# STOP LOOK CARE

## Supporting you to deliver great care

- Adapted for Surrey Heartlands

# Supporting you to deliver great care

This booklet is designed to support Care Workers/Carers working across health and social care. It will support them to feel confident that they have reached the right level to provide the care they are giving. Alternatively, it can be used as a reference guide for families and personal assistants to promote awareness of certain needs and encourage a referral, if concerns are identified.

Care Workers / Carers are in the ideal position to identify changes in a person's condition by monitoring them and/or recognising any deterioration in a person's wellbeing. This booklet highlights:

- **Why different aspects of observation and care are important**
- **What to look for**
- **What action to take**

**The actions are colour coded like a traffic light system providing a STOP LOOK CARE approach:**

Q **GREEN - ACTION - None**

Q **ORANGE - ACTION - Monitor and Document**

Q **RED - ACTION - REFER - Seek further support and advice**

The Stop Look Care booklet also acts as a hand held record of attainment by supporting paid workers with undertaking the National Care Certificate. The National Care Certificate Standards are included at the beginning of the booklet, which your manager can sign, once completed.

# Are you concerned about an individual?*

*Please check Anticipatory Management Plan before ringing

|  |  |  |  |  |
|---|---|---|---|---|
| **NHS 111** | **Local Community Pharmacy** | **Adult Social Care** | **GP/Paramedic Practitioners/ Nurse Practitioners** | **999** |
| **Medical help that is not for a 999 emergency, which could include:**<br>Unwell client (not normal to client)<br>Breathing problems<br>Worsening confusion<br>Worsening pain<br>Need health information | **Advice, recognise and treat common illnesses**<br>• Minor skin conditions<br>• Coughs and colds<br>• Bruises, sunburn and minor burns<br>• Constipation and piles<br>• Hay fever<br>• Aches and pains, including earaches, headaches, migraines and backpain<br>• Vomiting, heartburn, indigestion, diarrhea and threadworm<br>• Period pain<br>• Head lice<br>• Conjunctivitis<br>• Nappy rash and teething<br>• Warts and verruca's | **Consideration of personal social care needs and eligibility as outlined in the Care Act (2014)**<br>Consideration of carers needs and eligibility as outlined in the Care Act (2014)<br>Help to source appropriate services to help support for the cared for person.<br><br>**Contact Adult Social Care**<br>**Availability:** 9am to 5pm, Monday to Friday<br>**Phone:** 0300 200 1005<br>**Email:** contactcentre.adults@surreycc.gov.uk<br>**Textphone (via Text Relay):** 18001 0300 200 1005<br>**SMS:** 07527 182 861 (for the deaf or hard of hearing)<br>**Fax:** 020 8541 7390 | **Available on telephone advice during surgery hours, home visits and surgery appointments**<br>General medical concerns<br>Medication concerns<br>On-going medical/ psychiatric problems<br>**GP Out of Hours** | **24 hours**<br>Chest pain<br>Choking<br>Fitting (new or prolonged)<br>Severe breathing problems<br>Stroke<br>Unconscious<br>Severe loss of blood<br>Diabetic emergency (Hypoglycaemia with other symptoms such as drowsiness, or Hyperglycaemia with increased thirst and urination)<br>Head injury - on anticoagulant medication |

**For medication issues, please contact your community pharmacy before contacting the above services**

**If you need to refer someone, use this chart to help you remember all the important information to hand over:**

# SBARD TOOL Situation Background Assessment Recommendation Decision

| **This tool can be used to help you when you are referring someone to another service - when action is needed** | |
|---|---|
| **S** Situation | I am a carer (Name) working for (Organisation)<br>I am calling about Mr/ Mrs Name<br>I am calling because I am concerned that/ I am unsure about / I need advice |
| **B** Background | Their normal condition is (e.g. alert / drowsy/ confused/ self-caring)<br>How has this changed?<br>Their relevant history includes (e.g. asthma, dementia, ischaemic heart disease) Current medications include (e.g. x, y, z) |
| **A** Assessment | I have found that he/ she is (e.g. struggling to breathe/ walk/ has pain/ has injured/ confused)<br>Vital signs if equipment available (e.g. blood sugar, temperature, blood pressure, pulse) I think the problem is / may be<br>OR I don't know what's wrong but I'm really worried |
| **R** Recommended | I now need your assistance<br>I would like you to visit the resident (when is it urgent or routine?)<br>I would like your advice as to what to do next / in the meantime |
| **D** Decision | We have agreed that the following decisions were made and the action(s) that will now be taken I will record the decision and action in the service users/patients record or communication sheet Record decision and action where appropriate |

SBAR was developed for healthcare by Dr M Leonard and colleagues from Kaiser Permanente in Colorado, USA

# Top Tips for Recognising the rapidly deteriorating person

**Continuous assessment, both visually and audibly, of people being cared for is a really important skill. If they have any changes in the areas listed below, ask more probing questions/ report changes.**

**N.B Check what is normal and then consider the items listed below**

**Score: 1 for Green and 2 for Red**

| | | |
|---|---|---|
| Is the individual drinking | | |
| Is the individual eating | | No |
| Any changes in mobility (i.e. less mobile) | Yes | |
| Do they appear in pain (i.e. a change from normal) | Yes | No |
| Do they appear distressed (i.e. a change from normal) | Yes | |
| Are they vomiting | Yes | No |
| Are they confused or muddled (i.e. changed mental state) | Yes | |
| Is there any change in urine output (i.e. passing more or less) | Yes | No |
| Is there any change in bowel habits | Yes | |
| Are there any signs of skin infection or deterioration (i.e. redness, broken skin) | Yes | No |
| Any new skin damage | Yes | |
| Any cough (i.e. change in the normal) | Yes | No |
| Any change in breathing (i.e. change from the normal) | Yes | |
| Are they hot to touch (i.e. have they got a temperature) | Yes | No |

Remember: Action is appropriate.

**When to Report Changes**

- A score of 15 or more?
- Any new or increase in symptoms
- Any change in symptoms
- Abnormal observations

## Consider using the S.B.A.R tool when reporting changes

**S Situation** - Identify service user, concern, location of problem

**B Background** - Patient's Medical History & any background information

**A Assessment** - Concerns

**R Recommendations** - Explain what you need i.e. seek advice/guidance from Health Care Professional

**D Agree the decisions/actions** to take and record where appropriate

# SEPSIS (Severe Infection)

**SEPSIS - COMMUNITY SCREENING AND ACTION TOOL**

Sepsis is a life threatening condition that arises when the body's response to an infection, injures its own tissues and organs

Sepsis leads to shock, multiple organ failure and death especially if not recognised early and treated promptly

Screening, early intervention and immediate treatment saves lives

**1. Could this be a severe infection?**

For example:

Chest/ lung infection
Water / bladder/ kidney infection
Does the person have new tummy / belly pain
A new severe headache or neck pain
- A new red rash or swollen joint

**2. Are any of the 2 present?**

Feverish / hot with uncontrolled shaking
Fast or irregular breathing
A fast heart beat or palpitations
New confusion or difficult to wake up

**3. Is any red flag present?**

Unable to feel a pulse at the wrist
- Very fast breathing (more than one breath every 2 seconds)

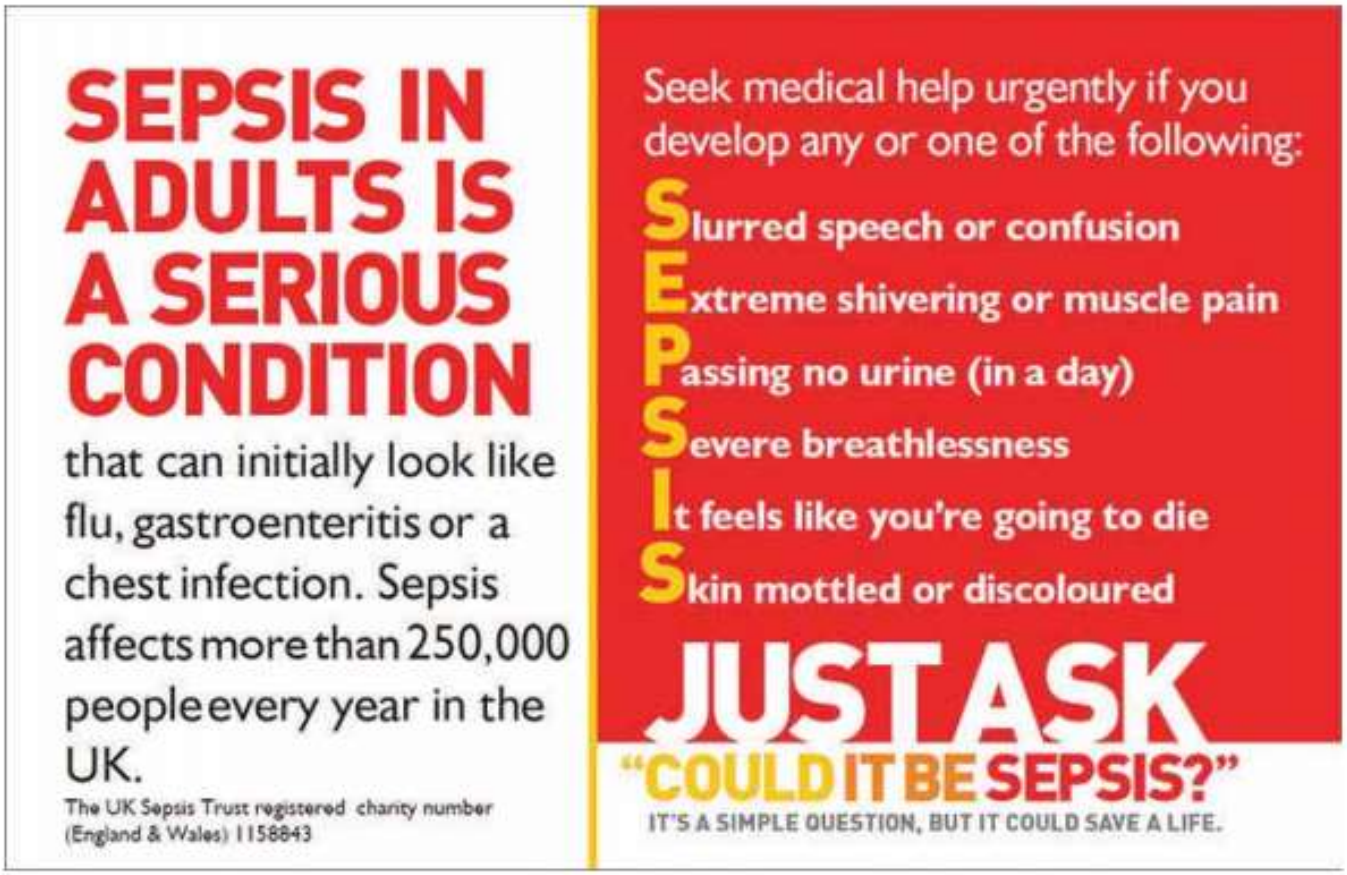
Blue lips
Responds only to voice or pain / unresponsive
Non-blanching rash or mottled skin

