Enhancing Clinical Care Framework for NI Care Home Residents. BHSCT MDT Workstreams

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Older Peoples Division
Oonagh Galway, Lead Nurse, Care Home Support Team

Background

88 Nursing /Residential Care Homes and 3000 beds in BHSCT Care Homes.
Residents with Increasing care complexities.
WHO identified care home residents as a vulnerable population.
Post COVID learning is the need to strengthen Nursing, Medical and MDT support, clinical leadership and specialist skills in care homes.
Key priority in the Rebuilding Programme

Enhancing Clinical Care Framework (ECCF)

In June 2020 the Minister tasked the Chief Nursing Officer, Professor Charlotte McArdle to take forward in partnership with the Independent Sector a new framework for enhancing clinical care for residents in care homes
The aim of the project is to ensure that people who live in care homes are

- supported to lead the best life possible
- have access to equitable healthcare provision.

MDT Task and Finish Purpose

Is to progress MDT Working and understand input into BHSCT care homes in the development of a Wellness Framework to support care home residents and staff in Care Pathways in Rehabilitation, Long Term Conditions, Palliative Care

Key Deliverables

Data set for each AHP discipline collated and circulated to give baseline each month of input into BHSCT care homes

A Pilot with 6 homes implementing assessment tools- Frailty/ restore/ respect

Increased ACPs and numbers dying in preferred place of death

Enhanced MDT clinical care model for acute , chronic and rehabilitation needs of residents

Reduction in avoidable hospital admissions

Reduction in falls

BHSCT Care Home Workstreams-Wellness Pathway Task and Finish Groups and reporting structure

Workstreams

- 1. Reduction of Falls
- 2. Increase in Advanced Care Plans in Place and Residents place of death recognised
- 3. ED case finding to prevent avoidable hospital attendance:

-Catheter
-Enteral Feeding
-Pallitative

- 4. Reduction in Choking Episodes
- 5. Implementing weekly MDT reviews
- 6. Pilot to test out elements of wellness pathway

Strategic Groups

Enhanced Clinical Care Framework (ECCF) Trust Rep- C Wilkinson/D Grey

Wellness Pathway testing- Trust rep-D Gray/ O Galway

Blocked Catheter- Trust rep-R OToole

Deterioration Assessment tools- Trust Rep-C Wilkinson

Falls Pathway-Trust rep- H Kelly/ B Walker

Respect -Advanced Care Planning- Trust rep-Rema Wilson

Workforce/education and training- Oonagh Galway/ B Walker AHP workforce

BHSCT Care Home Steering Group

Chair Gillian Traub

BHSCT Task and Finish Falls Reduction

Chair- Barbara Walker

Helen Kelly, OT CHST

Eamon Doherty, Physio Falls Team

Siobhan Dalton-Core OT

BHSCT Task and Finish Testing Wellness Pathway

Chair -Christine Wilkinson

Oonagh Galway, CHST

Fiona Rowan, MH

Gillian McAleer , DN/ACAH

Deborah Grey, SLT

Jennifer Madden, Podiatry

Olga McAllister, Physio

Lucy Hull, Dietetics

Siobhan Dalton/ Postural band 7 OT

GP

Each T and F group Chairs to schedule 1 monthly meet for 1.5 hours, 1st week each month Aug-Dec

Workstream 1- Falls Reduction in Care Homes

Lived Experience
47% of yearly incidents received by BHSCT from Independent Sector homes relates to falls. Highest reason for attendance to ED from care homes.

No More Silos
In October 2020 The Department of Health COVID-19 Urgent and Emergency Care Action Plan No More Silos has specified the need for a:

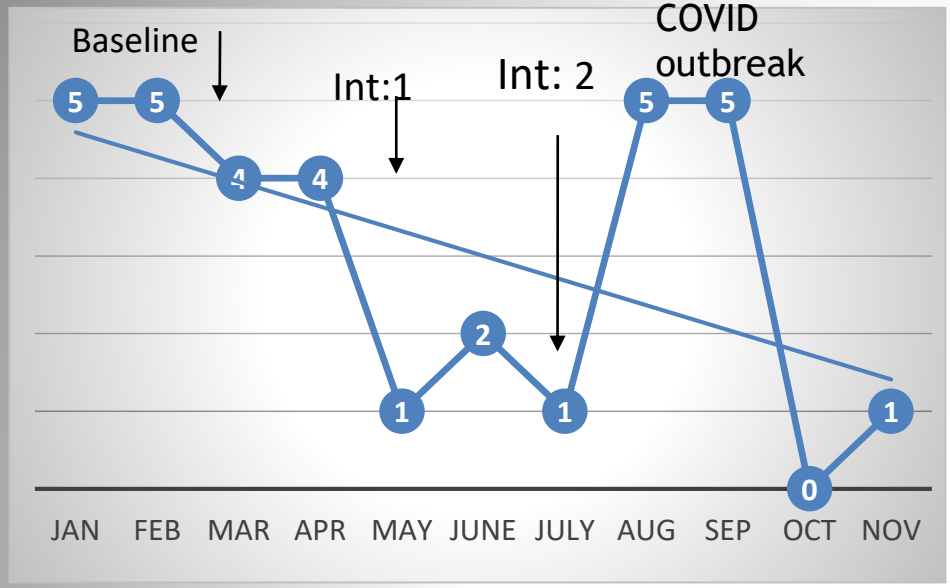
"Regional agreement on a standard falls pathway (not age-related) … [which] would avoid the commonest reasons for hospital transfer of care home residents." (Action 6)

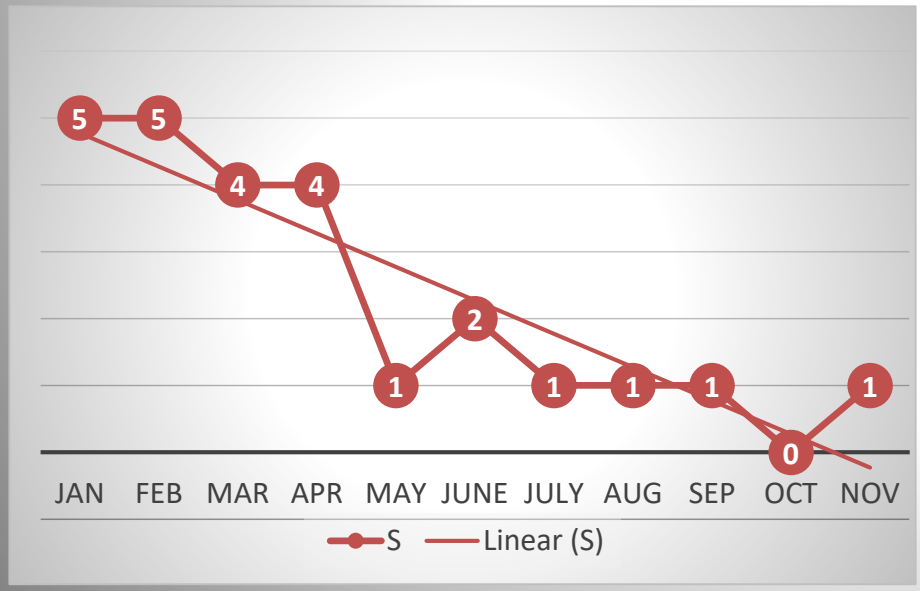
Project Specific Aim:

To improve resident experience and quality of life in 4 Care Homes (nursing and residential,) by March 2022 and aligning with the development of a regional Falls care pathway and bundle.

frailtynetwork@hscni.net

Nursing Home 1





Interventions

1 (8th April 2021)

- Provision of BHSCT Falls Checklist
- Advice, guidance & support on use of checklist
- Advice on alternative electronic assistive technology and guidance on appropriate use
- Guidance on referral pathways/processes to refer to Falls Team
- Facilitated onsite demonstration of sensor alert mats

2 (18th & 25th May 2021

- Specific instruction on Pool Activity Level (PAL) with NH Activity Coordinator to assist in identifying appropriate meaningful activity

