Improvement Academy

Care Homes and Domiciliary Care

INTERACT™

NHS
Vale of York
Clinical Commissioning Group

Recognising and Responding to Deterioration in Residents and Clients

WORKBOOK

RECOGNISE • RESPOND • COMMUNICATE

STOP AND WATCH

Individuals will often deteriorate for a variety of health reasons and it is essential that these changes, however subtle are recognised and responded to promptly.

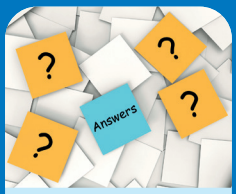
This interactive workbook is designed to support the process of recognising and responding to deterioration of individuals across care settings. It will provide staff with opportunities to test their knowledge and explore their thoughts, feelings and work practices as they learn. Where possible, it should be supported by the NHS Vale of York Quality & Nursing team, however, it can be used as a stand alone resource if necessary.

Short tasks are set throughout the workbook and are indicated as below:

READING

THINKING

WRITING



FINDING OUT

The workbook is appropriate for use by all staff and all grades including senior experienced care staff and those new to a caring role. In taking a whole home approach to recognition and responding to deterioration, teams can work and communicate within the care setting and with other health and social care services to benefit the residents and clients they care for.

For further details, please contact:

Helen Degnan, Senior Nurse, Quality Improvement
email: h.degnan1@nhs.net

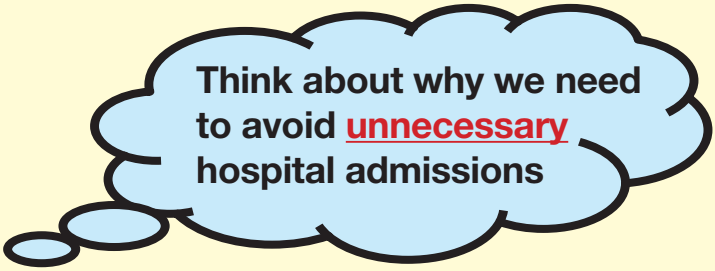
Maureen Hole - Project Nurse
email: maureen.hole@nhs.net

What do we mean by DETERIORATION?

- When a client or resident is becoming unwell or seems different to usual 'not their usual self'
- If a person becomes unwell and it goes unnoticed it might increase their risk of morbidity, organ failure, **hospital admission**, further disability and even sometimes death.

We need to be able to recognise and respond to deterioration or changes in ALL residents

The recognition tool **STOP AND WATCH** should be used for **ALL** residents that show any signs of changes in their normal condition and/or deterioration, due to any causes.



- Exposure to avoidable harms such as deconditioning, infection, pressure ulcers
- Disruptive and upsetting for residents/clients
- Significant demand on staff time and resources
- Financial - average cost per hospital visit is £1603 (NHS Improvement Nov 2018)

By recognising deterioration earlier, we can prevent harm and hospital admissions

Knowing the person you care for!

Study's show that carers can spot signs of illness up to 5 days before they become evident in observations.

Think about how long you have worked in a care setting and how many people you have looked after. Can you recognise when something is wrong with a client/resident?

Using a prompt tool can help spot signs of deterioration by supporting your 'Gut Instinct' or your 'first' reaction to 'something's not right with…' it can help explain to colleagues why you are worried, so better care decisions can be made.

The Stop and Watch tool

The tool consists of 11 prompts. There are clinical reasons why each of these questions are in the tool and will help make sense of the changes in the resident/client.

You do not need to be able to carry out clinical observations such as blood pressure or temperature to use the **STOP and WATCH** tool, however ***if you do*** you can add this information to your overall observations. The **STOP and WATCH** tool uses 'softer signs' that recognises and helps to make sense of your observation of a resident/client that is deteriorating.