**RED FLAG SEPSIS**

- This is a time critical condition, immediate action is required.
- Communication: Phone 999
  Inform ambulance call taker that the person has 'Red Flag Sepsis'
- Tell the paramedic team about any allergies the person may have (especially antibiotic allergies)

**If time allows:**

Find all the client's medication they currently take and give them to the paramedic
Inform next-of-kin what is happening and where the patient is going

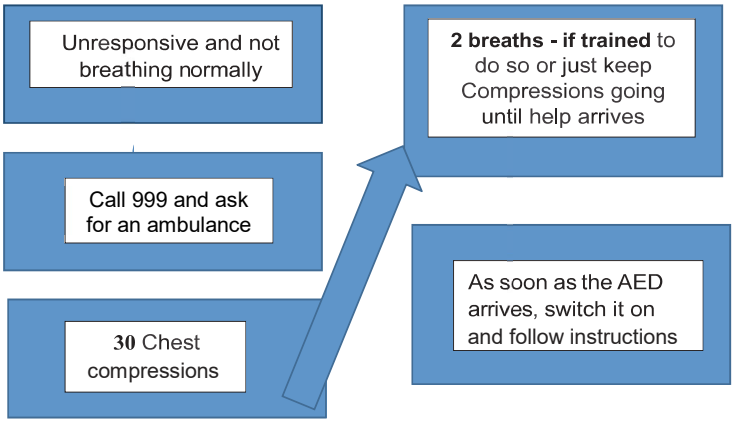

SEPSIS IN ADULTS IS A SERIOUS CONDITION
that can initially look like flu, gastroenteritis or a chest infection. Sepsis affects more than 250,000 people every year in the UK.
The UK Sepsis Trust registered charity number (England & Wales) 1158843
Seek medical help urgently if you develop any or one of the following:
Slurred speech or confusion
Extreme shivering or muscle pain
Passing no urine (in a day)
Severe breathlessness
It feels like you're going to die
Skin mottled or discoloured
JUST ASK
"COULD IT BE SEPSIS?"
IT'S A SIMPLE QUESTION, BUT IT COULD SAVE A LIFE.

# Adult Basic Life Support

Resuscitation Council (UK) GUIDELINES 2015

## Chain of Survival


Figure 1. The Chain of Survival




Rescuers who have not been trained to give rescue breaths should do compression-only CPR as this can still help save a life.

Rescuers who have been trained **should** perform chest compressions **and** rescue breaths, as this can provide additional benefit for children and those who have sustained a cardiac arrest due to not being able to breathe e.g. airway obstruction, choking, drowning and depressed respiratory drive.

# Urinary Tract Infection (UTI)

## What is a UTI?

A urinary tract infection (UTI) is an infection in any part of the urinary system - the kidneys, ureters, bladder and urethra.

## Causes

UTIs typically occur when bacteria enters the tract through the urethra and travels to the bladder and multiplies. The defenses sometimes fail and the bacteria can spread to the kidneys.

## Common signs of a UTI

- **Strong and frequent urge to urinate**
- **Cloudy, bloody urine**
- **Strong smell**
- **Pain or burning when passing urine**
- **Nausea and vomiting, muscle aches / pain**
- **New or worsening agitation or confusion**


Based on NHS England advice and the Eatwell guide, drink six to eight glasses of fluid a day.
https://www.nhs.uk/live-well/eat-well/water-drinks-nutrition/

# Preventing & Managing Urinary Tract Infections (UTIs)

Complications of a UTI are not normally common, but can be serious for older people and can lead to kidney failure or septicemia. Complications can affect people with pre-existing health problems, such as Diabetes or weakened immune system. A sudden change in behavior is one of the best indicators of a UTI in older people.

## Preventing UTIs

**Prevent dehydration**
Encourage people to drink 6-8 glasses of fluids every day *(unless advised not to by the GP)*

**ALSO**

- Regular good catheter care - make sure you have been shown how to do this properly
- Wash hands and wear gloves when handling urinary catheters
- Empty catheter bags into clean containers
- When supporting females with continence care, wipe from front to back
- Good Diabetes and diet management

**Urine dipsticks** should **NOT** be used to diagnose UTIs in older people; instead diagnosis should be based on symptoms of infection, which include 2 or more of the following;

- Pain on passing urine
- New or worsening incontinence
- Lower tummy pain
- Passing urine more frequently
- Blood in urine
- Inappropriate shiver or chills
- Temperature <36°c or >38°c
- New or worsening agitation or confusion

UTI suspected seek additional advice and support from GP, on day identified and document

# Preventing UTIs by recognising signs of dehydration

Complications of a UTI are not normally common, but can be serious for older people and can lead to kidney failure or sepsis. Complications can affect people with pre-existing health problems, such as Diabetes or weakened immune system. A sudden change in behavior is one of the best indicators of a UTI in older people.

**Urine Colour Chart**

Good

Good

Fair

Dehydrated

Dehydrated

Very Dehydrated

Severely Dehydrated


If urine colour either of the first 2 colours on urine colour chart, with no symptoms of dehydration
**No further action required**

If urine colour matches either of the middle colours (3 and 4) on the urine colour chart, and person is starting to show symptoms of dehydration, offer more water or fluid to drink. Keep a fluid chart so you can observe fluid intake.
**Monitor and Document**

If urine colour matches the last 3 colours on the urine colour chart (5,6, and 7), and the person is showing symptoms of dehydration. The person needs to be encouraged to drink more fluids. Keep a strict fluid chart, document fluid
Intake and urine output
**Seek additional support**

**Be aware some medications can change urine colour, so it is important look for symptoms of dehydration too.**

https://www.enhertsccg.nhs.uk/sites/default/files/TDONTD%20NHS%20Poster_Oct20171.pdf

Q GREEN - ACTION - None Q ORANGE - ACTION - Monitor and Document (W) RED - ACTION - REFER - Seek further support and advice

# Dehydration

**Dehydration occurs when our bodies don't have enough water.**

*Water helps to lubricate the joints and eyes, aids digestion, flushes out wastes and toxins, and keeps the skin healthy*

**Dehydration can directly contribute to:**

- **Increased risk of Urinary Tract Infections (UTIs)**
- **Feeling lightheaded which might cause the individual to fall**
- **Confusion and irritability**
- **Constipation**

**Some signs of dehydration include:**

- **Feeling thirsty, dry mouth, lips**
- **Lightheaded, tiredness, changes in mental health**
- **Only passing small amounts of urine and urinating infrequently**
- **Dark coloured, strong-smelling urine (but remember that some medications and foods will alter the colour and smell of urine)**

**Who is at risk of dehydration?**

- Aging itself makes people less aware of thirst
- Older people may be anxious about drinking due to continence issues
- People with certain diseases have increased water requirements, e.g. fever, diarrhoea, vomiting, kidney stones
- When the weather is hot, and in homes with high central heating, people will lose more fluid through sweating,
- People with oral discomfort and or swallowing difficulties

https://www.nhs.uk/conditions/dehydration/

https://www.slideshare.net/WessexAHSN/toolkit-improving-hydration-among-older-people

# Fluids

In climates, such as the UK, it is recommended we drink about 1.5 - 2 litres **(six to eight glasses)** of fluid every day, to stop us from getting **dehydrated.**

Sometimes an individual may be on a restricted fluid intake due to a health condition, but all others should be encouraged to drink the recommended amount.

Consider recording daily intake of fluids if person is at risk of dehydration or is dependent on full support.

If fluid charts are used, please ensure fluid levels are totalled at the end of each day. If total is less or more than recommended amount, escalate and take action as per individuals care plan.

There are a range of foodstuffs that are rich in fluid and can be offered to help with fluid intake, including:

- Custard
- Jelly
- Ice-cream
- Yoghurt
- Soup
- Fruit and vegetables
- Gravies and sauces

Drinks the recommended six to eight glasses of fluid daily and independently
**No further action required**

Drinks only five cups daily
**Monitor amount, may require some additional support and encouragement to drink. Refer if concerned**

Drinks two cups or less daily, with signs of dehydration
**Seek advice from GP on day identified and document**

https://www.nhs.uk/live-well/eat-well/water-drinks-nutrition/

file:///C:/downloads/Downloads/Hydration%20hints%20for%20older%20people%20Feb%202018%20v2%20(1).pdf

GREEN -ACTION - None ORANGE -ACTION - Monitor and Document RED -ACTION - REFER - Seek further support and advice

# A good diet is important for maintaining general good health. If a person is underweight or overweight, they may need to alter their diet.