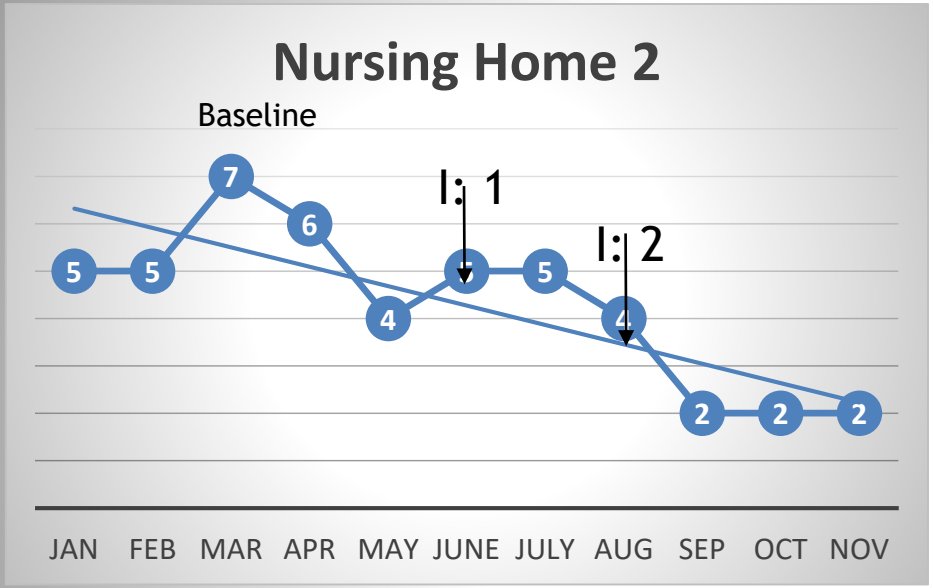
Outcomes

- Overall reduction in falls over intervention period April – Nov (52.44%)
- NH now ensure residents at high risk of falls are supervised in communal areas where there is a higher staff/resident ratio
- NH have invested in electronic assistive technology (Ramblegard seat pad) for use with appropriate residents
- NH staff report increased confidence in
  - Proactive approach to falls prevention
  - Referral process to Falls Team
  - Creating relevant care plans

Note:

- Spike in August
  - 4 falls can be attributed to 2 residents who both fell x 2. Both with advanced deteriorating dementia & all falls occurred when residents were in own bedrooms. 1 resident required change in category of care
- Spike in September
  - COVID Outbreak in NH
  - 4 falls attributed to 3 residents who had tested +ve for COVID
  - Residents had associated delirium, respiratory problems and mobility problems

Nursing Home 2



Interventions

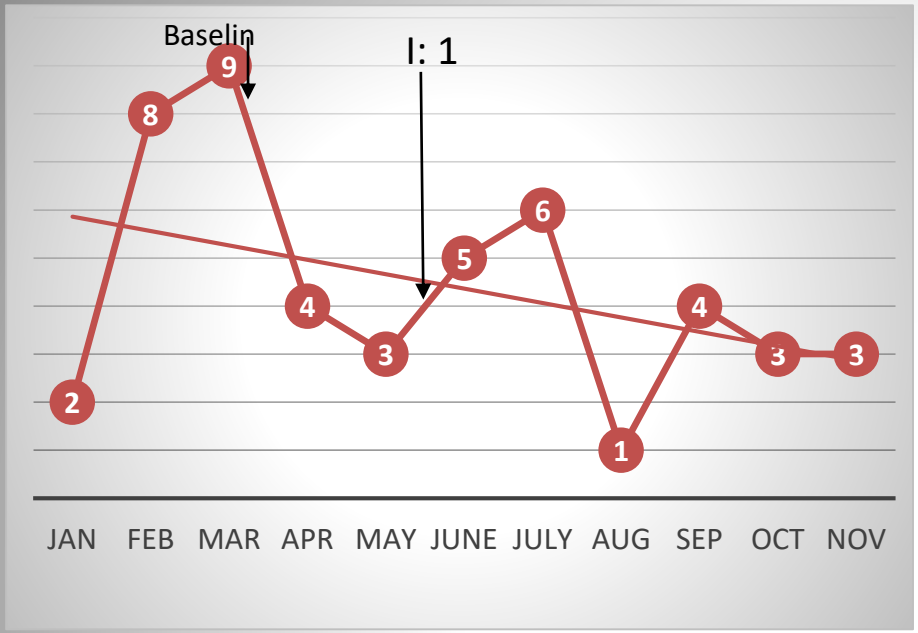
1(24th May 2021)

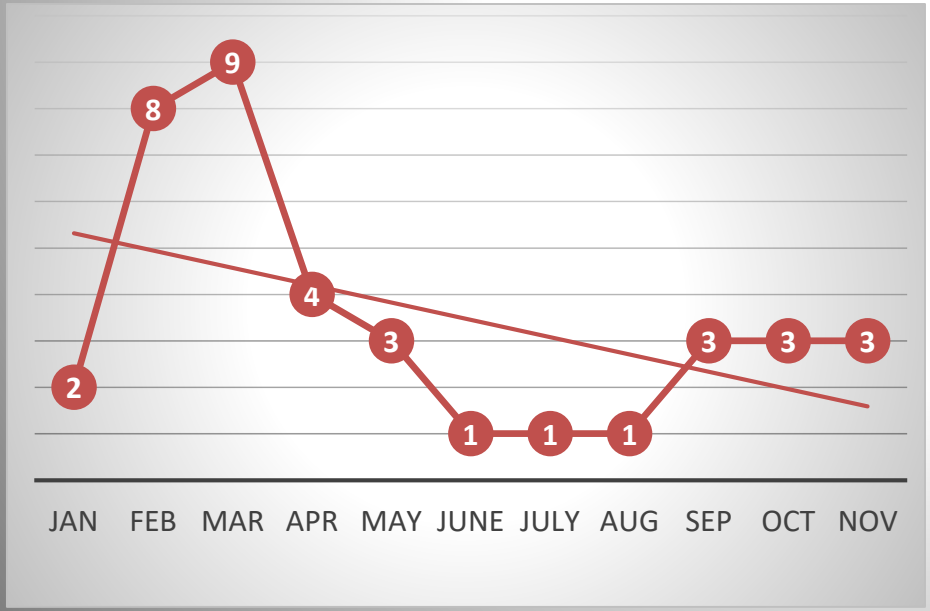
- Provision of BHSCT Falls Checklist
- Advice, guidance & support on use of checklist
- Advice on alternative electronic assistive technology and guidance on appropriate use
- Guidance on referral pathways and processes to refer to Falls Team
- Guidance of Falls Awareness Training session 2 (June 2021)
- Specific instruction on Pool Activity Level (PAL) with NH Activity Coordinator to assist in identifying appropriate meaningful activity

Outcomes

- Overall reduction in falls over intervention period June - November (38.33%)
- Review of post falls processes in RH indicated
  - Falls Checklist completed appropriately
  - Referrals to Falls Team were reduced and appropriate
  - Care Home staff report increased confidence in early identification of falls risk, management of falls and reporting/referral processes
- Activity Coordinator embedded theory of PAL into practice. During review visits, it was noted that PAL had been used to match the functional ability of residents with meaningful activity, thus enabling the coordinator to plan her weekly groups and 1:1 sessions.

Residential Home 1





Interventions

1 (29th April 2021)

- Provision of BHSCT Falls Checklist
- Advice, guidance & support on use of checklist
- Advice on alternative electronic assistive technology and guidance on appropriate use
- Guidance on referral pathways and processes to refer to Falls Team

2 (12th May 2021)

- Specific instruction on Pool Activity Level (PAL) with NH Activity Coordinator to assist in identifying appropriate meaningful activity