S	Seems different to usual
T	Talks or communicates less
O	Overall needs more help
P	Pain new or worsening: participating less in activities
A	Ate less
N	No bowel movement in 3 days; diarrhoea
D	Drank less
W	Weight change
A	Agitated or more nervous than usual
T	Tired, weak, confused or drowsy
C	Change in skin colour or condition
H	Help with walking, transferring or toileting more than usual

Seems Different to usual

However small the change; if YOU feel a resident/client is different, assess using the **Stop & Watch** tool. Often early signs of a problem show when a client is not 'quite right' or acting out of character - like a gut feeling. This may be changes in a client's daily routine, or not joining in as much as usual.

Talks or communicates less

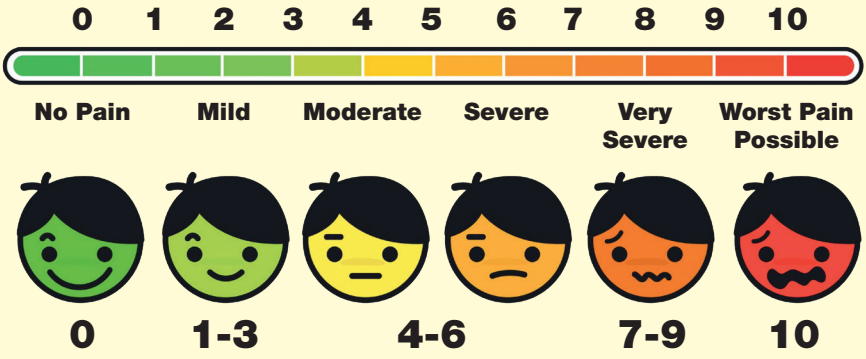
What is your resident's/client's usual way of communicating? Are they doing it less effectively? Reduced communication could be a sign a resident/client is becoming more confused, depressed or tired.

Overall needs more help

Is your resident/client more dependent than usual? Are they asking for more help? Do they need more staff to support with transfers or with activities of daily living? Lower energy levels can point to infection or deterioration in a resident or client's medical condition.

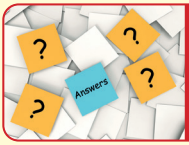
Pain, new or worsening; Participating less in activities

Pain is often a sign of something being 'not right'. However not all residents/clients can tell you when they are in pain. Look for non -verbal clues such as agitation, discomfort, or not being able to move as well as usual. Is the pain new to them or worse than normal? Pain scales are useful to assess the level of pain someone is experiencing.



Ate less

Appetite can vary, even from day to day and can be a good indicator that something may be wrong. Some residents/clients may have Dementia or other memory problems that mean they may not accurately recall if they have eaten - you might use food diaries to monitor this with some residents/clients.



Find out which of your residents have food charts and why. Are they always completed accurately?

You may notice a resident/client's normal eating pattern has altered, eating less or avoiding certain foods.

Lack of appetite can be a sign of lots of different medical conditions and can lead to malnutrition with potentially serious consequences.

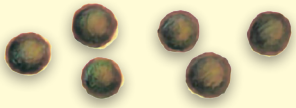
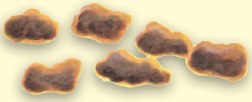
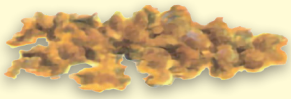
Does the resident need help with feeding or have any problems with their mouth, teeth or dentures?

No bowel movement in 3 days; or diarrhoea

Monitoring of bowels is an important indicator of ill health. As well as frequency it is useful to also note the colour of stools.

Use the Bristol Stool Scale to identify, monitor and record bowel movement.

Bristol Stool Chart

Type 1		**Seperate 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 mushy stool**
Type 7		**Watery, no solid pieces, Entirely Liquid**

Drank less

This can be difficult to spot until a resident becomes dehydrated, which can lead to serious health consequences.

Recognise the signs - Can you think of 4 signs to look out for that may suggest a resident is becoming dehydrated?

1.

2.

3.

4.