**If an older person's appetite has decreased it is important to try and increase the amount of energy and protein in their diet using full-fat foods and lots of sources of protein**

**There are three ways to do this:**

- Encourage small, high-energy meals and frequent snacks, fortified with extra butter/oil, cheese or milk powder (this is high in protein)
- Offer nourishing drinks (eg: Horlicks/Ovaltine made up with full fat milk and extra milk powder)
- Avoid filling up on liquids that contain little but sugar (eg: fizzy drinks) and offer nourishing drinks or high quality snacks (below) instead

**Some high-energy meal and snack ideas:**

- Porridge made with whole (full-fat) milk and extra milk powder, with fruit or dried fruit on top
- Sardines on toast
- Peanut butter on toast
- Soups with pulses, pasta or meats
- Cottage/shepherds' pie
- Beans on toast with cheese sprinkled on top
- Milky drinks as a bedtime snack
- Unsalted nuts

**If the individual cannot chew well soft or pureed food may be preferred**

The Eatwell Guide shows the food groups, and the proportions in which we should eat them, to create a balanced diet when we are a healthy weight or overweight. **BUT** if a person is **underweight** it is important to increase the energy in their diet by increasing the amount of fats and protein that they eat each day.

# Nutrition

Being **underweight** can be especially serious for older people and can increase their risk of health problems, eg:

- **Bone fractures if they fall**
- **Pressure damage**
- **Weakened immune system with increased risk of infections**
- **Increased risk of vitamin and mineral deficiencies**

Being very **overweight** can cause problems, such as:

- **Breathlessness/Difficulty with physical activity**
- **Swollen legs**
- **Feeling very tired a lot of the time**
- **Joint and back pain**

And can increase the risk of:

- **Type 2 Diabetes**
- **High blood pressure**
- **Asthma**

You may be asked to record a person's daily intake if there are concerns about dietary intake. Make sure you record what is eaten AND the amount eaten.

Eats a healthy diet, independent with eating, weight is normal
**No further action required**

Eating less than normal. May need limited support to alter their diet.
Overweight or underweight.
**Monitor and document.**

Eats a poor diet, sudden weight loss or gain
**Seek additional advice and support from their GP and document**

**To help reduce weight** use smaller portion sizes, avoid high energy snacks (eg: crisps, cakes, biscuits, fizzy drinks) and increase intake of fruit and vegetables

https://www.bda.uk.com/food-health/food-facts.html#healthy_eating

https://www.nhs.uk/live-well/healthy-weight/keeping-your-weight-up-in-later-life/

https://www.nhs.uk/conditions/obesity/

# Swallowing

Swallowing difficulties (also sometimes known as "dysphagia") can be common in people with **frailty, neurological conditions, head and neck cancer, respiratory and other conditions.**

## Some signs and symptoms of swallowing difficulties include:

- Wet or 'gurgly' sounding voice during or after eating or drinking
- Food, drink or saliva spilling from the mouth
- A feeling of food sticking in the throat
- Discomfort during eating/drinking
- Holding food in the mouth
- Coughing during or after eating/drinking
- Choking (airway blocked by food)

**Swallowing Cifficulties may impact on the amounts of food and drink that people can manage. This can lead to malnutrition, dehydration and reduced quality of life.**

A person with swallowing difficulties may experience food / fluid / saliva entering the airway.
If the person is unable to effectively clear this, some may enter the lungs, this is called **'aspiration' .**
People who have associated risk factors (e.g. not mobile, poor oral health etc) may be vulnerable to Aspiration Pneumonia (chest infection).

**Some swallowing difficulties and aspiration occur silently. They may be detected by unexplained recurrent chest infections.**

# First-Line Safer Swallowing Strategies

## (For mild swallowing difficulties/ when awaiting specialist assessment)

If the person is sufficiently alert to eat and drink, you can try the following First-Line Safer Swallowing Strategies.
Successful use of these strategies may mean that referral for specialist assessment by Speech & Language Therapist is not required.
Close monitoring will be important.

**If the person is not sufficiently alert to eat and drink, contact the GP.**

| | |
|---|---|
| **Positioning** | Make sure the person is **sitting as upright as possible** to optimise their swallowing safety<br>Try to keep the head in a neutral position or with the chin slightly tucked-down.<br>**Reduce distractions** in the environment (e.g. consider turning off the television) |
| **Mouthful size** | **Small sips** are generally safer than large mouthfuls. Try a smaller spoon for food |
| **Equipment** | **Wide-brimmed open cups or Kapi-Cups** (nosey cups) are helpful as these encourage a neutral head position.<br>**Avoid using lidded beakers, medicine cups, sports bottles, drinking straws, tall/narrow cups.** |
| **Support** | **Support the person to be independent as possible** but provide **partial or full assistance if required**<br>Encourage small mouthfuls of food and small sips of drinks. Allow plenty of time between mouthfuls<br>Ensure that no food is left in the mouth after meals, support with mouth care may be required |
| **Mouth Care** | Ensuring that the mouth is healthy, moist and comfortable will help with eating and drinking.<br>Complete an oral health assessment and ensure the person maintains a clean, **healthy mouth** (see next section) |
| **Food** | If concerned about choking, discuss/consider **avoiding high-risk foods (dry, crumbly, chewy, fibrous, hard foods and bread-like products).**<br>If there are problems with chewing, discuss/consider **choosing softer/moister foods.** Add extra sauce. Ensure that the food is liked! |

# Swallowing

Being able to eat and drink safely is fundamental to maintaining health and wellbeing.

Support Workers are in an ideal position to **identify concerns** about people's difficulties with eating and drinking and to **use first-line safer-swallowing strategies** to help improve comfort and safety. Some people will require a specialist assessment of swallowing by a Speech & Language Therapist.

If the first-line swallowing strategies are not helpful or you are concerned that a person is at risk of harm from their swallowing difficulties, refer to Speech & Language Therapy.

Following specialist Speech & Language Therapy assessment, some individuals may require texture-modified diet and/ or drinks as described in the International Dysphagia Diet Standardisation Initiative (www.IDDSI.org) descriptors.

It is important to follow the Swallowing Management Plan to reduce the risk of serious complications.

What to do if someone doesn't want to follow the Swallowing Management Plan:

- Explain why the recommendations have been made
- Discuss with your supervisor and ensure that the Speech and Language Therapy Team are contacted for further advice/support.

Person is able to swallow with no identified problems
**Monitor for any change**

Person is managing mild swallowing difficulties by using First-line Safer Swallowing Strategies.
No concerns about chest infection / dehydration / weight loss OR
Swallowing has been assessed by a Speech and Language Therapist and specialist recommendations are in place.
**Monitor for any change**

First-line Safer Swallowing Strategies or Speech & Language Therapy guidelines are not helpful
**OR**
Person has new difficulties and is at high risk (e.g. susceptible to chest infection)
Seek specialist support as appropriate:

- Contact the GP if person unwell/ at high risk of potential harm
  Refer to Speech and Language Therapy

# Mouth Care

Good oral health care enables people to take a normal diet without difficulty. Carers play an important role in supporting people to maintain good oral health. Carers are ideally placed to monitor changes in individual's mouths and refer on as appropriate.

Gum disease and poor oral health may increase the risk of all kinds of other health complications, including:

**Lack of appetite**
**Malnutrition**
**Heart disease**
**Pneumonia**

Mouth is healthy, clean and moist
**No further action required**

Mouth is dry, food and bits remain around teeth **Monitor, document and support individual with mouth care if needed and explain the importance of mouth care to the individual**

Mouth is inflamed, dry and sore or ulcerated
**Seek additional support on day identified from GP, or their own Dentist and document**

# Guidance on Supporting Mouth-Care

| | | |
|---|---|---|
| ■ Explain how you are going to support them, as some people can feel anxious. Encouraging individuals to look in the mirror whilst being supported will enable them to see what is happening. It can be easier for the carer to stand slightly behind, or to the side, when supporting individuals with oral health care | ■ Some individuals gums may bleed when brushing, this is a sign that their gums are unhealthy. The only way to improve gum condition is to gently brush the bacteria away<br>■ Teeth should be brushed in a circular motion with a small amount 'pea sized' toothpaste | ■ Ensure dentures are labeled in a denture pot, as these can go missing when individuals are admitted to hospital<br>■ Loss of dentures may cause great distress and can be expensive and time consuming |
| ■ Ensure the person is comfortable and ensure that you are not rushed.<br>Remember you may not be able to support brushing the person's whole mouth in one go | ■ Encourage people to spit out after brushing and not to rinse<br>■ It is better to leave a little toothpaste residue in the mouth to maintain fluoride concentration levels | ■ Support individuals with false teeth to clean them daily<br>■ Dentures should be removed at night and soaked in plain water |
| ■ Support the person twice a day to clean their teeth<br>■ Replace the tooth brush every three months or sooner if required | ■ The frequency and amount of sugary food and drink should be reduced and where possible, kept to mealtimes | ■ Ensure when the person's dentures are removed they do not have any residual food left in their mouth |
| ■ Dentures which do not fit well can affect eating, drinking and speaking and can be uncomfortable | ■ **Frequent oral health care is important for those who are unable to take any food or drink orally. It is important to minimise oral bacteria that might be aspirated, as well as optimising oral comfort** | https://www.dentalhealth.org/caring-for-my-teeth |

Q GREEN - **ACTION** - None Q **ORANGE - ACTION - Monitor** and Document '-1 RED - **ACTION** - REFER - Seek further support and advice

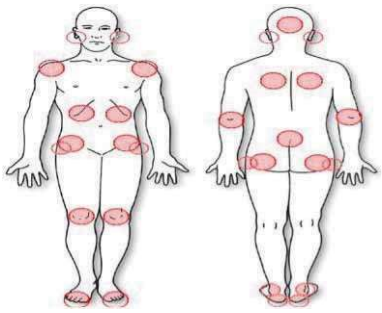
# Skin

## Preventing Pressure Damage (bed sores/ pressure sores)

Maintaining good skin condition is really important; pressure damage can have a huge impact on individual's wellbeing, causing pain, distress etc.