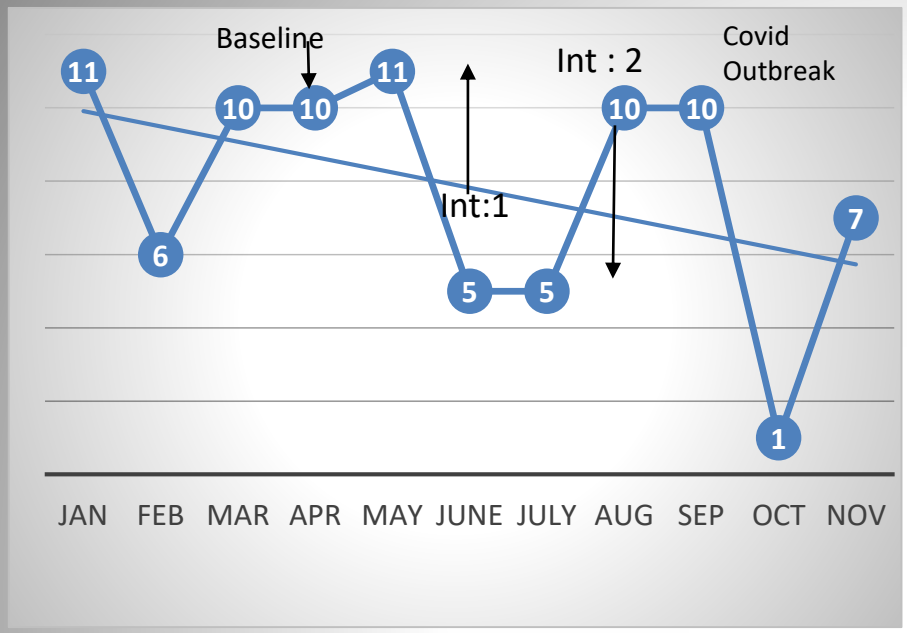
Outcomes

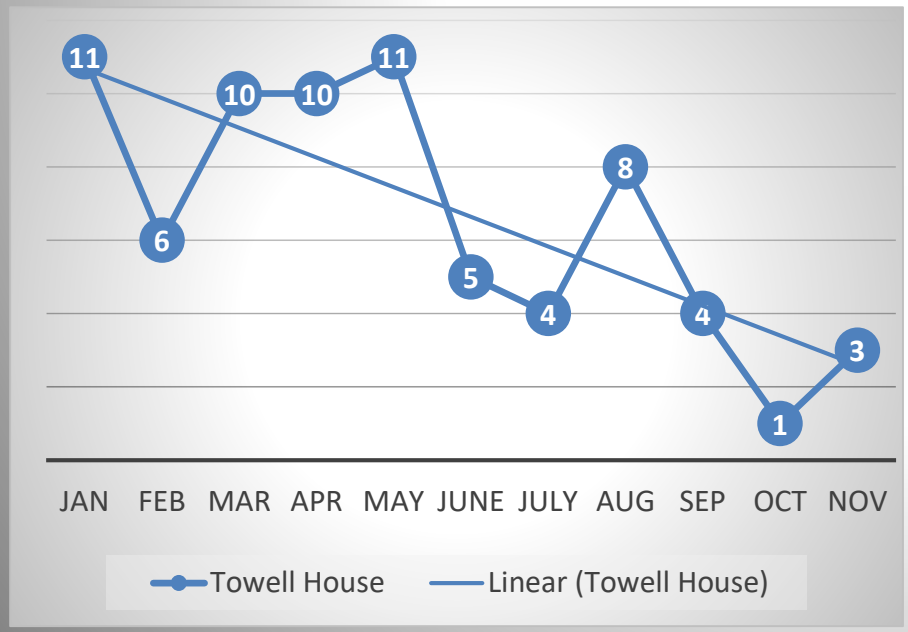
- Overall reduction in falls over intervention period May - Nov (37.9%)
- Review of post falls processes in RH indicated
  - Falls Checklist completed appropriately
  - Referrals to Falls Team were reduced and appropriate
  - Care Home staff report increased confidence in early identification of falls risk, management of falls and reporting/referral processes

Note:

- June
  - 2 x falls attributed to resident with deteriorating mobility
    - Assessed by CHST OT and change of walking aid→ no further falls
  - 2 x falls attributed to resident with recurrent UTI's
- July
  - 2x falls in July attributed to one resident with recurrent UTI and on long-term antibiotics
    - OT liaised with RH staff re wheelchair use for longer transfers to assist in conserving energy for shorter transfers
    - No further falls reported for this resident
  - 3x falls in July attributed to one resident secondary to multifactorial: polypharmacy, frailty, postural hypotension and UTI
    - 1 further fall (August)
    - CHST OT liaising with keyworker and RH staff re resident specific falls management strategies e.g. orientation clock/electronic assistive technology

Residential Home 2





Interventions

1 (17/05/21)

- Provision of BHSCT Falls Checklist
- Advice, guidance & support on use of checklist
- Advice on alternative electronic assistive technology and guidance on appropriate use
- Guidance on referral pathways and processes to refer to Falls Team

2 (28/06/21)

- OT recommended using the Rockwood Frailty Scale as a tool to identify residents who could be at potential risk of falls and utilising the falls team checklist to reduce the risk of a fall happening.

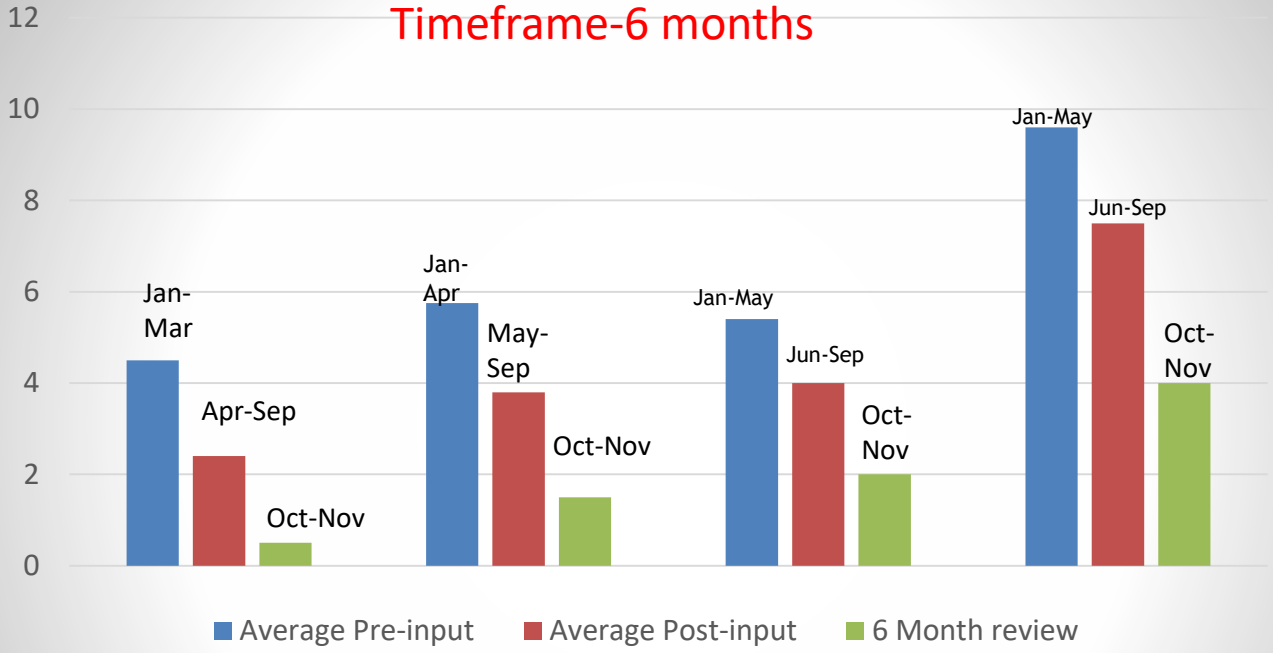
Outcomes

- Reduction in falls over intervention period (34.88%)
- Review of post falls processes in RH indicated
  - Falls Checklist embedded,
  - More robust in Falls analysis
- RH report
  - BSHCT Falls Checklist was helpful when used in conjunction with their post-fall monitoring chart.
  - This has led to more meaningful/relevant data collated within RH. This inn turn assists in gathering timeline data pertaining to falls

Note:

- 1x fall in July attributed to a COVID positive resident
- 2x falls in August and 1x fall in September attributed to a palliative resident who has since passed away
- 5x falls in September attributed to 3x residents who were COVID positive at time of fall.
- 4x falls in November-PHA declared Noro virus outbreak resulting in 2 residents having collapse episodes recorded as falls

Average falls per month:
(pre OT input)
(post OT input)
Timeframe-6 months



Overall reduction per Care Home

NH 1 – 52.44%

NH 2 – 38.33%

RH 1 – 37.9%

RH 2 – 34.88%

Average 40.75% reduction across the 4 homes

Care Home Staff Feedback

All homes report:

- Increased confidence in when/how to refer to the Falls Team
- Increased confidence in completing the Falls checklist and action plan
- That they valued the level of support offered from the CHST OT

Increased knowledge of best practice and getting more information on the falls referral process

We where given contact number for sensor mats equipment. We then put some alarm chair mats and bed mats in place for residents that where very high risk from falls.

We valued Helen's advice and support and welcomed her help

Helen has been a great support and a good point of contact

With all the advice and support we have received from OT, we have reduced our number of falls

Workstream 2- Audit of resident deaths from Care Homes within BHSCT – Jan-November 2021