A Urine Colour Guide to Hydration
Dehydration can become visible in urine colour

1	**1 to 3 is a Healthy Pee**
2	**Pale, odourless urine is an indication that you are well hydrated**
3	
4	**At number 4?... Drink some more...**
5	**By 5, 6, 7, 8 you really need to RE-HYDRATE**
6	
7	**If blood is present in urine either red or dark brown, seek advice from your GP**
8	

Do your residents/clients always finish their drinks?

Just because they were given a drink may not mean they drank it!

Some residents/clients may not want to drink because of making trips to the toilet - reassure them you are there to help

Dehydration can lead to urine infection, constipation and confusion. If someone is confused due to dehydration, this could also lead to a fall. Find out more by visiting React to Nutrition & Hydration & React to Falls www.reactto.co.uk

Find out what hydration tools your organisation uses to assess residents/ clients risks of dehydration and how your clients/residents hydration is monitored

Weight change

You may notice a resident/client has lost or gained weight through weekly monitoring, or you may notice other signs such as loose or tight fitting clothing, jewellery or a drawn face.

Causes of weight loss can include decreased intake, due to ageing or dementia, stress or depression, but can also be due to illnesses such as infection or cancers.

Weight gain could be due to ill health such as heart or renal failure.

Agitated or more nervous than usual

You may notice a resident fidgeting, trying to get out of their chair or bed, looking scared or anxious. Residents/clients may become more active and aggressive, or become nervous, withdrawn or tearful. This can be an important sign of a developing infection, pain, lack of oxygen or problems with medication.

Tired, weak, confused or drowsy

You may notice a resident/client appears to have less energy than usual or they may have new or increased confusion or agitation. This could be due to infection or worsening dementia or it could be a sign of delirium. Delirium is an acute confusional state (often worse at night) that can be successfully treated.

	Cause
D	DRUGS - new medications, medication side effects, interactions, withdrawal.
E	ELECTROLYTE DISTURBANCES - acute kidney disease, sodium or potassium imbalance.
L	LOW OXYGEN - due to COPD, heart failure, heart attack, pulmonary embolism.
I	INFECTION - UTI, chest infection, cellulitis.
R	RETENTION - of urine or constipation.
I	INJURY / PAIN / STRESS - fracture, head injury, pain from internal problem, lack of sleep / mental health problems.
U	UNDER-HYDRATION / UNDER NUTRITION - dehydration or malnutrition, weight loss.
M	METABOLIC - high or low blood sugar, diabetes, pancreatic problems.

Delirium may be difficult to spot in those with Dementia - Remember <u>you</u> know your residents/clients

Change in skin colour or condition

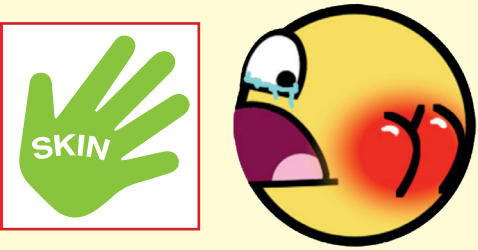
Dry skin is a sign of dehydration. Other changes may include increasing bronzing of the skin (problem with iron), a yellowing of the skin and whites of eyes (liver failure). Poor circulation or inadequate oxygen levels in blood can also cause your skin to turn bluish (Hypoxic).

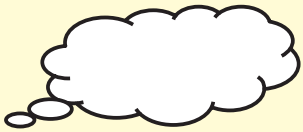
A rash that does not respond to treatment, and is accompanied by other symptoms, such as fever, joint pain, and muscle aches, could be a sign of an internal problem or infection.

If a resident/client becomes unwell and is not mobilising as usual or is confined to their chair, bed or room

Think pressure areas!

REACT TO RED





Think about pressure area prevention - what do you know about preventing pressure damage?

Have you had React to Red training?

Refresh your memory or find out more about pressure area prevention:

React to Red
www.reactto.co.uk

Help with walking, transferring, or toileting more than usual

You may notice a resident/client has "Gone off their legs". This usually refers to older people who were previously mobile and active, having a sudden deterioration in their mobility. It may be a sign of acute illness such as UTI, dehydration, malnutrition or chest infection.