Carers are ideally situated to monitor individual's skin condition; the parts of the body that are at higher risk of developing pressure damage are:

- **Shoulders or shoulder blades**
- **Elbows**
- **Back of the head**
- **Rims of the ears**
- **Knees, ankles, heels or toes**
- **Spine**
- **Tail bone (the small bone at the bottom of the spine)**



**Wheelchair users, are at risk of developing pressure damage on:**

- Buttocks
- The back of arms and legs
- The back of the hip bone


https://nhs.stopthepressure.co.uk/

# Skin

If you see discoloured skin that does not turn white when pressure is placed on it or any of the below signs, the person could be starting to develop pressure damage
**Seek further advice and support**

**At the start of pressure damage, you may see:**

- Skin that appears discoloured
  - It is red in people with paler skin
  - It is purple or blue in people with darker skin
- The skin is intact, but it may hurt or itch
- It may feel either warm and spongy, or hard
- Individual complains of pain to the area
- **The skin does not turn white when PRESSURE IS PLACED ON IT**

https://www.nhs.uk/conditions/pressure-sores/

Skin intact and good colour
**No further action required, follow skin-care guidance on previous page (see hand picture)**

Skin is painful, swollen, discoloured (for a short time only and returns to normal quickly) or sweaty. If the individual has reduced mobility or is unwell or has very thin skin or poor nutrition / hydration, they are at increased risk of pressure damage - permanent/ temporary
**Follow skin care guidance**
**Refer on for further support, monitor and document as needed**

Skin is red, blistered or broken / open
**Seek additional support on day identified from GP, or Community Nurse if known to them and document**

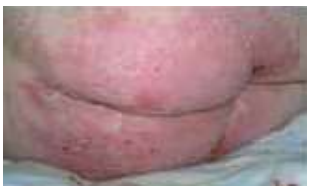

**If you see something unusual or not right about the individual's skin - React!**

Supporting and encouraging a person with regular changes of position is important to prevent and maintain good skin condition. They may need prompting to do this, assisting or need your help. How often to reposition either in bed or be in a chair/ wheelchair is based on individual assessments. Ask if you are not sure.

If the person has pressure-relieving equipment, check it - if you have any concerns, contact the equipment store where it was delivered from. Equipment should be regularly serviced. Remember individuals with Alternating (Air) Mattresses still need regular repositioning.

https://nhs.stopthepressure.co.uk/care-homes.html

# Skin Excoriation Tool

| | | | |
|---|---|---|---|
|  | **Healthy Skin**<br>No evidence of tissue damage, no erythema (redness) | Skin can be cleaned with mild soap and water, soap substitute or skin cleanser.<br>Apply small amount of moisturiser to keep skin healthy and hydrated | |
|  | **Mild Excoriation**<br>Erythema (redness) no broken skin.<br>No Moisture lesions but area may be uncomfortable to clean and apply creams | Clean area gently with soap substitute or skin cleanser.<br>**Medi Derma-S / Cavilon** -Apply thin layer every 12 hours. or **Proshield Plus** - apply thin layer every toileting session.<br>Allow to absorb | Consider the cause.<br>If erythema is diffuse and satellite lesions present, consider fungal infection and treat accordingly.<br>Consider allergy or contact dermatitis. |
|  | **Moderate Excoriation**<br>Extensive erythema with diffuse broken skin and moisture lesions<br>Moderate exudate and may bleed on contact. Painful to clean and apply cream | Gently clean with soap substitute or skin cleanser.<br>**Medi Derma-S film/ Cavilon Barrier Film/spray** apply once every 48 hours or **Proshield Plus** - apply a liberal layer to the excoriated skin at every toileting session Allow to absorb. Do not rub vigorously | Consider: Fungal infection, Allergy<br>Continence issues and pad absorbency.<br><br>**Refer to Tissue Viability if not improving** |
|  | **Severe Excoriation**<br>More than 50% broken skin and moisture lesions. Bleeds easily<br>Extremely painful on movement, passing urine or faeces , when cleaned and creams applied or exposed to air | Gently clean with soap substitute or skin cleanser.<br>Pat dry as much as possible.<br>**Medi Derma-S / Cavilon Barrier Film/ spray** apply once every 48 hour or **Proshield Plus** - apply a liberal layer to the excoriated skin at every toileting session.<br>Allow to absorb. Do not rub vigorously | Consider faecal management system and / or short term urinary catheter.<br>Consider fungal infection<br><br>**Refer to Tissue Viability** |

# Falls Prevention

| | |
|---|---|
| **Environmental** | • Keep rooms and stairways lit, using the brightest bulb available, try low energy light bulbs to reduce bills, but remember they take a minute or two to warm up<br>• Removing clutter, trailing wires and frayed carpet<br>• Mop up spillages<br>• Using non-slip mats and rugs, or ensure they are tacked down or removed<br>• Make sure there are suitable grab rails around the house if needed<br>• Ensure easy access to commode or toilet<br>• Ensure nightlight<br>• Advise not to rush<br>• Make sure cats or dogs have bright collars or bells to help prevent tripping over them |
| **Impaired Sight and hearing** | • Support those who wear glasses to keep them on or have them close by, ensure they are clean and in good condition and they can see out of them and are the right prescription.<br>• If vision seems to be deteriorating, check they have had a recent eye test. If not refer to optician.<br>• Advise annual eye tests<br>• Is hearing reduced? Check hearing aids for wax, check for cleanliness, do they need a hearing test? |
| **Unsteady on feet** | • Support clients with recommended exercises and equipment<br>• Ensure aids are well maintained<br>• Promote physical activity and mobility<br>• If unsteadiness is new - seek support from Community nurse or GP |
| **Feet, footwear and clothing** | • Check condition of feet, check for pain, problematic bunions or toenails - may need to see podiatrist<br>• Check footwear is suitable, fits well, is in good condition and supports the ankle.<br>• Ensure shoes have non-slip soles<br>• Ensure clothing allows the person to move their legs and feet freely. Encourage people not to wear clothes that are too tight or too loose-fitting, trailing clothes that might trip them up<br>• Footwear to be Velcro or laces, so shoes can be adjusted if feet swell. |
| **Illnesses and medication** | • If known to have low blood pressure when standing (Postural Hypotension), advise to stand for 10-12 seconds.<br>• If complaining of dizziness , ensure eating and drinking adequately, may need to seek support from Community Nurse, GP or Pharmacist<br>• Medications may cause imbalance, be aware if on 4 or more medications of started new medication - seek support from pharmacist<br>• Over 65years should have an annual medication review |

# Mobility and Falls

Mobility and prevention of falls is fundamental in supporting people to retain their independence.

**Falls can have a significant effect on people's health**

Keeping people mobile can reduce the incidence of

**Infections**
**Pressure damage**

It is important that people seek early intervention from specialists to maintain mobility. A fall may affect confidence levels; it may also increase anxiety and reduce mobility levels.

If the answer is yes to any of the 3 questions below, consider a referral to your local Falls Prevention Team:

1. Has the person fallen in the last year?
2. Do they have problems with your strength and balance when walking?
3. Do they have a fear of falling?

https://www.nhs.uk/have advice on exercises for older people, which can be undertaken
in the home - including exercising when seated and exercises to improve balance, flexibility and strength.

**Mobility** Independently mobile with or without aids
**No further action required**
**Falls Risk** Good mobility, good mental status and good continence
**No further action required**
Encouraging people to increase their strength and balance through exercises will help maintain mobility and reduce the risk of falls. Consider introducing the "Get up and Go Booklet" and signposting to local exercise groups.

**Mobility** Needs assistance beyond their usual level
**Monitor and document, consider further advice and support**
**Falls Risk** Near misses, unsteadiness, reduced confidence **Monitor and document, consider further advice and support from GP, or Community Nurse/Physiotherapist or Community Falls Prevention Team.**

**Mobility** Can no longer move independently when could before **Seek additional support and advice on the day identified and document**
**Falls Risk** Recent falls, falls causing injury, dementia or medication affecting balance and coordination
**Seek additional support and advice on the day identified from GP, and document. Consider 999... if fallen and injured**

# Rockwood Clinical Frailty Scale

Is a toolkit to measure how frail someone is and can be used to monitor any deterioration.

**1. Very Fit** - People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

**2. Well** - People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

**3. Managing Well** - People whose medical problems are well controlled, but are not regularly active beyond routine walking.

**4. Vulnerable** - While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

**5. Mildly Frail** - These people often have more evident slowing, and need help in high order Instrumental Activities of Daily Living Scale (IADLs) (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

**6. Moderately Frail** - People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

**7. Severely Frail** - Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within - 6 months)

**8. Very Severely Frail** - Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

**9. Terminally** Ill -Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

**Scoring frailty in people with dementia**

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

Rockwood et al 2005 K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

# Frailty

**Frailty varies in severity, people should not be labeled as 'frail' rather described as living with frailty.**

Signs of frailty can include:

- **Falls** - collapse, legs giving way
  **Immobility** - sudden change in mobility
  **Delirium** - sudden change in levels of confusion
  **Incontinence** - change or worsening in continence
  **Medication** - change or increase in side effects

People living with frailty can have a fine balance between vulnerability and resilience.

**Encouraging people to:**

Maintain physical activity can improve strength and balance

Eat a healthy diet, and drinking enough fluids can help minimise the impact of frailty. Carers should check how much fluid people have had, particularly those dependent for support.

Although these symptoms can indicate frailty there can sometimes be a straight forward explanation with no further problems, however, it is best to get the person reviewed by a GP if concerned.