Audits of deaths has taken place annually since 2012

Average return rate 69%

2021

(Jan-Nov) return rate = 100%

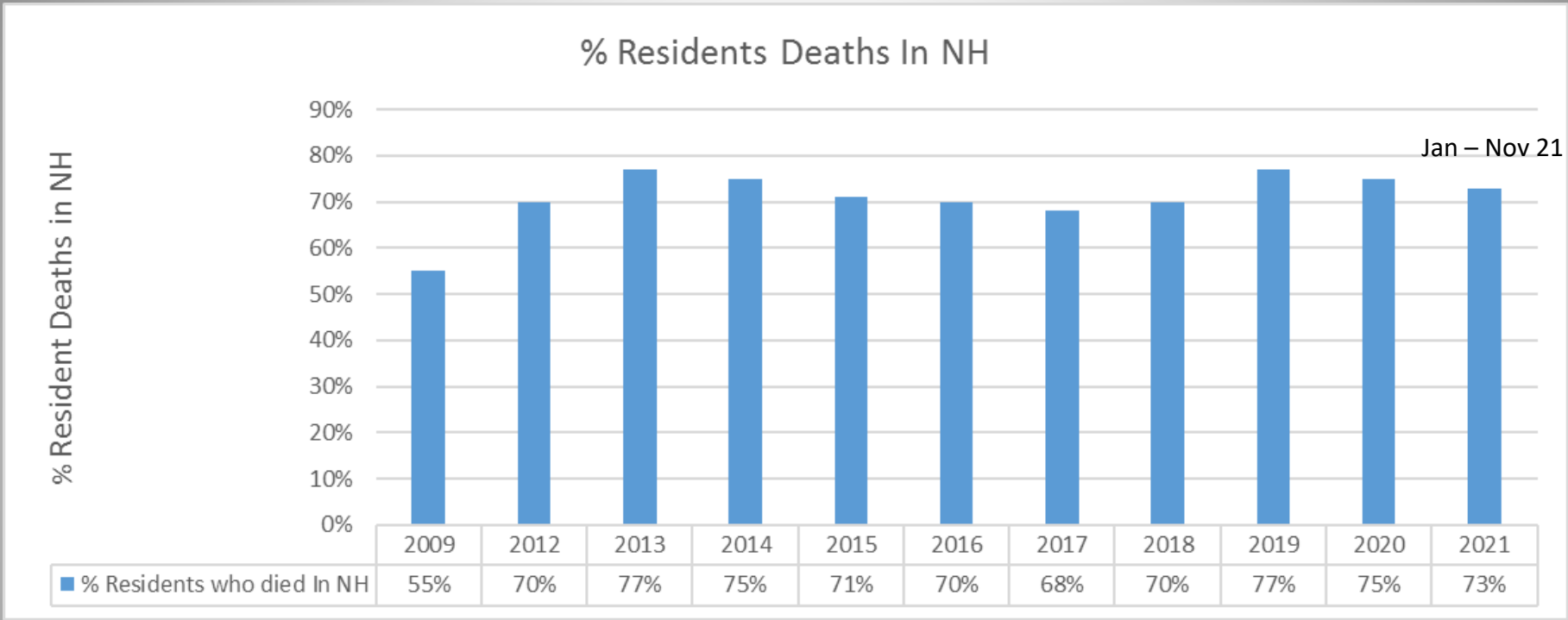
From September 2021 data collected monthly → December available mid January 2022

Aim- to increase numbers of residents with ACP in place and preference of place of death recognised

Areas of Focus-

- Case finding of those admitted to ED
- Audit of Resident Deaths data monthly
- RESPECT tool part of pilot testing for every new admission
- Collating Data in monthly audit relating to Preferred Place of Death and whether Anticipatory Medications were prescribed at end of life

How many residents died in the nursing home?



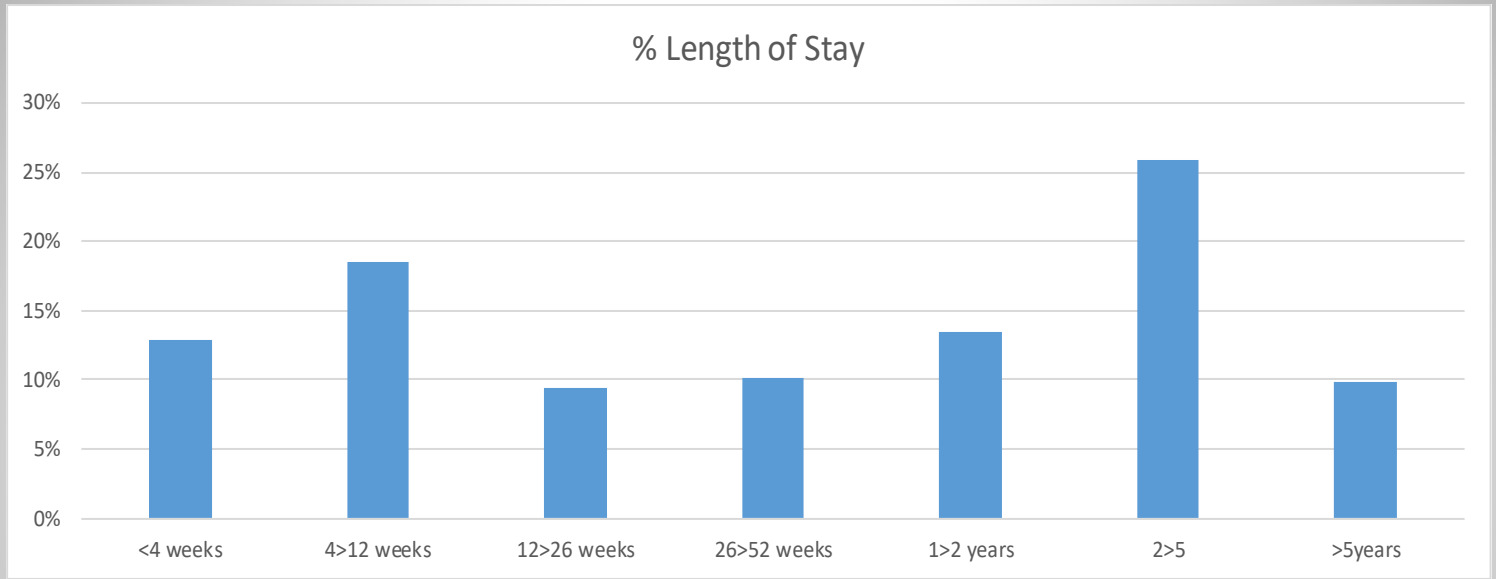
NOTE

Approx ¼ of residents RIP in hospital. This data collection is unique to BHSCT and therefore no comparison is available. From October 2021 data has been collected monthly. When CHST at full capacity deaths that occurred in hospital will be followed up as to evidencing appropriate admission.

Aim to identify those residents who could have remained in NH rather than admission to ED, to prevent avoidable unscheduled care, not to prevent necessary escalation to inpatient care

To note increase staffing to CHST through transformational funding in 2018 produced significant increase in training and development and practice based observations for palliative care/ end of life / deteriorating residents, active follow through of reducing avoidable hospital admissions

Length of stay-Admission to Care Home 2021 → RIP

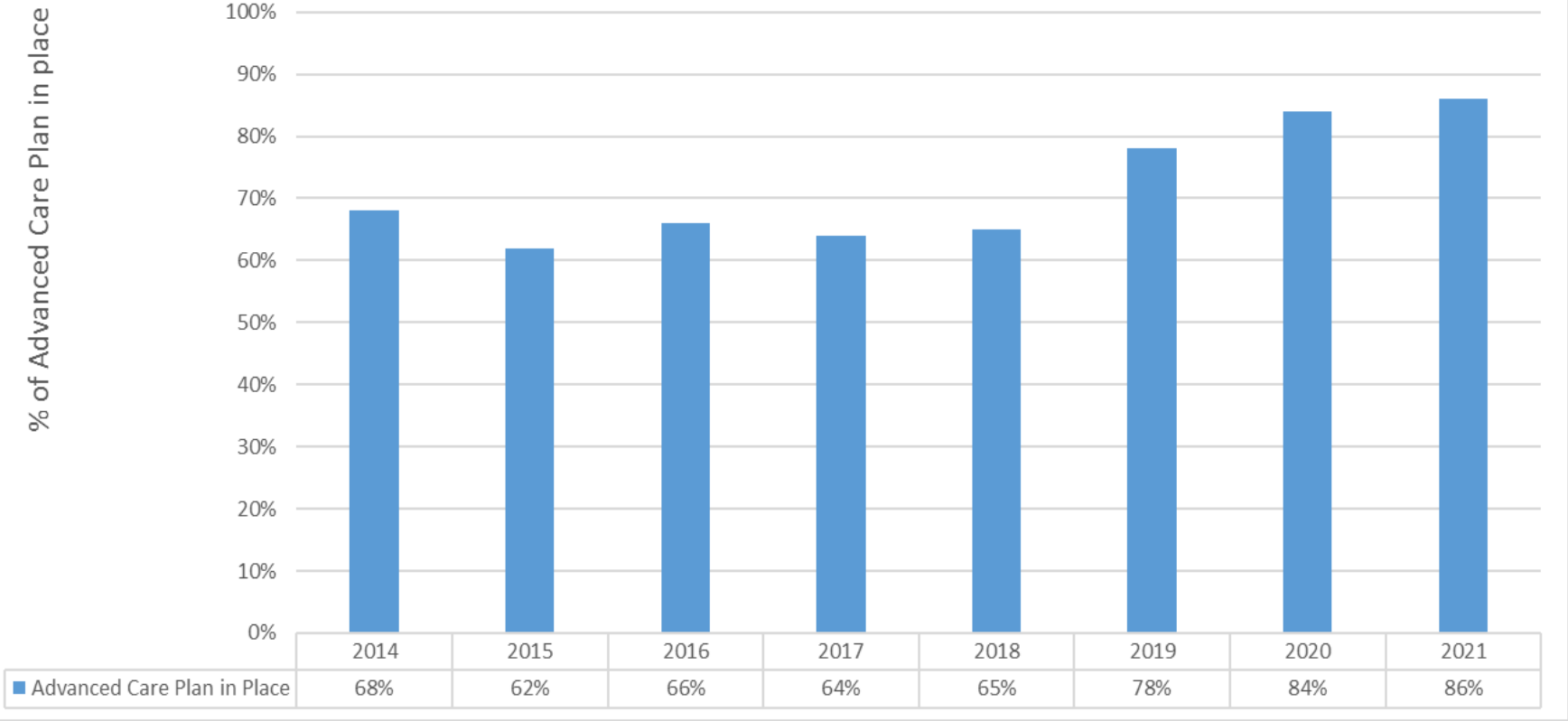


Length of Stay	13%	18%	9%	10%	13%	27%	10%
	13%	31%	40%	50%	63%	90%	100%

NOTE

- These figures mirror those from previous years audit
- 30 % of residents RIP within 3/12 of admission, demonstrating stage of illness on admission
- 50 % of residents RIP within 1 year indicating the palliative nature of admissions to NH's