If a resident seems different to usual

Next steps…

- Complete the Stop and Watch early warning tool
- Team work - talk to senior, discuss action
- Gather info, use SBAR (see next page) to communicate with appropriate health/care services
- Document & handover to team

If you are concerned about anyone that you are caring for, the most important thing is to:

Tell Someone!

Accurate and timely communication with your colleagues is vitally important when a client / resident is deteriorating.

To help communicate with others outside your teams including GPs, YAS, DNs etc the SBAR communication tool can be used.

SITUATION:

- Who are you calling about?
- How long have you been concerned and why?

BACKGROUND:

- Important medical history (e.g. heart failure, diabetes)
- Do they have a DNR, CPR or advanced care plan?

ASSESSMENT:

- Identify any changes from **Stop and Watch**

RECOMMENDATION:

- What would you like the responder to do?
- Are there any other actions you should take?

Having looked at the signs and possible causes of deterioration you now need to read the case study of Joseph. You may be caring for younger people than Joseph, you may be caring for people in supported living, in their own homes or in nursing care. This case study will give you an insight in recognising deterioration and how to respond. Remember the **Stop and Watch** tool can be used for any adult showing signs of deterioration and in any care setting.

Joseph

- A care package was put into place two years ago when his wife died because he wasn't managing at home. His daughter visits once a week.
- He has a past medical history of bowel cancer and he had an operation in his 60's to remove part of his bowel, leaving him with a stoma that he can manage himself.
- He was diagnosed with prostate cancer 5 years ago, which has spread to his hip bone and can cause him some pain on walking. He walks with one stick, but can mobilise.
- He is sometimes a little forgetful but does not have a diagnosis of dementia.
- He struggles with practical tasks such as washing, dressing and food preparation.
- He can mobilise slowly with his stick.
- He is normally an early riser and enjoys a large breakfast to start the day.
- During the day he watches TV, reads the paper and socialises with staff and other residents. He likes to talk about his days in the Navy.
- He also likes to sit out in the garden on a sunny day and watch the birds.
- He enjoys his life in the home and gets on well with all staff.

Now you know a little bit about Joseph, his medical history, his likes, dislikes and daily routine. You should be able to understand how you can recognise when a resident or client is not 'themself'

This is your 'gut instinct'

To help you respond to changes you see in a resident/client, the **STOP and WATCH** prompt tool can be completed. Working through the prompts in a structured, logical way can help you assess a persons condition, and keep track of further changes or deterioration

Inserted into this workbook you will find a blank copy of the tool which you can practice filling in as you chart Joseph's deterioration over the next few pages. On the reverse of the tool you will find an **SBAR** communication form to help inform your communication with other professionals.

These tools should be used in addition to your existing documentation and not as a replacement.

So… If you notice any change in your client / resident, grab a **STOP and WATCH** tool and complete it.

Now let's take a look at how Joseph's health changes during the week and by using the **STOP and WATCH** prompt tool we can recognise deterioration and respond.

Monday

- Joseph gets up at his usual time but comments to carers that he feels a bit 'groggy' and that he didn't sleep well.
- He sits in his chair and watches TV and doesn't chat to staff like he usually would.
- He dozes off a few times during the day, which isn't like Joseph but staff leave him to sleep because he has had a disturbed night.
- He hasn't had much stoma output today, but he doesn't mention this to carers.
- Joseph does not mobilise as much as usual during the day.

Do you think Joseph is different to usual? Yes, he is so complete the STOP & WATCH tool

Using the blank form at the back of the workbook, complete the changes you have observed on Monday.

The Important Bit!.....
Team Work & Communication

An effective team is far more able to recognise when things are going wrong.

A team that works together well is a safe team as they are more likely to know what is happening around them.

Teams work best when all members feel safe and have a voice.