**Person fit and active,** independent with most activities of daily living, washing, dressing, provision of food
**No further action required**

**Person less fit and active,** requires some support with activities of daily living, monitor and support in a person centered way
**Document as this enables better detection of increased frailty**

**Change in person's level** of independence; appears frailer
**Seek additional support and advice from GP or Community Nurse on the day identified and document**

https://www.bgs.org.uk/resources/introduction-to-frailty

# Respiratory - Breathing

There are a number of different respiratory problems which can affect people, these include:

**Asthma**
**Chronic Obstructive Pulmonary Disease (COPD)**
**Fibrosis**

People with respiratory problems can require extra time support and patience with their activities of daily living, particularly activities which may cause them to become breathless. Breathlessness can increase anxiety in people, so being calm and understanding can help.

People may use inhalers, nebulisers and/ or oxygen to support their breathing.

**Correct inhaler and nebuliser use can prevent complications, for example chest infections, which can potentially cause admissions to hospital**

**People should be using their oxygen as per their prescription, this should be written in their yellow folder in the oxygen section. If in doubt phone and check with respiratory team**

**Inhaler technique is really important to ensure the correct amount of medication reaches the lungs**

People will generally know what is normal for them. People can present as anxious, and more confused if breathless.

**Breathing** is a normal rate and depth for individual
**No further action required**

**Know how to support individuals with inhaler /nebuliser if they require this**
**Monitor and document**

**Breathing** is abnormal for individual above 20 or below 1O breaths per minute, the person could have blue lips /nails

**Seek additional support from GP or Community Respiratory Team if known consider dialing 999 and document**

# Inhaler Technique

**There are many different types of inhalers, below are some examples of how to use the main ones.**
Asthma UK have hand outs on how to use each type, these can be found on their website https://www.asthma.org.uk/advice/inhalers-medicines-treatments/using-inhalers/

## Advice on how a person should use their inhalers

**'Press and breathe' Metered Dose Inhalers (MDIs)** are often called 'puffers'.

- Shake the MDI inhaler, breathe out gently, then put the mouthpiece in your mouth and wrap your lips around it.

Breathe in **SLOW AND STEADY,** press the canister down to release the medicine and continue to inhale deeply.

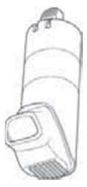
Remove the inhaler from your mouth and hold your breath for up to 10 seconds before breathing out slowly.

*MDIs can be used with spacers. Spacers collect the medicine inside them, so you don't have to worry about pressing the inhaler and breathing in at exactly the same time. This makes these inhalers easier to use and more effective*


**Encourage the person to 'Breathe in hard' Dry Powder Inhalers (DPIs)** release medicine in a very fine powder form instead of a spray

When they breathe in through the mouthpiece, they need to breathe in quite QUICK and DEEP to get the powder into their lungs.

Examples of DPIs include Accuhalers, Clickhalers, Easyhalers, Handihalers,Turbohalers, Diskhalers, Genuair and Twisthalers.



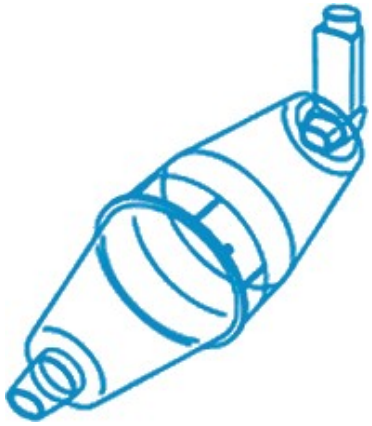
**Breathe in normally 'breath actuated' inhalers** are usually given to people who have difficulty using a standard 'puffer '.

These inhalers are activated by your breath, so when you breathe in **SLOW and STEADY** through the mouthpiece, it releases the medicine in a fine spray form.

With this inhaler you don't have to push the canister to release a dose. Autohaler and Easi- breathe are examples of breath actuated MDIs.

**People should be encouraged to rinse their mouths after using inhalers as this can reduce the incidence of oral thrush**

# Supporting use of a Spacer



**People with COPD sometimes can find it difficult to take in a deep breath. Using a spacer means the inhaler can be pressed and then the user can put their lips round the spacer and then just breathe normally for 5 breaths.**

## Improper inhaler technique is associated with poor control of disease.

The use of a spacer helps to overcome the problem of pressing the inhaler and coordinating breathing in.

Using a spacer allows the user to press the inhaler first and then take a breath, as the medicine will stay in the spacer until it is inhaled.

Using a spacer also reduces the risk of side effects as more medicine reaches the lungs and less medicine hits the back of the throat and is swallowed.

## IMPORTANT ADVICE ABOUT CLEANING A SPACER

Spacers should be cleaned regularly - preferably once a month.

They should be washed in warm soapy water using a mild detergent without rinsing.

**Leave parts to dry at room temperature DO NOT rub the inside of the spacer with a cloth as this causes static electricity.** The static electricity attracts the medicine to the sides of the spacer and sticks there and reduces the amount available to be inhaled in the lungs.

People can present as anxious and confused if breathless, however people will know what is normal for them.

# Inhaler Technique

**Person** competent and able to use inhaler correctly
**No further action necessary**

**Person** requires some support to use inhaler or nebuliser correctly
**Seek further support from Community Pharmacist, Practice Nurse, GP, Respiratory Team for advice, monitor and document**

**Person** unable to use inhaler and has no support in place to help them using their inhaler
**Seek additional support and advice on day identified and document**

# Continence

## Urine

Problems with continence both bladder (urine) and bowels (faeces) are relatively common; however embarrassment can often cause people to not ask for help.

Carers are again in a perfect position to support and refer people on for help and advice.

People generally go to the toilet to pass urine four to seven times in a day.

However, some people may develop incontinence; some of the common signs that indicate people may need to have a proper continence assessment include:

| | |
|---|---|
| Leaking when exercising | Described as having a sudden urge to pass urine and often described as unable to get to the toilet in time |
| Leaking small amounts of urine when sneezing | Going to the toilet frequently, either during the day or overnight |
| Leaking small amounts of urine when laughing | |
| Leaking urine when lifting heavy objects | |

**The colour of urine can indicate dehydration; however, some foods and medicines can also cause urine to become discoloured. If the person is drinking the recommended six to eight glasses per day and urine appears an unusual colour or darker, please monitor and seek advice if necessary.**
https://www.nhs.uk/conditions/urinary-incontinence/

## CATHETER CARE

It is recommended that all carers who support individuals with a catheter, should undertake some sort of formal training, but here is some advice.

## HOW TO CHANGE A LEG BAG

Always wash your hands with soap and water first and dry hands well and wear gloves and apron

Empty the existing leg bag as you usually would, remembering to close outlet tap

Remove existing leg bag

Remove cap from new leg bag and quickly attach to catheter

- Ensure the outlet tap is closed
- Leg drainage bag will need to be changed according to manufacturers instructions, usually every 7 days unless there is a problem sooner

Wash hands with soap and water and dry hands well

## CATHETER CLEANSING

Cleansing around the catheter is recommended twice daily and following any bowel action. Use a cloth with mild soapy water

Catheters should be cleaned by wiping away from where the catheter enters the body. This is to reduce the risk of infection

Any discharge from around the catheter should be noted and observed. The frequency of cleansing may need to also be increased.

**If you feel you need further advice or support please contact the community bladder and bowel service**

https://www.nhs.uk/conditions/urinary-catheters/

**Urine Continence Care** Urine light in colour, continent

**No further action required**

**Catheter Care** Flowing clear urine light in colour

**No further action**

**Urine Continence Care** Urine dark or cloudy - encourage fluids. Long term urinary incontinence, support with appropriate pads

**Monitor, document and support individual**

**Catheter Care** Cloudy with sediment Encourage fluids monitor

**Document and refer on to Community Nurses if concerned**

**Urine Continence Care** New urinary and faecally incontinent

**Seek further ADVICE AND SUPPORT**

**Catheter Care** Catheter blocked, pus, blood, dark urine

**Seek additional support from GP or Community Nurses immediately and document**

# Continence

## Bowels

**Different people have different bowel habits**

Most people have a bowel movement more than 3 times a week and pass good textured faeces (not too hard or soft) without straining.

Since it can be hard to state what is normal and what is abnormal, some health professionals use a scale to classify the type of stool passed.

*Type 1 is described as a constipated stool this has spent the longest time in the bowel, and type 7 has spent the least amount of time in the bowel, which could be described as diarrhoea.*

An ideal stool should be a type 3 or 4, and depending on the normal bowel habits of the individual, should be passed every one to three days without straining.

If stools are very dark (black) or very pale encourage the person to speak with their GP. Some medication can change the colour of stools, this can be discussed with a pharmacist.

### Bristol Stool Chart

| | | |
|---|---|---|
| Type 1 |  | Separate hard lumps, like nuts (hard to pass) |
| Type 2 | | Sausage-shaped but lumpy |
| Type 3 |  | Like a sausage but with cracks on the surface |
| Type 4 | | Like a sausage or snake, smooth and soft |
| Type 5 |  | Soft blobs with clear-cut edges |
| Type 6 |  | Fluffy pieces with ragged edges, a mush stool |
| Type? |  | Watery, no solid pieces. Entirely Liquid |

# Continence

## Bowels

People may require additional support and personal care due to incontinence issues with their bowels for example, people may be incontinent of faeces, or have a stoma bag.

The colour of stools can vary; however, if someone has very dark stools (black) it may be related to medication (iron) or something more serious. Ensure care plans document any medication that may affect the colour of stools.

## Continence Pads

- Continence pads should be stored out of bright light and in a damp free environment - not in the bathroom
- People's skin should be clean and dry before support with pad application
- Only use a pea sized amount of barrier/ cream should be used as more may interfere with absorbency (unless advised otherwise by a professional)
- Pads should be opened for a minute or two prior to application to allow pad to expand
- Pad should be folded in half and inserted from the front to back, this prevents faeces coming to the front if passes stool during application

**Bowels normal** for individual
**No further action required**

**Change in bowel habit,** constipation without pain, make a routine referral to GP

**Monitor, document and support individual with continence care if needed**

**If stools are very dark (black) or very pale encourage the person to speak with their GP.**

**Some medication can change the colour of stools, this can be discussed with a pharmacist.**

https://www.bladderandbowel.org/bowel/bowel-resources/bristol-stool-form-scale/

# Diabetes

It is important that people with diabetes receive regular check-ups to help manage their condition. Supporting people to keep their blood glucose, blood pressure and blood fat levels under control will greatly help to reduce the risk of developing complications in diabetes.

