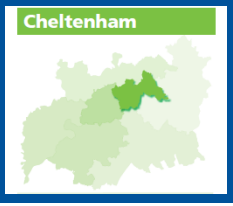
Background



Overview

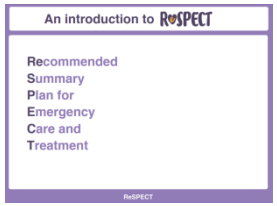
- Cheltenham had high number of admissions to hospital from care homes (county outlier).
- A project team was established involving GPs, CCG, Care Home Support Team and implemented best practice from Vanguard sites and localised interventions and tools to suit the Cheltenham population.

Aims and Objectives of Project

- To improve the quality of care for care home patients by working collaboratively across the system and developing a multidisciplinary team approach.
- To develop a gold standard for care homes and share learning to other PCNs/Care Homes in time for the national Enhanced Health in Care Homes DES commencing on 1 October

Interventions and Tools

- This 'toolkit' highlights practical tried and tested interventions/tools used in the Pilot which the group recommends for countywide implementation. These Include:
  - MDT reviews & working in partnership
  - ReSPECT conversations
  - Me at My Best form
  - Red Bag Scheme
  - Telehealth
  - Care home training and education
  - NEWS2
  - RESTORE™ 2



MDTs & working in partnership

Multidisciplinary Team (MDT) reviews are when a group of health and social care professionals from one or more clinical disciplines come together to make decisions regarding recommended treatment of individual patients.

Gold standard recommendations:

- Care homes to collate patients to discuss at MDTs, taking a proactive approach
- MDTs to be at least monthly; in person or virtually on MS Teams
- Care homes and PCNs to work collaboratively to ensure the right HCPs are attending MDTs
- Healthcare professionals to actively engage in MDTs
    - Care home staff; GP; District Nurse (if residential rather than nursing home)
    - Along with specialists when clinically necessary i.e. Geriatrician; Dementia team; Dietician; OT; Physio etc.
- Specialists to be available for MDTs, not necessarily physical presence, could be a verbal/written recommendation
- Use standardised MDT templates (Ardens) and documentation
- Develop relationships between multidisciplinary agencies in order for staff to feel more inclined to seek appropriate assistance
- Ensure that communication is responsive and timely particular around care coordination, weekly visits and MDT attendances.

ReSPECT

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) follows an Advance Care Planning conversation between a patient and healthcare professional.

Gold standard recommendations:

- All care homes residents should have a ReSPECT conversation and a completed form
- ReSPECT discussions should be standard process for all new residents.
- A copy of the ReSPECT form should remain with a patient to (and from) hospital (in Red Bag).
- Embed this form into standard care home documentation in order to facilitate acute teams finding useful information in a crisis.

Additional information

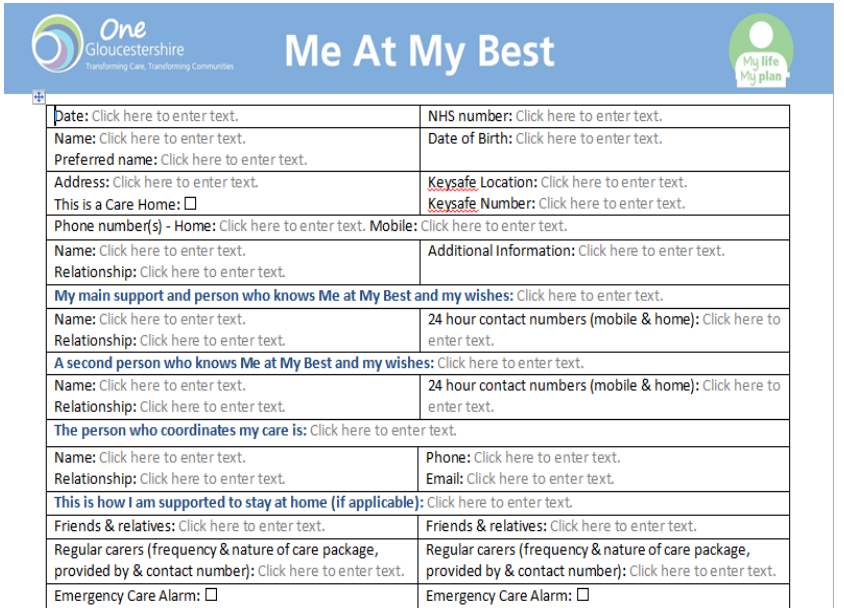
- ReSPECT information available on G-care
- Orders for can be placed via this form
- Information for Care Home Staff can be found here
- Patient leaflet

Me at My Best

Me At My Best Form is designed for residents to have a record of their 'normal' stats, in order to support emergency staff if they require an ambulance or are admitted to hospital.

