Care Homes
Our Partners in Care
Care Homes and Domiciliary Care

NHS
Humber and North Yorkshire
Integrated Care Board (ICB)

For further information please contact:

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HYDRATION

Think Drink!

Older people, particularly those living in care homes are at risk from dehydration, which can lead to serious health consequences i.e., UTI's, confusion, delirium, falls, pressure ulcers, constipation. It is recommended that adults drink at least 1500mls of fluid every day. This equates to approximately 6-8 mugs or glasses. All fluids count (except alcohol) … water, juice, tea, coffee, milk…

NOT DRINKING ENOUGH FLUIDS CAN CAUSE DEHYDRATION WHICH BECOMES VISIBLE IN URINE COLOUR.

A Urine Colour Guide to Hydration

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

Further Information is available at:
https://www.valeofyorkccg.nhs.uk/about-us/partners-in-care/care-home-domiciliary-care-staff/improving-hydration-in-care-home-residents/

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HYDRATION

Have we missed anything?

How many days since our last missed or incomplete fluid balance chart?... what have we learnt?

! WHO ARE WE WORRIED ABOUT TODAY?

T Tool... Hydration risk assessment tool completed?

H Hydration Chart... Accurate & up to date?

I Identify... Residents requiring prompting or encouragement

N Needs assistance... cognitive or swallowing difficulties?

K Know your resident... spot the signs!

D Dry mouth, lips or tongue, dizziness, headache or tiredness?

R Restless, confused, disorientated?

I Irritable - signs of pain or discomfort, Fever, or pyrexia?

N Nil or reduced bowel movement/constipation?

K Kidneys - reduced urine output, smelly dark urine, new or worsening incontinence...

? WHAT ARE WE GOING TO DO AS A TEAM TO REDUCE THE RISKS OF DEHYDRATION?

- Increase drinking opportunities - provide drinks with medications/meals
- Provide fluid rich food i.e. ice cream, jelly, fruit/veg, sauces, soups, stews
- Explore preferences, increase choice – GET CREATIVE
- Provide appropriate support, assistance, prompts and encouragement
- Ensure appropriate and pleasant drinking vessels are used

Improvement Academy

Care Homes — Our Partners in Care — Care Homes and Domiciliary Care

INTERACT™

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DETERIORATION?

RECOGNISE ● RESPOND ● COMMUNICATE

STOP AND WATCH

Not recognising quickly that someone is becoming unwell can lead to delays in getting help, possible hospital admission or longer stays in hospital

Using a prompt tool can help spot signs of deterioration by support your gut instinct to 'something's not right with...'
It can help explain to colleagues why you are worried, so better care decisions can be made.
There are clinical reasons why each of the questions are in the tool to help make sense of any changes tin the resident/client.

- **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

Further Information is available at:
https://www.valeofyorkccg.nhs.uk/about-us/partners-in-care-1/care-home-and-domiciliary-care-staff-area1/recognising-and-responding-to-deterioration-in-residents-using-a-softer-signs-tool/

Effective Communication for
Increased Patient Safety

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

The SBARD communication tool can help you communicate with others outside your team, including GP's D/N's etc...

Use for escalating a clinical problem or facilitating an efficient handover to contribute to increased patient safety

SBARD An effective and easy to use, structured form of communication that enables information to be transferred accurately between individuals

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 DNRCPR or advanced care plan?

Assessment:

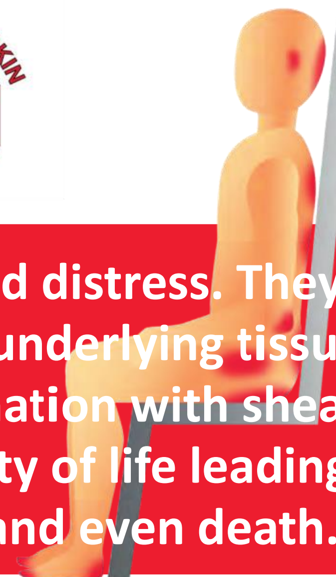
- Identify any changes from **Stop and Watch**

Recommendation:

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

Decision:

- What has been agreed (i.e. I will do..... and/or you will do....)



REACT TO RED

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Pressure ulcers are a major cause of harm and distress. They are serious, localised injuries to the skin and/or underlying tissue as a result of pressure, or pressure in combination with shear. They have a huge impact on a patient's quality of life leading to increased pain, risk of infection, depression and even death.

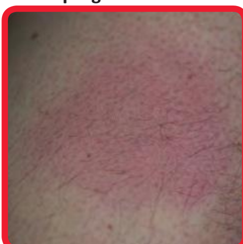
What to look and feel for?

- **Redness**/erythema - non-blanching when finger pressure applied
- **Pain, soreness**
- **Warmer** or **cooler** area over bony prominence
- **Boggy** feeling
- **Hardened** area
- **Discolouration** – dark red, purple, black
- **Broken skin**/ulcer

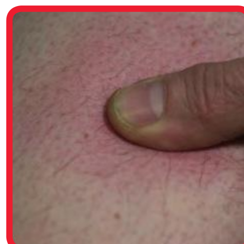
N.B. Document any changes & continue to monitor closely!

The Skin Tolerance Test also known as the Blanch Test

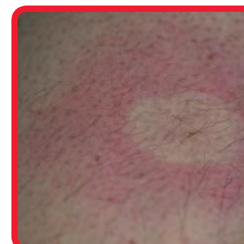
There is a simple test you can do to see if there is skin damage and a possible pressure ulcer developing.



Normal skin response to pressure, like your elbow when you lean on it.



Press finger over reddened area for 5 seconds, then lift up finger.