**The short-term complications can include:**

**Low-blood sugar (Hypoglycaemia)**

**Signs:** Feeling shaky short tempered pale, sweating, tiredness, lack of concentration.

**High-blood sugar (Hyperglycaemia)**

**Signs:** Feeling thirsty, tiredness, headaches, passing more urine

**The long-term complications can include problems with:**

- Vision
- Heart (cardiovascular disease)
- Kidneys (nephropathy)
- Nerves and feet (neuropathy)

No diagnosis of diabetes - follow health lifestyle, eat varied diet and exercise regularly
**No further action required**

Diagnosed with diabetes - well controlled and managed with no problems
**Monitor, document and support individual and refer on if concerned to the GP or Practice Nurse**

Diagnosed with diabetes - poorly managed, presenting unwell or with hypoglycaemic (low n blood sugars) / hyperglycaemic (high-blood sugars) episodes.
**Seek additional support and advice on the day identified from the GP, Practice Nurse or Community Nurse and document. Consider 999 ... if confused or a change in normal symptoms**

Further information can be found at:
https://www.nhs.uk/conditions/diabetes/

# Diabetic Foot Care

Foot Care is particularly important, as people with diabetes can have reduced feeling and sensation or abnormal feelings in the feet (Peripheral Neuropathy).

People with Diabetes can also have a reduced blood supply to the feet due to narrowing of the arteries in the legs (Peripheral Arterial Disease).

## Legs

Carers, who support diabetic individuals, should check their feet on a regular basis when supporting with personal care. Refer on if any concerns for example red areas, inflammation, or blisters, corns / callus or open areas.

## Here are some top tips for the promotion of good foot care:

- Check feet daily for redness, swelling, pain or hard skin - monitor for changes and escalate if concerned
- Good control of blood sugar level can prevent foot problems or help heal open wounds
- Keep feet clean, wash and dry thoroughly daily and dry well particularly in between the toes
- always ensure shoes / slippers fit well
- Explain importance to client of never walking barefoot, especially outdoors
- Cut or file toenails regularly. If the person is unable to see or reach their feet or have no carer / family to help with nail care then a referral to a Podiatrist could be arranged. Ensure corns or hard skin are treated by a podiatrist if gentle filing and emollient cream do not control the hard skin
- If there are any changes in sensation or feeling to the feet ensure you report this to your health professional
- Make sure they attend their annual diabetic review with your GP, Specialist Diabetic Nurse or Practice Nurse as a foot check should be performed every year

https://www.diabetes.org.uk/guide-to-diabetes/complications/feet/taking-care-of-your-feet

# Medication

Medicines need to be stored appropriately and safely so that the products are not:

**Damaged by heat or dampness**

**Mixed up with other people's medicines**

**Stolen**

**Posing a risk to anyone else**

**Remember the 'Eight Rights'**

1. **Right person**
2. **Right medicine**
3. **Right route**
4. **Right dose**
5. **Right time**
6. **Person's right to decline**
7. **Right Information about the medication**
8. **Right Documentation**

**Classifications of Medication:**

**P-** Pharmacy
**POM** - Prescription only medication
**GSL** - General sales list
**CD** - Controlled drugs

Homely remedies (vitamins, herbal etc.) have no legal classification.

**Assist, Administer, Administer by special techniques:**

**Level 1** - Assist (Prompt, Pass, Prepare under supervision, Open but not give)

**Level 2** - Administer (Prepare unsupervised, Give, and Apply)

**Level 3** - Administer by special techniques (Rectal or Vaginal medicines, PEG, RIG, Injections, Nebuliser, Oxygen canister changing, Buccal Midazolam)

Ask the pharmacist for advice if you have a medication related query, they are usually best placed to respond to queries.

**Tip:** Write the telephone number of the patient's pharmacist on the Medication chart or care plan along with the GP surgery in case of any queries.

**Key tasks to be carried out during medicines administration by the care worker:**

Confirm that the medication and dose is correct; on the MAR chart *and* the medicine label

Confirm it is the right person
Ask whether the person wants the medicine
Makes sure that no-one else has already given this dose to the person
Prepare the correct dose for the time of day, ensure medication is appropriately spaced out following directions
Give the medicine to the person and also offer a drink of water
Sign the administration record

# Medications

Managing medicines for someone you look after can be a challenge, particularly if they are taking several different types.

Medicines can legally be administered by anyone, as long as it has been prescribed by an appropriate practitioner.

**Advice for Carers who support with medication:**

Always read the instructions on the packaging or DOSETTE box before giving medicines to anyone. They should always be given either according to the instructions or as advised by whoever prescribed them.

Instructions for when and how to give medication should be clear. If you are experiencing any problems, ask a doctor, nurse or pharmacist to explain.

It is important to give medicines at the recommended time of day. Not doing this can make them less effective. You also need to know whether or not the medicines should be taken before food, with food or in between meals.

**Please ensure that you follow your employing organisation's medicines policy, which may have information regarding what you can and cannot administer after appropriate training.**

**Person competent** and able to take their own medication with no problems
**No further action required**

**Requires support taking medicine** assist in a person centered way
**Monitor and document**

**Problems** with taking medication.
**Seek additional support and advice from Pharmacist, GP or Nurse on the day identified and document**

# Adult Social Care

Adult social care refers to a person's ability to manage their own personal needs and environment in order to live their lives in a comfortable and safe manner. Some people require additional practical and physical help to maintain their wellbeing due to additional needs, such as mental health, physical health, learning disabilities, older age and frailty.

**When might a person need support with social care?**

Sometimes day-to-day tasks can become difficult and a little extra help may be required. Some examples are doing the shopping, cooking meals, cleaning the house, managing finances, laundry, having a wash, getting dressed or getting out into the community. Help is available for these types of tasks from various community sources.

**Here are some ideas of where to get additional support or advice:**

- Family and friends
- National charities
- Local charities
- Care agencies
- Church group
- Community groups
- Cleaning services
- Meals on Wheels
- Dial a Ride
- Day centres
- Local council for telecare
- Carers Groups

**Carers**

A person who provides a significant level of support to another person in their day-to-day life is usually considered as a Carer. This is not the same as a person who provides care in a professional or paid capacity. Carers may also be able to have support from the above sources, as well to help them take a break.

# Adult Social Care

Sometimes people are not able to manage their own social care needs or require additional, professional support from a Social Care Worker. Everyone is entitled to a social care assessment or a corer's assessment, as outlined in the Care Act (2014). This can be completed by your local Social Care Team who will consider the following factors in relation to eligibility:

- **The adult's needs for care and support arise from or are related to a physical or mental impairment or illness, and are not caused by other circumstantial factors.**
- **As a result of the adult's needs, the adult is unable to achieve two or more of the outcomes specified in the Care Act (2014); examples include unable to manage personal care, nutritional needs or accessing the community.**
- **As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult's wellbeing.**

A similar eligibility criteria exists for Carers. **If** you feel an adult social care assessment would be of benefit, please contact your local authority.

Person's needs are met through their available support networks - for example family and friends

**No further action required**

Person is having social care difficulties that cannot be managed by family or friends. Person can access support from various community sources listed overleaf. Consider whether a social care assessment would be of benefit

**Monitor, document and escalate to local Social Care Team if appropriate.**

Person is struggling with daily tasks to the point they are putting themselves at risk, or there is a high risk of Carer burnout

**Contact the local Social Care Team to request an Adult Social Care Assessment**

# Adult Safeguarding

**What is adult safeguarding?**

- Protecting an adult's right to live in safety, free from abuse or neglect
- Promoting the wellbeing of the adult
- Showing regard of the adult's views, wishes, beliefs and feelings when deciding on action
- Providing support and interventions for adults who have experienced or are experiencing abuse
    - Learning how to support and protect people from abuse and harm
    - Strategies to prevent abuse and harm occurring
    - Partnership with other agencies and professionals
    - Avoiding blaming and taking responsibility within our roles
    - Reflection and learning on our work practice

**You must raise a safeguarding concern if you are working with an adult who:**

- Has care and support needs, and
- Is experiencing, or is at risk of, abuse or neglect, and
- Is unable to protect themselves because of their care and support needs

**Report adult safeguarding concerns to**

**Concerns for an adult:**

Call 0300 470 9100 or email ascmash@surreycc.gov.uk

(available 9am to 5pm, Monday to Friday)

**Concerns for a child:**

Call 0300 470 9100 or email csmash@surreycc.gov.uk (available 9am to 5pm, Monday to Friday)

**Concerns of domestic abuse:**

Call 01483 776 822 (available 9am to 9pm, 7 days a week)

**Out of hours:**

Call: 01483 517 898

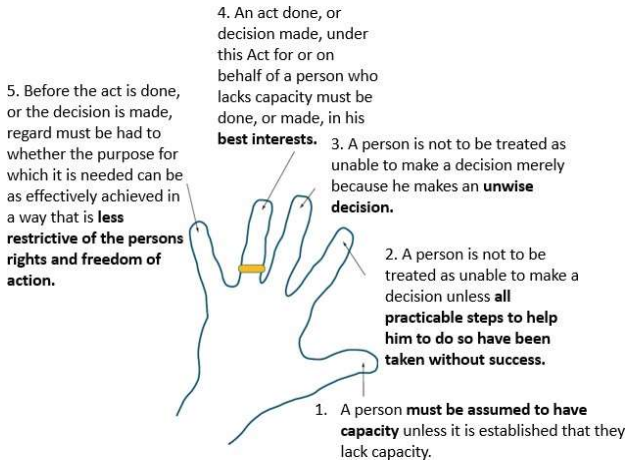
**In an emergency dial 999 for the police**

# Mental Capacity

**What is mentalcapacity?**

Mental capacity is the ability to make a decision
It can vary over time
It can vary depending on the decision to be made
Physical conditions and ɔcation, can affect a person's ability to make decisions

**Five principles of the Mental Capacity Act (2005)**




http://www.legislation.gov.uk/ukpga/2005/9/section/1

Person has capacity to make their own decisions

**No further action required**

Person has fluctuating capacity or is unable to make some decisions. Support them to make decisions when they do have capacity. Use pictures and familiar objects to help support them to make the decision

**Monitor and document**

Person lacks capacity to make serious decisions, such as managing their finances, moving house

**Contact the Adult Social Care Team to request a Capacity Assessment. For medical decisions, contact the GP**

# Mental Health

Adverse mental health affects one in four of us in any one year. Carers are in an ideal position to identify and signpost any concerns they have, in relation to the individuals they support.