Gold standard recommendations:

- Ensure that all residents have a Me At My Best form
- Ensure that a copy of the Me At My Best form stays with the patient to (and from) hospital (in the Red Bag).
- Embed this form into standard care home documentation in order to facilitate acute teams finding useful information in a crisis.
- Conduct a timely review of personal care plans; written by care home staff with input from residents and their families.



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Me At My Best

My life My plan

Date: Click here to enter text.	NHS number: Click here to enter text.
Name: Click here to enter text. Preferred name: Click here to enter text.	Date of Birth: Click here to enter text.
Address: Click here to enter text. This is a Care Home: ☐	Keysafe Location: Click here to enter text. Keysafe Number: Click here to enter text.
Phone number(s) - Home: Click here to enter text. Mobile: Click here to enter text.	
Name: Click here to enter text. Relationship: Click here to enter text.	Additional Information: Click here to enter text.
My main support and person who knows Me at My Best and my wishes: Click here to enter text.	
Name: Click here to enter text. Relationship: Click here to enter text.	24 hour contact numbers (mobile & home): Click here to enter text.
A second person who knows Me at My Best and my wishes: Click here to enter text.	
Name: Click here to enter text. Relationship: Click here to enter text.	24 hour contact numbers (mobile & home): Click here to enter text.
The person who coordinates my care is: Click here to enter text.	
Name: Click here to enter text. Relationship: Click here to enter text.	Phone: Click here to enter text. Email: Click here to enter text.
This is how I am supported to stay at home (if applicable): Click here to enter text.	
Friends & relatives: Click here to enter text.	Friends & relatives: Click here to enter text.
Regular carers (frequency & nature of care package, provided by & contact number): Click here to enter text.	Regular carers (frequency & nature of care package, provided by & contact number): Click here to enter text.
Emergency Care Alarm: ☐	Emergency Care Alarm: ☐

Copy of the Me at My Best form is available here:

Microsoft Word Document

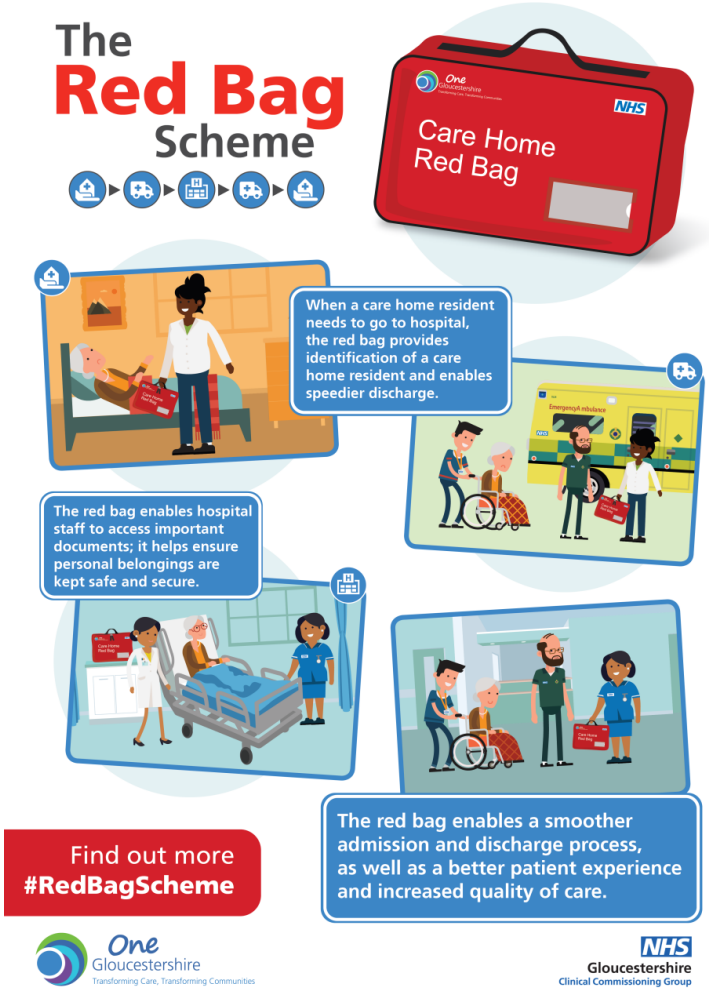
Red Bag Scheme

The Red Bag Scheme is based on national best practice, the red bag helps improve the handover between care home staff, ambulatory staff and hospital staff, evaluation from Sutton CCG found that residents with a red bag spent four days fewer in hospital than those without.

Gold standard recommendations:

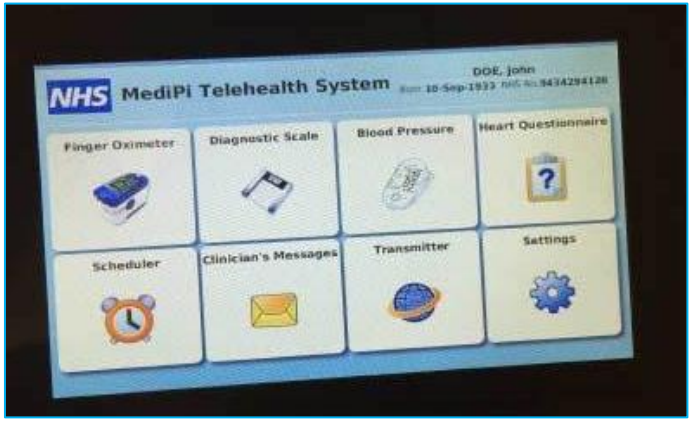
- The Red Bag scheme should be implemented across the county to increase awareness and standardise across the system
- Keep copies of all documents (i.e. ReSPECT and Me at My Best) in the Red Bag along with personal items (i.e. hearing aids, glasses) and will stay with the patient throughout their hospital visit.
- Ensure that all documents and items noted in the checklist will stay with the patient through their hospital visit.
- A checklist for what to include in the Red Bag has been developed which is available here:

Microsoft Word Document



Digital Support

Telehealth involves a small electronic unit, roughly the size of a telephone, being connected to the telephone line in the your home. Depending on your condition, these devices can take readings such as: blood pressure; oxygen levels; blood glucose levels; heart rhythm; weight; pulse; temperature.



Gold standard recommendations:

- To implement telehealth or suitable alternative to enhance the coordination and quality personalised care and establish baselines.
- Further information is available on G-care

NHS mail is available to all care homes to facilitate secure communications with GP practices and hospital staff.

Gold standard recommendations:

- All care homes to have NHS mail to facilitate secured sharing of documents and facilitate use of MS Teams

Care Home Roles and Training

Care coordinator is a function or role that provides dedicated support to residents and their carers who are having multiple simultaneous interactions with different health, care, and voluntary sector services.

Gold standard recommendations:

- Care Homes to collate patients to be discuss at weekly home rounds and MDTs, taking a proactive approach
- Care homes and PCNs to work collaboratively to organise MDTs and ensure the right HCPs are attending

Care home training and education is a function or role that provides dedicated support to residents and their carers who are having multiple simultaneous interactions with different health, care, and voluntary sector services.

Gold standard recommendations:

- The ICS to offer care home staff support (emotional), training and education; including basic standard care training (skin/feet/diet)
- To enable the Care Home Support Team (GHC) to offer more mentoring, coaching and embedding of documents such as ReSPECT and always asking ‘what matters most to you’.
- To support care homes with future pandemics
- To establish a culture and forum in care homes where all members of team feel able to contribute to the ‘whole picture’ of the individual. They may divulge different things to each member but we need the whole picture to make the best decisions.

National Early Warning Score (NEWS) 2

NEWS2 identifies patients at risk of acute deterioration. It Based on a simple scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital.