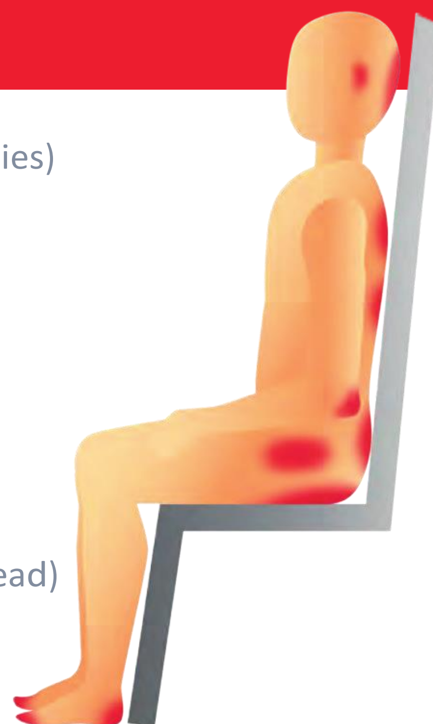


If the area blanches, it is not a stage 1 pressure ulcer. If it stays red, it is a stage 1 pressure ulcer.

Take your 'BEST SHOT'

LOOK at all the areas which are at risk from pressure damage at every opportunity (as a minimum - morning and at night)

- **B** - **BUTTOCKS** (ischial tuberosities)
- **E** - **ELBOWS/EARS**
- **S** - **SACRUM** (bottom)
- **T** - **TROCHANTERS** (hips)
- **S** - **SPINE/SHOULDERS**
- **H** - **HEELS**
- **O** - **OCCIPITAL AREA** (back of head)
- **T** - **TOES**



REACT TO RED

If you find an area of redness that does not blanch:
Report to your Tissue Viability Link Champion or senior member of staff

REACT TO RED Training Film:

https://vimeo.com/153224148/16f79dea61

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PRESSURE ULCERS

Have we missed anything?

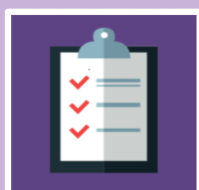
Skin inspection?

Surface – appropriate mattress/cushion/other?

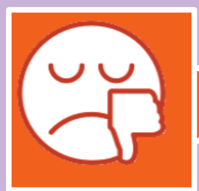
Kept moving/turning?

Incontinence /Moisture?

Nutrition / Hydration?



Equipment checked and working?



Is your patient declining help?
*If yes, **why**?*

Improvement Academy
Part of the Yorkshire & Humber AHSN

Care Homes and Domiciliary Care

REACT TO FALLS PREVENTION

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React to Falls Prevention is a simple framework developed by Nottinghamshire Healthcare NHS Trust that identifies 3 key areas of risk, Physical, Behavioural, and Environmental, prompting carers to consider these risks and REACT to reduce the risk of falls.

REVIEW MEDICAL HISTORY AND PHYSICAL HEALTH

Encourage and support care leaders to review residents' history of falls (frequency and patterns); any medical and physical health such as low blood pressure, dizziness, fractures /osteoporosis, foot problems, nutrition/hydration, illness or infection, both on admission, regular basis and /or as condition changes; referring to other professionals as required. This should include reviewing residents' medications, are they taking 4 or more different types, do they have any side effects such as drowsiness, sedation, increased toilet needs. Have they had a recent medication review with a GP or Pharmacist?

ENVIRONMENT & EQUIPMENT

The environment should be clear of clutter & hazards with suitable lighting. Call bells should be accessible and working and alarm sensors considered where appropriate. Consideration should be given to the suitability of footwear and clothing. Floor patterns should be kept to a minimum and surfaces not too slippery or difficult to push aids on, such as thick pile carpets.

ACTIVITY

Residents should be supported to continue to be active, make their own lifestyle choices and mobilise safely with assistance/support/supervision as required. Ensuring appropriate mobilisation aids are used and referral to appropriate services - GP, Occupational or Physiotherapy, Podiatry, District Nurses and voluntary sector organisations.

COMMUNICATION & UNDERSTANDING

All residents should be supported with communication and comprehension, recognising and supporting residents that are confused/disorientated or otherwise impaired; ensuring that communication aids are clean, functioning, and being used appropriately. Vision and hearing tests should be up to date.

TOILETING & CONTINENCE

Residents should be supported with continence/toileting as appropriate, promoting regular toileting and ensuring continence assessments are completed. Any changes in toilet habits need to be recognised and appropriate signage for the toilet in place as required. The use of commodes considered for nighttime use as required.

REACT TO FALLS PREVENTION

Have we missed anything?

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How many days since our last fall, what have we learnt?

! WHO ARE WE WORRIED ABOUT TODAY?

R — REVIEW MEDICAL HISTORY AND PHYSICAL HEALTH

- Pain
- Unwell/Infection
- Medication Risks
- Diet and Fluid Intake
- Recent Falls/Fractures

E — ENVIRONMENT & EQUIPMENT

- Use of Sensors/Alarms
- Flooring & Doorways
- Clutter
- Lighting
- Footwear & Foot Care
- Transfers & Stairs

A — ACTIVITY

- Altered Gait
- Stumble & Trip
- Walking Aids
- Sleep
- Mobilisation
- Dizziness/Loss of Balance

C — COMMUNICATION & UNDERSTANDIN

- Cognition/Risk Awareness
- Communication difficulties
- Vision
- Hearing
- Mood
- Communication Aids

T — TOILETING & CONTINENCE

- Frequency/Urgency
- Constipation
- Change of Habits
- Assessment
- Assistance/Aids
- Clothing
- Signage

? WHAT ARE WE GOING TO DO AS A TEAM TO REDUCE THE RISKS OF FALLING?

Further Information is available at:
https://www.reactto.co.uk