**Mental health conditions include:**

- **Psychosis i.e. Schizophrenia or Bi-Polar Affective Disorder**

  Can cause confusion and acute distress, due to hallucinations, delusions and lack of self-awareness or profound lethargy.

- **Depression**

  Can cause a change in mood / personality and problems with sleeping, dietary intake and relationships.

- **Anxiety**

  Can induce problems sleeping, heart palpitations, dry mouth.

  Feelings of panic or fear and cold or sweaty hands or feet.

- **Personality Disorder**

  Where a person struggles to cope with life, manage relationships and regulate emotions.

Carers can help by supporting individuals with personalised care, assisting individuals to feel empowered and in control. Your attitude can impact both positively and negatively when supporting a person with mental health conditions.

It is important to give people time and space to talk about how they may be thinking and feeling.

To help mental health wellbeing, some people may like to connect with activities e.g. music, singing, creative activities, gardening, learning something new or spending time outside.

Early detection of concerns about mental health is important to ensure that people are supported in the correct way.

**Legislation that you as a Carer need to have a basic understanding of:**
**Human Rights Act 1998**
http://www.legislation.gov.uk/ukpga/1998/42/contents

**Data Protection Act 2018**
https://www.gov.uk/data-protection

**Mental Capacity Act 2005**
https://www.legislation.gov.uk/ukpga/2005/9/contents

# Dementia

Dementia is an umbrella term for a number of conditions that affects thinking skills, such as memory, language, object perception, attention and the ability to plan and organise.

The most common types of dementia are Alzheimer's Disease, Vascular Dementia, Lewy Body Dementia, Fronto-Temporal Dementia and dementia in Parkinson's Disease.

Dementia is a progress illness; so an early diagnosis of dementia can help planning for the future, including conversations around Lasting Power of Attorney and end of life wishes whilst the person still has capacity. In some cases, an early diagnosis of dementia can improve access to certain types of medication, which may support the person.

A person-centred and individualised approach is needed for all people with dementia. The approach needs to change as this develops for each person.

People can live well with dementia. If individuals are showing signs of distress , then they may have physical or mental health issues that can be managed.

**Normal presentation** no concerns identified, support in a personalised way as normal
**No further action required**

Person has a diagnosis of dementia: support in a personalised way and follow care plan.

**Monitor and document**

Person is showing some changes in their behaviour - liaise/ inform the GP or mental health team if known

Sudden or serious change in presentation: urgently contact the GP surgery or mental health team if known to document concerns
**Refer and seek advice**

# Delirium

Delirium is a common, **serious** but often treatable condition that starts suddenly in someone who is unwell. It is a serious condition that is sometimes mistaken for dementia .

**Symptoms** The symptoms of delirium will start suddenly and may come and go over the course of the day. They can be worse in the evening or at night. A person with delirium will show some of the following changes.

Rambling speech. Showing changes in behaviour.

Having disturbed patterns of sleeping and waking.

Being prone to rapid swings in emotion.

Experiencing hallucinations.

Rambling speech. Showing changes in behaviour.

Having disturbed patterns of sleeping and waking.

Being prone to rapid swings in emotion.

Experiencing hallucinations.

Having abnormal or paranoid beliefs.

**Hypoactive Delirium** is when delirium can cause an individual to be abnormally withdrawn and sleepy. It can easily be missed or mistaken for depression, even by a health professional.

**Hyperactive Delirium** is when delirium can cause a person to become abnormally alert, restless or agitated, and possibly even aggressive. The person may have hallucinations (seeing or hearing things that aren't really there) or delusions (strongly believing things that are not true, for example that others are trying to harm them).

**Mixed Delirium** is when individuals can also alternate between hypoactive and hyperactive delirium over the day.

https://www.youtube.com/watch?v=FstSYkold5c

# Treating Delirium

If someone suddenly becomes confused, the person will need to see a doctor urgently. **The cause of delirium must be treated.** For example, an infection may be treated with antibiotics.

The individual can recover very quickly, but it can take several days or weeks. People with dementia can take a particularly long time to get over delirium.

## Think Delirium!

**Delirium often has more than one cause & might include:**

- Infection or severe illness
- Dehydration or metabolic problems
- Side effect of some medications
- Uncontrolled pain
- Constipation or urinary problems
- Suddenly stopping some medications
- Suddenly stopping heavy drinking
- Infection or severe illness

**Signs of delirium**

- Suddenly being confused anxious or frightened
- Disorientated, behaving out of character
- Difficulty following what is being said
- Feeling afraid, irritable, anxious, depressed
- Drowsy and withdrawn
- Difficulty speaking clearly
- Mood swings and fluctuating levels of consciousness

No evidence of risk factors which cause Delirium, individual is acting and responding normally for them. **No further Action required**

Monitor the person carefully if they have any of the risk factors for Delirium. Be observant for the signs and symptoms of delirium. **Report and document any deterioration in physical or mental health**

**If someone suddenly becomes confused, seek additional support and advice immediately, they need to see a doctor.**

**Most people living in care homes will be at risk.**

Care staff have an important role to play in looking out for any changes and providing support to reduce the risk of delirium occurring and act quickly if they suspect it.

# Pain

Assessing pain and communicating it to the healthcare team will be one of the most important things you can do. As carers, you get to understand a person really well and can read both the verbal and non-verbal signs.

There are different types of pain:

- Acute pain starts suddenly and is short-term
- Chronic pain lasts for a longer period of time
- Breakthrough pain often happens in between regular, scheduled painkillers
- Bone pain happens when cancer is affecting a bone
- Soft tissue pain happens when organs, muscles or tissues are damaged or inflamed
- Nerve pain happens when a nerve is damaged
- Referred pain is when pain from one part of your body is felt in another
- Phantom pain is when there is pain in a part of the body that has been removed
- Total pain includes the emotional, social and spiritual factors that affect a person's pain experience

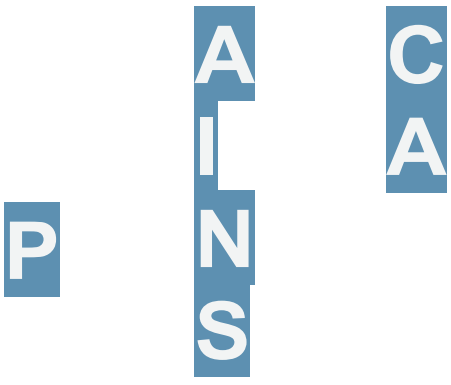
It can be difficult to assess a person's pain if they are unable to verbalise it and/ or unable to point to the FACES scale. There are some signs and symptoms that a person may exhibit if they are in pain that can clue you in:

- Facial grimacing or a frown
- Writhing or constant shifting in bed
- Moaning, groaning, or whimpering
- Restlessness and agitation
- Appearing uneasy and tense, perhaps drawing their legs up or kicking
- Guarding the area of pain or withdrawing from touch to that area

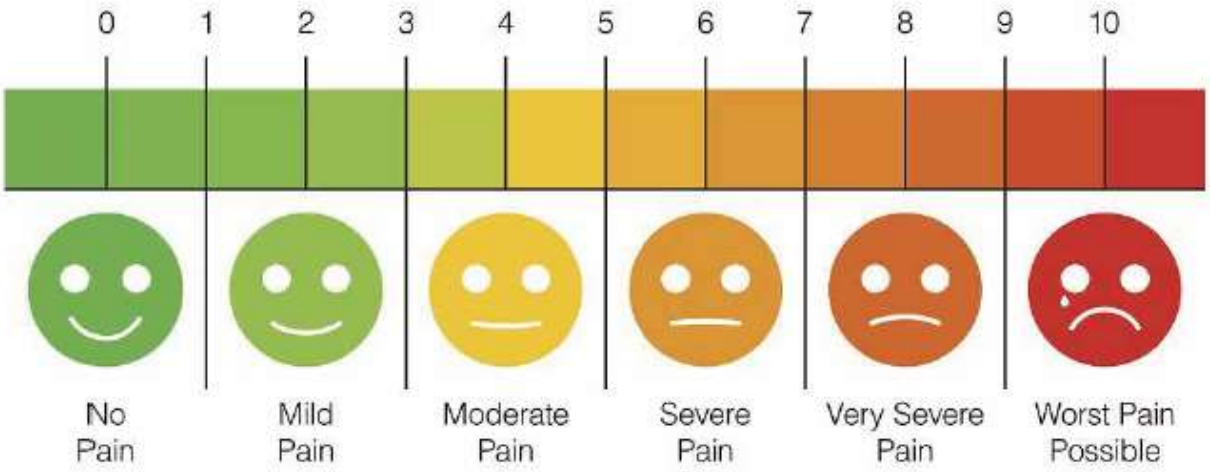
The more symptoms a person has, and the more intense they appear to be, the more you will get a grasp of the degree of pain they are experiencing. You can then record their pain as "mild", "moderate",or "severe". Seek medical assessment and/or advice if you think the person you care for is experiencing a level of pain that is distressful for them.