Gold standard recommendations:

- NEWS2 should be an embedded scoring system used in care homes.
- NEWS2 should be used by care homes for all pre-hospital patients who are ill or at risk of deteriorating.
- For people in care homes, knowing their baseline NEWS2 score may help a GP who has to assess them acutely to determine whether they are worse than baseline or not (especially if this is not their usual doctor).
- NEWS 2 implementation guide available here
- Frequently Asked Questions

Chart 1: The NEWS scoring system

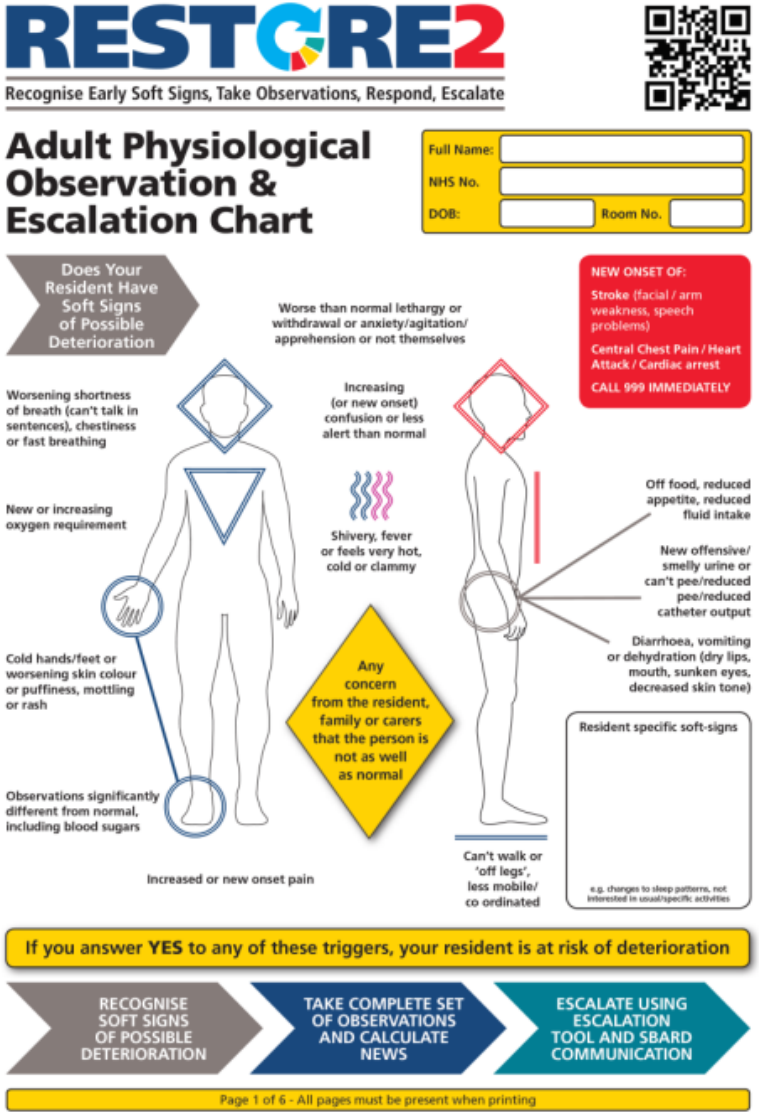
Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

RESTORE™ 2

RESTORE™ 2 is a physical deterioration and escalation tool for care/nursing homes it makes the NEWS2 accessible to care and nursing homes through the soft signs of deterioration.
It includes a communication and escalation procedure and communication tool (SBARD) specifically for care homes to escalate concerns.

Gold standard recommendations:

- RESTORE™ 2 should be promoted as may be a useful tool for care home staff to access a residents NEWS2
- For more information please see here



Care Home Feedback

"As a home, we feel we have already seen an improvement in our own service delivery, through collaborative working with outside agencies and stakeholders, creating an MDT driven towards creating a 'gold standard approach'. Our service and ultimately the care our residents receive, has been enhanced by the supportive network we have created through the project group and this is evident in outcome measures we ourselves have implemented."

Clinical Care Home Lead