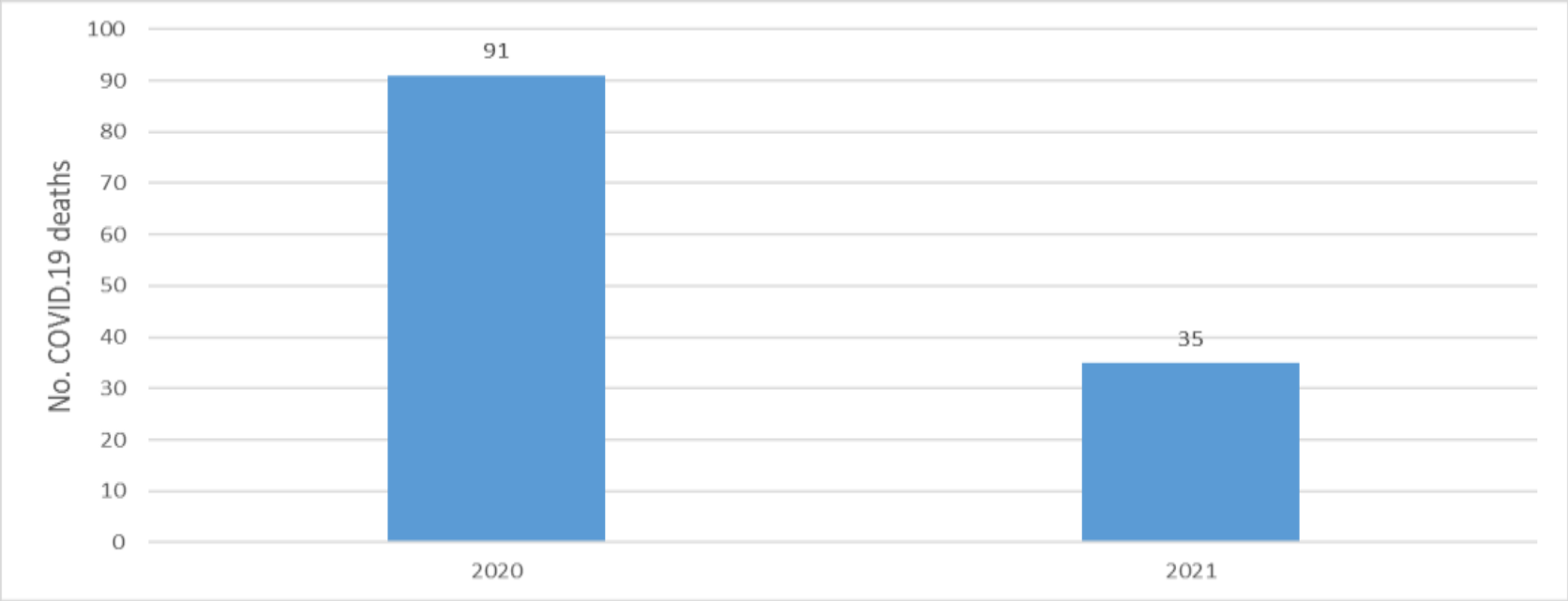
Advance Care Plan (ACP)/End of Life (EoL) Care Plan in place



NOTE

- Significant year on year increase in residents with ACP in place from 2018, a key training and practice focus by CHST with care home staff from 2018 relates to residents with capacity who have their wishes documented
- EoL Care Plan relates to residents who do not have capacity. Best interest decision (s) regarding future care agreed with GP, NH staff and family
- Most residents in NH do not have capacity to make these decisions and EoL care plans predominate
- Positive impact to ensure end of life wishes recognised

How many residents died within 28 days of a positive COVID-19 test result in your home within the last year?



NOTE

Reduced figure for 2021

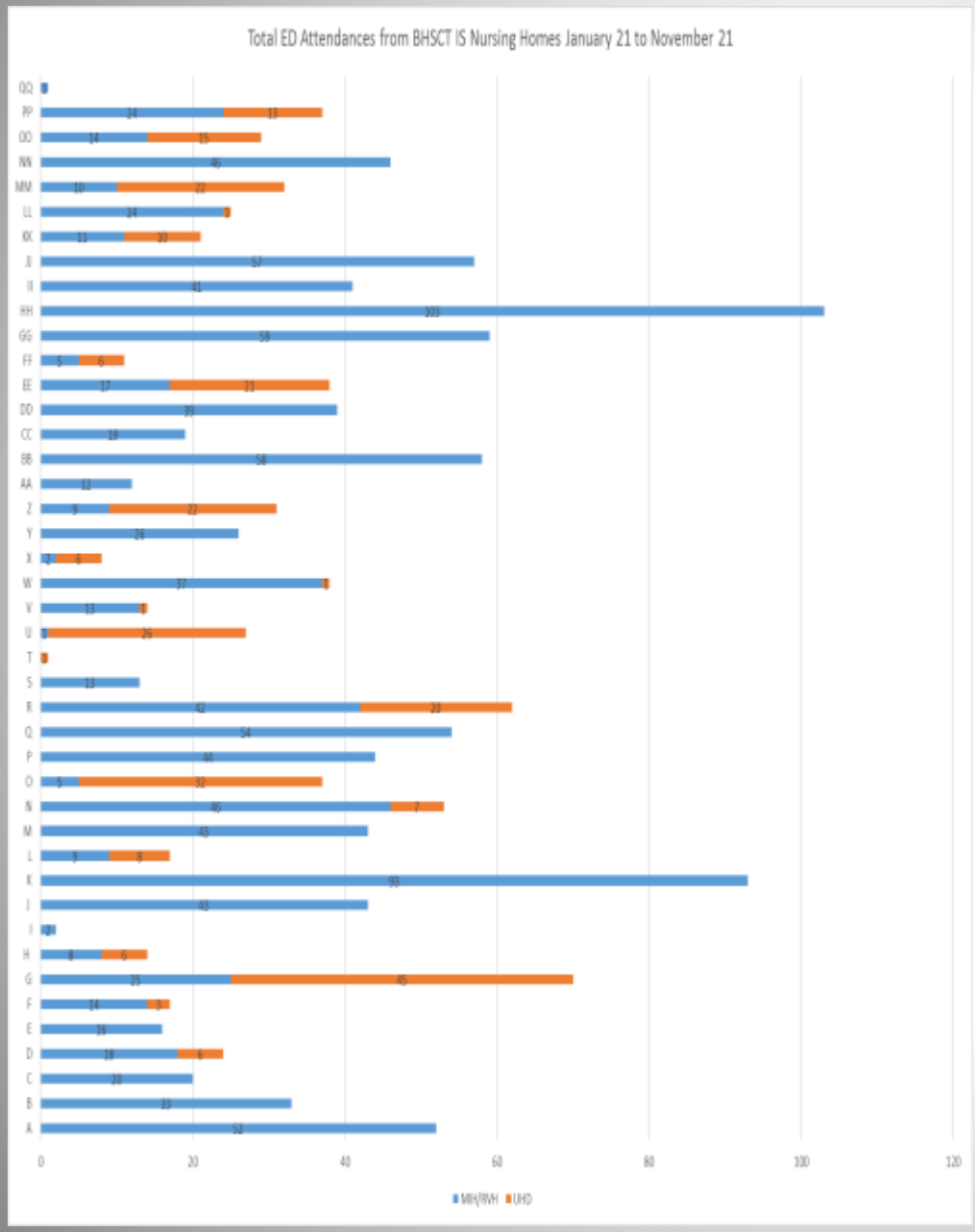
- Figures relate to Jan-Nov only. Decreased number may relate to following assumptions:
  - Increased bed vacancy within NH's
  - Successful vaccination programme
  - Training offered and provided by CHST – managing respiratory resident, managing deteriorating resident, key covid management weekly sessions
  - NH staff recognising early deterioration
  - NH staff have improved ability to manage the COVID +ve resident
  - Improved IPC measures with NH's