The numerical pain scale below is often used and is a very effective in describing pain. Asking the person their score and assisting them to keep a pain diary while doing various activities means that they can get the best treatment.





# PAIN SCALE


0
1
2
3
4
5
6
7
8
9
10
No Pain
Mild Pain
Moderate Pain
Severe Pain
Very Severe Pain
Worst Pain Possible

# Advance Care Planning

Advance care planning refers to a whole range of ways a person can work with their care teams and discuss, document and communicate their wishes about how they would like to be cared for in the future.

Common things Advance Care Plans cover and aim to prepare for include:

Details of the persons' current health and care needs and what care issues might be expected to happen to them in the future based on their conditions.
Information about the person's general likes and dislikes which affect their quality of life.
Religious, spiritual cultural beliefs or traditions.
Naming those they would like to be involved in their future care.
The overall approach they would like e.g. focus on life-sustaining care e.g. operations, chemotherapy, admission to hospital or focus on quality of life over quantity, less invasive tests for example.
The place they would like to be cared for in, including where they would like to die.
Care after death, organ donation, and funeral plans.
Anything else the person would want the care team to know if for whatever reason they were unable to express it in the future.

There are three main types of plans made:

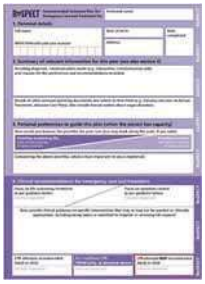
1. **Person-made** description of the nature of the care they would like to happen in the future based on their wishes, values, feelings and beliefs about their future care. Not legally binding but guides overall approach and goals of care.
2. **Person-made** specific refusals of certain treatments in a legally binding manner known as **Advance Decisions to Refuse** Treatment (previously a **Living Will).**
3. **Clinician-made,** but person-involved decisions about which treatments are clinically appropriate to offer to someone - such as whether or not to attempt cardiopulmonary resuscitation.

**ReSPECT is an example of an advance care plan which can be completed between the person, those important to them, and the health and care team:**

**https://www.resus.org.uk/respect/**

**Worthwhile website with real-life experiences and educational materials to support conversations about future care.**

Anyone can start advance care planning at any stage in life and is something that can be reviewed and updated.



It is particularly important for people who are at risk of deterioration, are frail or have long term conditions.

**The #last1000days** campaign encourages us to have conversations with people about what matters to them at this stage in life when time left is so valuable.


Ensure the content of any advance care plan is known about by the whole care team and store any written advance care plans in familiar and accessible places.

# Caring for Dying People

Everyone should be able to die as well and as comfortably as possible.

Recognising that someone is dying usually involves decision making from a clinical team, acknowledgement that there are no reversible causes to be addressed, documentation and communication to allow natural death such as through a **DNACPR** **or** **ReSPECT** form, and conversations involving the dying person and all those important to them, including carers.

Once this is agreed we can shift our focus from life sustaining, often more invasive care, to prioritising comfort, wellbeing, dignity and doing our best to respect their wishes. Though it can be difficult to be certain someone is dying, raising the possibility enables the whole team to work together to establish the right goals of care for the person.

We don't always like to talk about death though it will happen to us all. Research however has shown most people know when they are dying, prefer to talk about it if asked, and loved ones tend to experience regret after a person's death if we don't talk about it openly.

The national framework to support caring for dying people is called the **Ambitions for Palliative and End of Life Care.**

# Caring for Dying People

Some practical steps deliver the best care is to follow the **5 Priorities for Care of a Dying Person.**
Each of the 5 steps help us to create an individualized plan of care for the person and those important to them.


*Don't forget bladder, bowel, oral and skin needs too*

Though every death is different, there are some common symptoms to review regularly

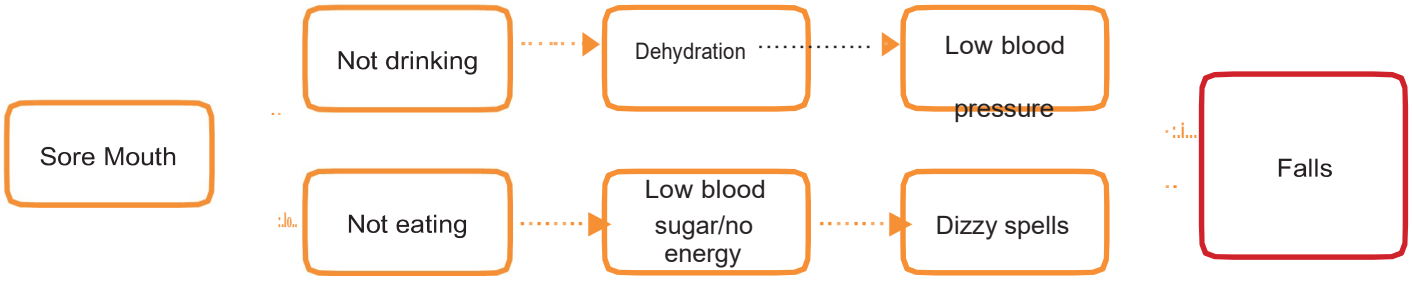
**1) Pain 2) Breathlessness 3) Nausea/Vomiting 4) Anxiety and Delirium 5) Secretions**

Ensuring there is a multidisciplinary plan for each of these including rapid access to relevant medications is essential and requires liaison with **medical** and **pharmacy** teams.

Care after death of those bereaved and the person's body after death is important too.

# Stop Look Care Case Study

**Remember that different conditions or different aspects of poor health can impact on another area of the body.**




## Example

A gentleman with dementia kept falling every time he stood up, his family thought he was falling backwards on purpose.

A home carer decided to check;

**How much he was drinking, she asked the family to keep record of his fluid intake.**

**She also looked at the gentleman's urine which was very dark and his hands were cold**

She decided he was dehydrated, and thought this could be causing low blood pressure, which may be making him dizzy when he stands

**She asked for support from the community nurses.**

The community nurses confirmed he did have low blood pressure when he stood up (postural hypotension), and agreed he needed to increase his fluid intake.

The family was able to make sure the gentleman drank a lot more and he was then able to stand without falling.

# Contacts

## National Contacts for support

**National Age UK**
0800 055 6112

**Alzheimer's Society**
0300 222 1122

**British Heart Foundation**
0300 330 3311

**Diabetes UK**
0345 123 3393

**MIND (Mental Health Charity)**
Infoline: 0300 1233393

**CQC (Care Quality Commission)**
03000 616161

**Emergency Ambulance**
999 **for immediate, life-threatening emergencies**

**Pharmacists**
The local pharmacist can support with advice regarding everyday health issues. Or with problems with prescriptions / medications.

**Skills for Care**

https://www.skillsforcare.org.uk/Home.aspx

## NHS 111

**You should use the NHS 111 service if you urgently need medical help or advice but it's not a life-threatening situation.**


111 is the NHS non-emergency number. It's fast, easy and free. Call 111 and speak to a highly trained adviser, supported by healthcare professionals. They will ask you a series of questions to assess your symptoms and immediately direct you to the best medical care for you.

NHS 111 is available 24 hours a day, 365 days a year. Calls are free from landlines and mobile phones.

https://www.nhs.uk/using-the-nhs/nhs-services/urgent-and-emergency-care/

| | | | |
|---|---|---|---|
| Understand Your Role | | | |
| Your Personal Development | | | |
| Duty of Care | | | |
| Equality and Diversity | | | |
| Work in a Person Centered Way | | | |
| Communication | | | |
| Privacy and Dignity | | | |
| Fluids and Nutrition | | | |
| Awareness of Mental Health Conditions, Dementia and Learning Disabilities | | | |
| Safeguarding Adults | | | |
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# The Stop Look Care Book

## created by Carol Hards and Helen Rignall

**Carol Hards** is a Registered General Nurse with over 20 years clinical experience specialising in Community Nursing and has a BSc in Health Studies. She worked as Nurse Assessor for NHS Continuing Healthcare before taking up her current post as a Clinical Quality and Patient Safety Manager for Brighton and Hove CCG. This role involves monitoring the quality and safety of commissioned services and working with providers to improve the quality of patient care throughout Brighton and Hove. She is particularly committed to the improvement of care in the community including Care Homes.

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**Helen Rignall** is a Primary Care Workforce Tutor working for Brighton and Hove Clinical Commissioning Group (CCG). She has had a vast and varied career, qualifying as a Registered Nurse in 1986, a midwife in 1989, acquired a BSc in Health visiting in 1998 and Adult Intensive Care Nursing in 2009. She lived and worked in the Middle East for 7 years, learning about different cultures, health beliefs and healthcare. Currently she is delivering on strategic projects in primary care to support education and workforce priorities and is also supporting projects across health and social care. Helen is committed to helping others acquire the correct knowledge, to be able to deliver safe, effective and good quality care.

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The Stop Look Care book won a Nursing Times Award in 2018. The book has gained national recognition and the Stop Look Care model and book has been adopted in several areas across the country.

Stop Look Care is also referenced in the NICE Guidance via the NICE Shared Learning Database

https://www.nice.org.uk/sharedlearning/stop-look-care

Building on the success and national recognition of Stop Look Care, Sussex Health and Care Partnership with the support Health Education England are rolling out a programme of training based on the Stop Look Care booklet. This is to targeted care homes and other statutory and voluntary sector organisations across the county. The training aims to support care workers and carers in feeling confident in managing the fundamentals of health care, being able to recognise deterioration in someone's health and know what action to take.

Thanks to the many NHS, Social Care and Provider organisations and professionals involved in the production of this book, with special thanks to the Frimley Health and Integrated Care System and South Kent Coast CCG.

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