Tuesday

- Joseph had another disturbed night with back pain. He is short-tempered with staff when they ask why he hasn't eaten all his breakfast.
- He sits in his chair watching TV again. It is a lovely sunny day, but Joseph shows no interest in sitting in the garden today.
- When walking to the toilet staff noticed he seemed a little unsteady on his feet and needed help with his trousers.
- When offered a cup of tea he declines, asking for juice because his mouth is dry.
- He finds that he doesn't really fancy the cottage pie for evening meal. He usually looks forward to this on a Tuesday. He has some soup instead.

Complete the **STOP and WATCH** again on Tuesday and you will see clearly how Joseph is deteriorating.

On the next page is an example of how to complete the form for Joseph. On Monday and Tuesday the deterioration is clear.

Once you have completed the STOP and WATCH tool talk to the senior in charge with the information to help make a team decision about Joseph's care. How frequently you observe a resident/client will depend on the individual and their care needs and how the deterioration is presenting.

You can use the STOP and WATCH to inform your safety huddles, flash meetings and handovers.

Date / time	1/1/20 9am	2/1/20 9am		Additional information
S Seems different to usual	Yes	Yes		
T Talks or communicates less	Yes	Yes		
O Overall needs more help	No	Yes		
P Pain new or worsening; participating less in activities	No	Yes		
A Ate less	No	Yes		1/1/20 But sleeping more
N No bowel movement in 3 days; or diarrhoea	Yes	Yes		1/1/20 Stoma not working usually daily
D Drank less	No	Yes		1/1/20 But sleeping more need to encourage fluids
W Weight change	No	No		
A Agitated or more nervous than usual	No	Yes		
T Tired , weak , confused or drowsy	Yes	Yes		1/1/20 Poor nights sleep
C Change in skin colour or condition	No	Yes		2/1/20 Pressure areas checked
H Help with walking, transferring or toileting more than usual	No	Yes		
Carer name	Kf	Kf		
Reported to (senior)	fk	fk		
Senior Action /call GP / 999/ 111 / DN etc **Resident monitored or other action**	1/1/20 Continue to observe, encourage fluids and mobility, observe PA, risk of falls, use SW again in 24hrs unless deterioration noted sooner. 2/2/20 Deteriorated - call GP for advice use SBAR to communicate.			

Joseph's condition continues to deteriorate! Read what happens next...

Wednesday

- Joseph is really not feeling himself today. He is tired and doesn't have the energy to eat or drink much.
- He decides to mention his low stoma output to carers and when they ask about his waterworks he realises that it has been darker and more smelly than usual.
- Carers dip his urine which is all clear
- Joseph asks for extra paracetamol during the day and before bed for his backache. Embarrassingly, he forgets the name of several carers and domestic staff during the day. He goes to bed early.

Thursday

- Joseph's daughter Maggie is visiting today. He always looks forward to the weekly visits, but today he seems to have forgotten, because the carers have to remind him this morning.
- He is eating and drinking less, and Maggie notices that his mouth and skin seem dry and his clothes appear looser than normal.
- He falls asleep during her visit, which is troubling for Maggie. She talks to carers.
- Carers inform her of Joseph's sluggish bowels and say they think it is because of the increase in pain medication at night. They reassure Maggie that they are giving him laxatives and keeping an eye on things.

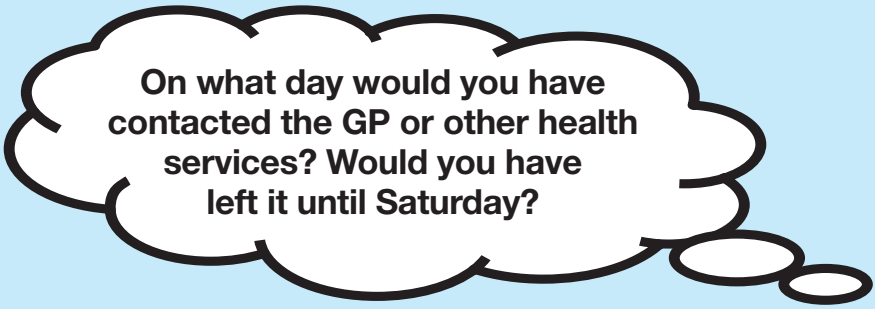
Friday

- This morning, carers find Joseph in the bathroom in a mess. His stoma has started working and is passing loose watery stool.
- He has obviously tried to change the bag, but has not managed this and has soiled his clothes and the bath room. He seems muddled and upset as to what he should be doing.
- Carers let him rest in his chair today and bring food to him at meal times. He picks at his food and leaves drinks unfinished.
- He is put to bed early because he is falling asleep in his chair throughout the day.