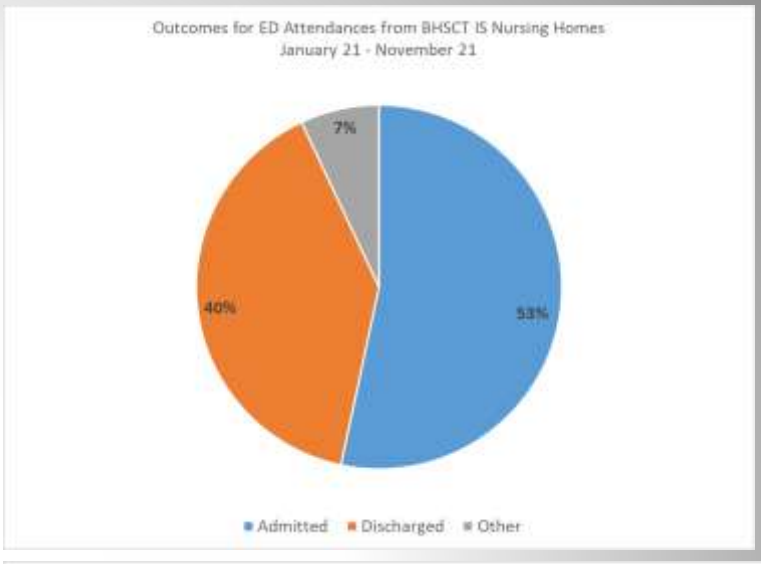
Workstream 3- Case finding with aim to prevent repeat avoidable ED attendances

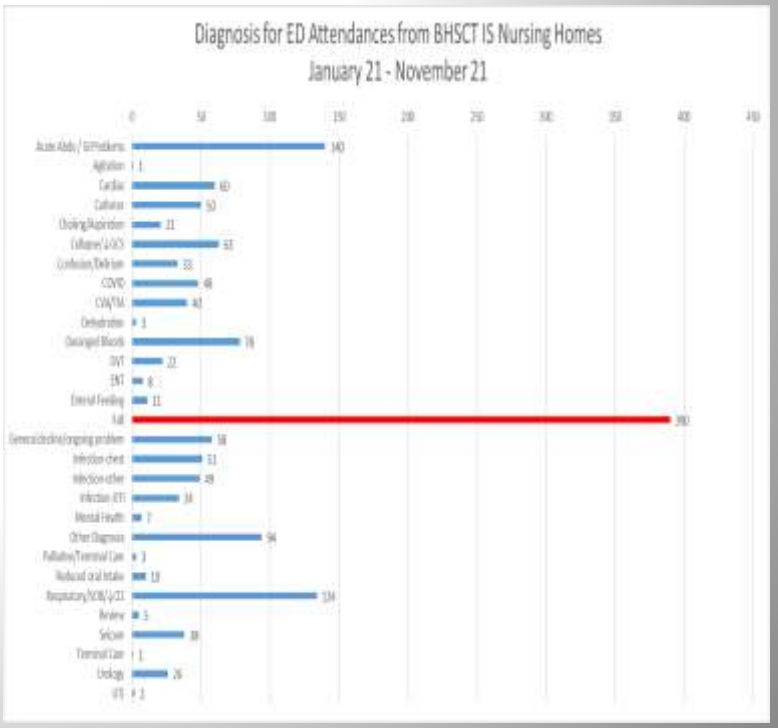
Since May 2021 CHST receive daily report indicating ED attendances from CH's located within BHSCT

- Analysed at Daily Team Huddle
- Case finder
    a) Palliative Care
    b) Clinical skill-catheter/gastrostomy tubes;
    c) Multiple attenders→ identification of patient specific pathway)

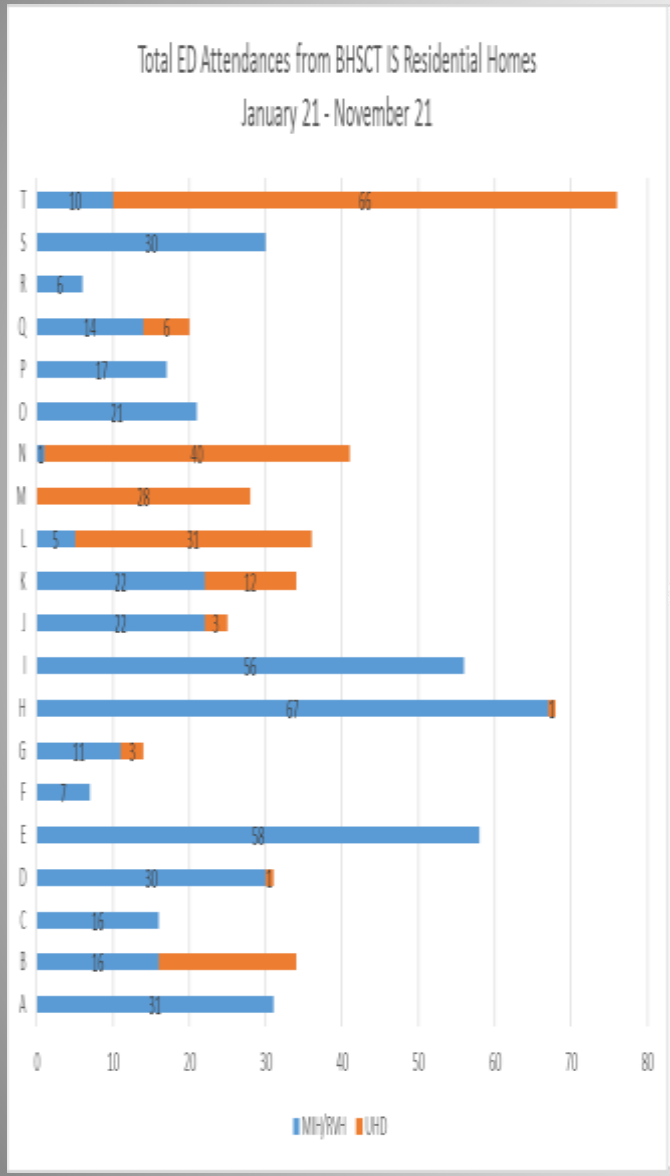
January - November 2021 – Nursing Homes

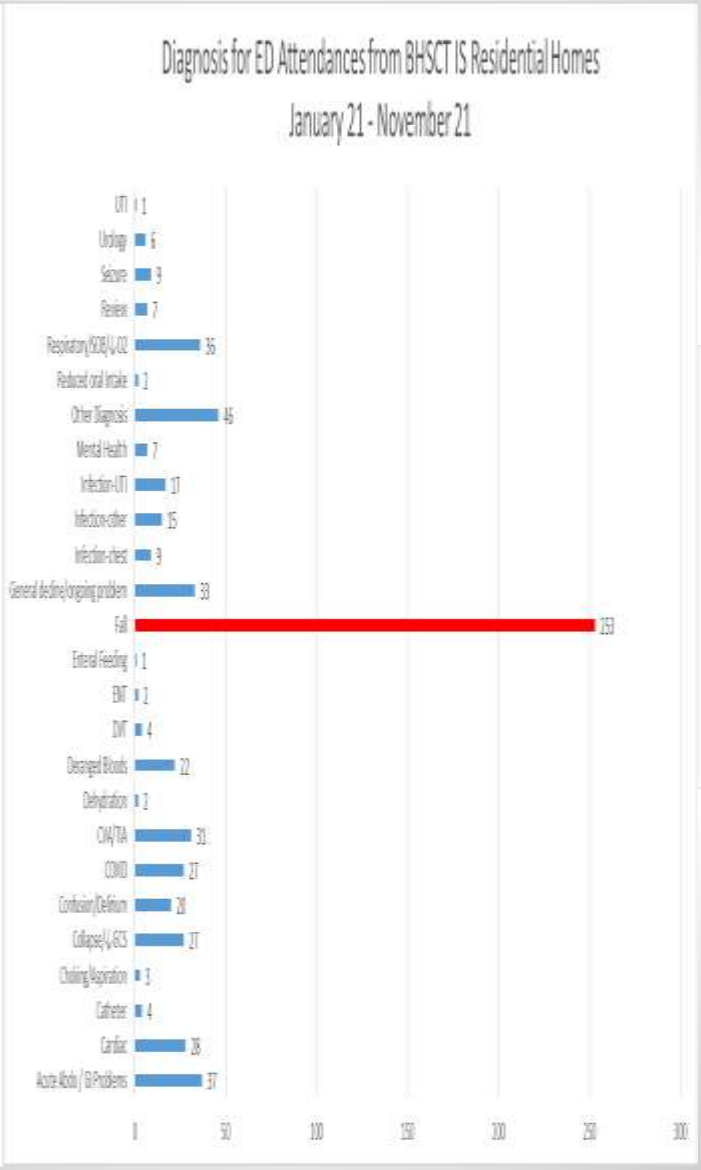


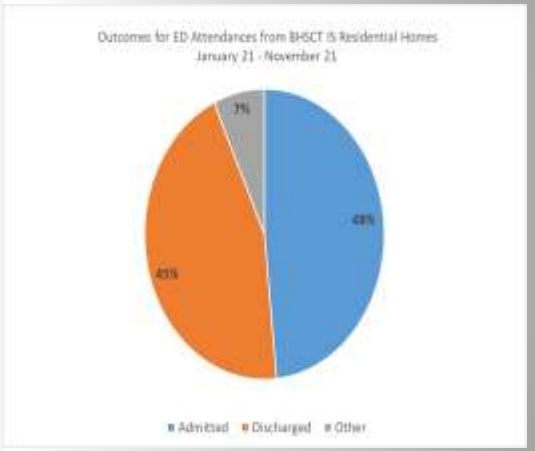




January - November 2021 – Residential Homes







Residents attending ED with catheter/enteral feeding related problem

2015-2019-range 71-94 attendances from NH's with catheter/enteral device related issue

- 2020-
  - 59 residents attended ED with catheter related issue
  - 32 residents attended ED with enteral feeding device related issue

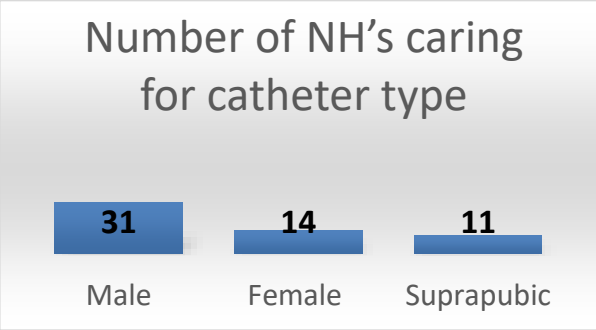
- 2021 (Jan to November)
  - 40 residents attended ED with catheter related issue
  - Daily analysis of ED attendances from NH's since May 2021→

    - 36 attendances for catheter
    - 14 (relating to 5 residents) of these attendances required ED attendance as apart of agreed Care Plan
    - 2 of these residents now has new pathway via Urology
    - 1 resident in new NH with untrained staff had 3 admissions to ED (June-Oct). CHST provided bespoke training-Oct→ no attendances since
    - I resident → CHST Ix reason for catheter-nil required and catheter removed
    - 4 x hospital appropriate hospital attendance for other reasons e.g. haematuria, MH problem, required for other reason
    - 4 residents should have been referred to CHST/District Nursing Services- NH's now clear of correct referral process- no attendances from these residents from September
    - 10 residents attended ED with enteral feeding device related issue in 2021 compared to 32 in 2020 (decrease of 69% attendances at full year)

Training Needs Analysis-Catheter December 2021

Findings

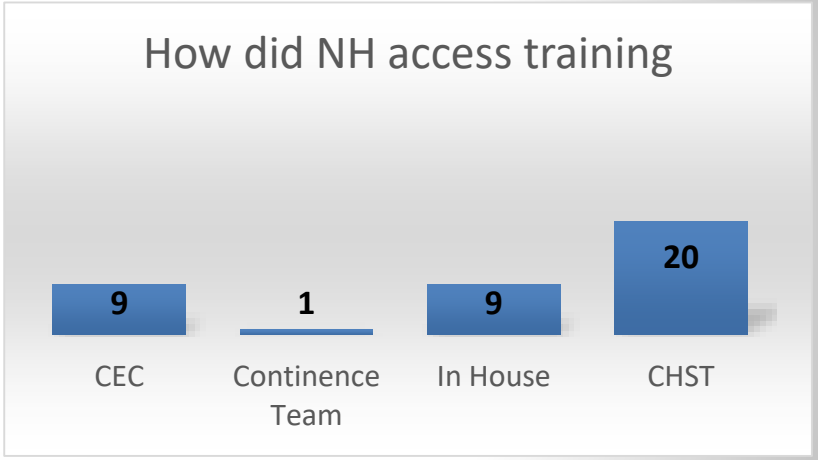
- Method: Questionnaire to each NH
- Response rate 39 NH's (93 % response rate)



- Regular ED attendances:4 NH's
- Reported reasons for regular ED attendances:
  - Problematic catheters-e.g. blocking (** see pt finder)
  - Device cannot be changed in NH

Findings continued

- Training in NH's
  - 36/39 (92%) have staff training in M, F & SP



CHST plan

- Continue with M, F & SP catheter training on rolling programme
- NEW: problem solving session to be devised & added to calendar 2022
- Aligned CNF to liaise with and support nursing home staff in catheter management/assist in patient specific careplans
- Continue to monitor ED attendance
- NEW-UHD figures are new to CHST-2022 will form part of monthly analysis and follow up

Analysis of ED daily attendances-Catheter (May-November 2021)

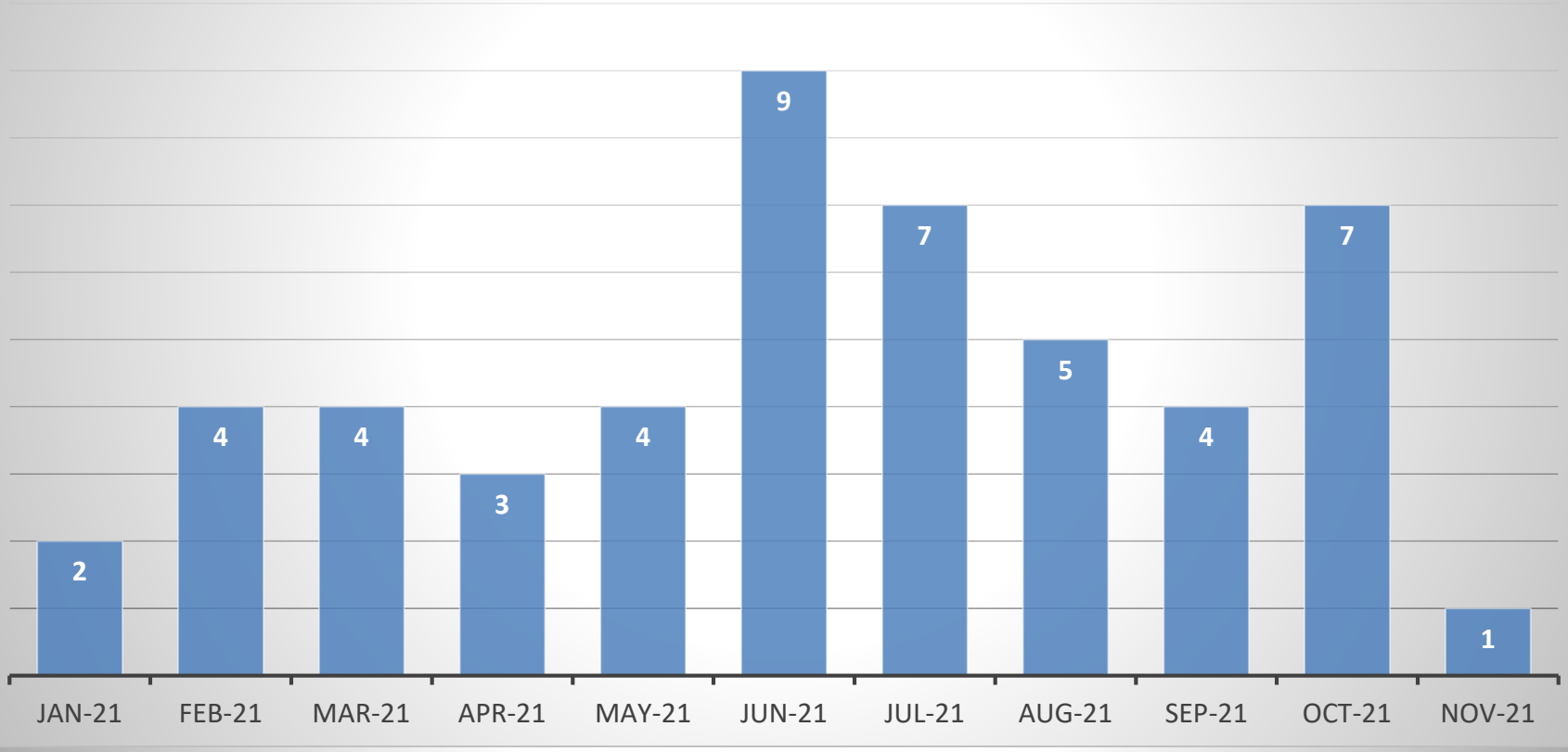
Resident	Attendances	Details	Action/Outcome
Resident 1	6 in 3.5 months (20/05/2021-09/09/2021)	NH had been advised on admission catheter could only be changed in hospital	• CHST reviewed ECR, ED & PARIS resident records • Noted no rationale for hospital attendance for change of catheter • NH staff upskilled, care plan put in place and catheter now being changed in NH • No additional ED attendances since intervention from start of Sept
Resident 2	2 (June 2021)	• NH staff unable to re-catheterise • Did not refer to CHST/Community Nursing	• CHST liaised with urology to confirm catheter required • NH re trained , supported and observed practice • NH reminded to seek support from CHST/Community Nursing if problems arise immediate onsite support • No further ED attendances