Saturday Morning
Joseph has significantly deteriorated overnight.

- He mobilised to the bathroom during the night without his stick and fell for the first time.
- Luckily, he does not seem to have significantly injured himself, and denies hitting his head.
- Staff helped him back to bed. He seemed disorientated and unsteady on his feet.
- Carers note that his skin is dry and he appears pale.
- This morning, Joseph was unable to get out of bed.
- He has had an accident and wet himself overnight.
- He is complaining of back and tummy ache.
- He is confused, asking for his wife Barbara.

How could this deterioration have been prevented?



Saturday Afternoon

Clear, accurate information is crucial to help clinical decisions be made

Carer / Nurse / Senior - calls GP or other responder for advice about Joseph; - using SBAR

- **Situation** - I am calling about one of our client's, Joseph. He is 81. He started to be unwell on Monday and has since deteriorated.
- **Background** - He has a past medical history of bowel cancer and prostate cancer which has spread to his bones. He does have a DNACPR. Does Joseph have an advanced care plan in place and preferred place of care / treatment?
- **Assessment** - Joseph is more tired and confused than normal, and the pain is new. He is not eating and drinking much. He seems dehydrated. He has a stoma and has been constipated. He can usually get out of bed on his own but can't today and he fell last night for the first time.
- **Recommendation** - I think Joseph needs to be seen urgently by a doctor. He may even need to go to hospital Is there anything else I need to be doing at this stage?

Saturday Evening

- Joseph is taken by ambulance to hospital.
- He is transferred to an elderly medical ward where he is found to have high calcium. This has probably been caused by his prostate cancer affecting his bones.
- High calcium causes dehydration, constipation, confusion and bony aches. It can be fatal if not treated quickly.

Think about…

Could this admission have been prevented by earlier recognition of Joseph's deterioration?

Did you have any ideas about what had caused Joseph's deterioration? Would you have considered high calcium being the cause?

Two weeks later

- Joseph had a prolonged hospital stay because of the severity of his symptoms. He was very dehydrated and he also needed lots of laxatives to get his bowels working again.
- Joseph's hospital stay may have been shorter if a GP Team had seen him earlier to assess and diagnose the problem.
- On day 6, he developed a chest infection which set his recovery back another few days.
- Earlier community treatment may have prevented a hospital admission altogether.

Now you have completed the workbook you should know the following. Tick the box when you can answer yes and if there are any areas that you are unclear about, revisit the section and discuss with your manager or trainer.

I understand what deterioration means	
I understand why recognising deterioration is important	
I understand how to use the STOP and WATCH tool to pass information on to colleagues about a resident/client who is deteriorating	
I understand how to use the SBAR communication tool	
I understand where and when I need to access emergency help	
I understand how to find information about a resident/client in my organisation	
I understand how to find other information and resources to support my learning	
I know where the blank and completed STOP and WATCH & SBAR tools will be kept	

If you think a resident may have deteriorated, grab a tool, and complete the Stop & Watch Assessment

- even if it's just a gut feeling!

Spotting signs of deterioration and taking prompt action early really does make a difference.

Improvement Academy

Care Homes and Domiciliary Care

NHS
Vale of York
Clinical Commissioning Group

Name...

Organisation...

NHS Vale of York CCG Quality & Nursing Team

DETERIORATION?

RECOGNISE ● RESPOND ● COMMUNICATE

STOP AND WATCH