Resident 3	3
	
	(June & July)
		• Catheter bypassing x1
		• Cardiac event x 2
			• No rationale for catheter-trial removal successful
			• NH reminded to seek support from CHST/Community Nursing if problems arise
			• Further analysis of 2 subsequent attendances
			  • Review of ECR, ED records
			  • Liaison with NH staff and encouraged conversations with GP/family re future care
			  • Decision for PC/Comfort care
			  • NH now being supported by CHST

Resident 4	5
	
	(June-October 2021)
		• Resident has dementia and pulls catheter out
		• NH report catheter must be changed in ED
			• CHST confirmed specialist catheter insitu and must be changed in hospital
			• Aim to reduce unscheduled changes. Interventions included
			  • Distraction techniques e.g. Twiddlemuff
			  • Care plan was updated
			  • CHST OT provided assessment/recommendations-impact on this to be determined

Resident 5	1 (July 2021)	• Tissue Viability issue at catheter site	• CHST reminded NH to access CHST or OOH's Nursing Team for support • Arranged for additional training for NH staff • No further ED attendances
Resident 6	1 (July)	• Hospital required change	• Resident is frail, bedbound, non-communicative & has multiple contracture and requires sedation for catheter change • CHST liaised with urologist re consideration of suprapubic catheter- alternative pathway to ED now in place. No further ED attendances

Number of catheter related ED Attendances from NH's located in BHSCT January-November 2021



Note

- Daily analysis of ED attendances since May 2021
- Used as patient finder → contact with NH to fact find and create patient specific plans
- Overall downward trajectory except for spike in October-this related to 1 resident who required hospital attendance & who had attendances x 3

Analysis of ED attendances-Palliative (May-Nov 2021)

Resident	Attendances	Details	Action/Outcome
Resident 1	3	Attended with heart failure, reduced O2 saturations, wheeze, haemoptysis	Contact with NH manager. NH had already discussed condition deterioration with family and commenced ACP. Advised to link in with Heart Failure Nurses who advised now palliative. Discharged from Heart Failure Nurses caseload. Now on CHST Palliative caseload. No admissions since July 2021 as regular review and support given
Resident 2	6	Multiple hospital admissions in previous 12 months relating to shortness of breath and one admission with bleeding around nephrostomy tube site	Contact with NH manager and referral made to CHST. Review and advise given regarding managing respiratory disorder and referral to respiratory team. Also advice given to management of nephrostomy tube and dressings. No ED attendances to ED with shortness of breath since June 2021. Advice being evidenced as followed by care home staff.
Resident 3	3 (Mar-Aug)	63 year old man. Medical history of Korsakoffs, alcohol liver and brain disease, varices, ascites, hepatic encephalopathy. Hospital admissions with constipation secondary to hepatic encephalopathy, seizures and ascites.	Contact with NH RN while resident in hospital to advise to discuss with hospital staff what the stage of illness is, what the plan for future care is and whether resident is now approaching palliative or end of life stage. Resident no capacity to make own decisions. On discharge from hospital advised linking in with GP to discuss the same and ensure family discussions as family not accepting of same and request hospital admission. NH have plans now in place for EOLC. With family /GP engagement and family now accepting of stage of illness
Residents 4 & 5	X 1 each	2 residents admitted to hospital at EoL despite having advanced palliative care need and DNACPRs in place	CHST have made direct contact with NH and have directed staff to CHST regular training, agreed to provide onsite support, training and guidance to new staff and will continue to monitor/review avoidable unscheduled admissions

NOTE

- CHST note that residents often require 2-3 hospital admissions for decisions regarding stage of illness and plan for future care
- Even residents with specific plan for palliative/EoL of care may require unscheduled care for unexpected events.
- Where stage of illness is identified and plan of care is in place with GP and family engagement, unscheduled admissions can be avoided
- Frequently admissions are appropriate om review of ED information

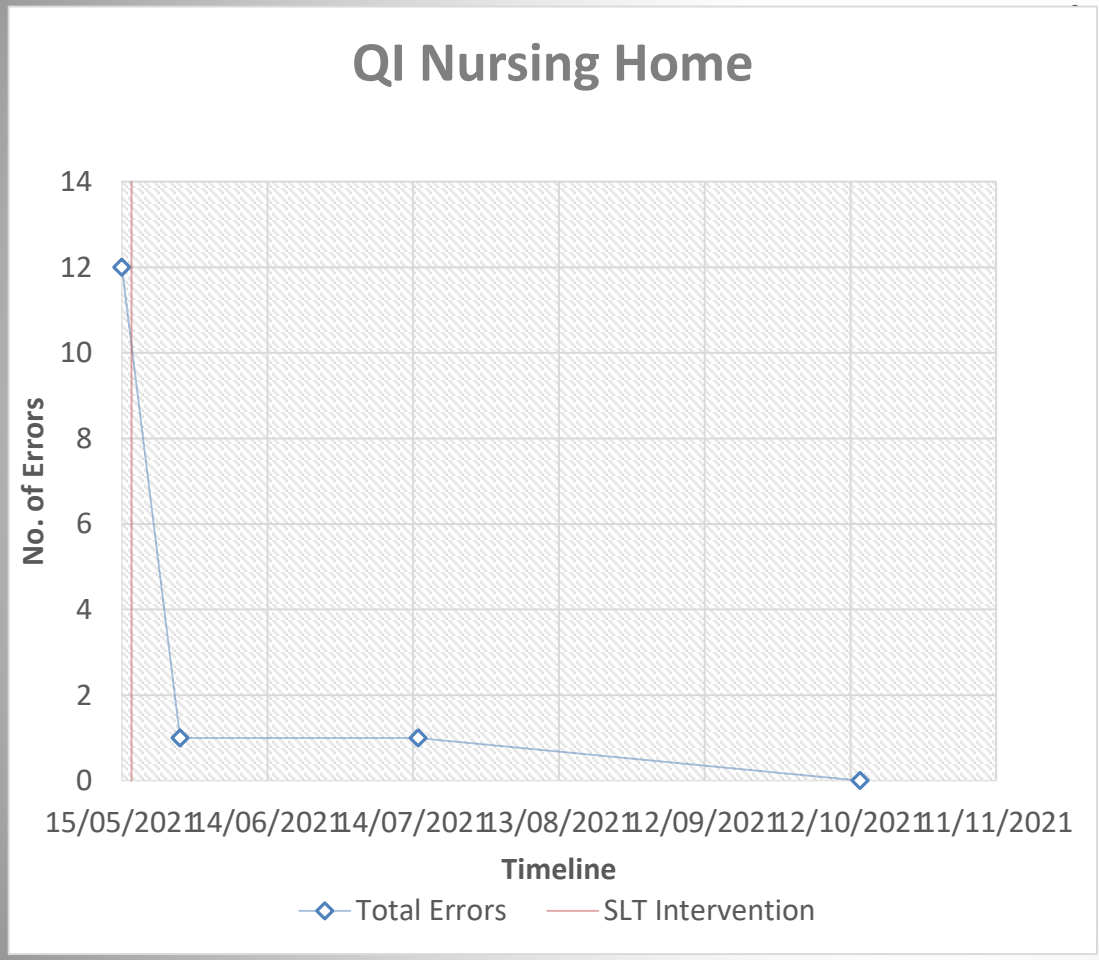
Multiple Attender-Pathway

Resident	Attendances	Details	Action/Outcome
Resident 1	16 Jan-November 2021	• ED attendances for pseudo obstruction of bowel • Requires deflation of bowel	• Until 2019 there was no pathway for NH residents of NH's who had pseudo obstruction and required decompression/deflation of bowel • In 2019. Pseudo obstruction and decompression of colon-via audit of attendances at ED of NH residents a cohort of patients were identified who where attending ED up to 3-4 times per month to have a procedure that previously was only carried out by surgical team in hospital. CHST collaborated with BHSCT Colorectal Surgical Team, Continence Team, ASM for General Surgery to • devise a Pathway for specific NH residents • Develop and deliver a training programme to RN's in NH's • Supervised competencies • This resulted in significant reductions in unscheduled care for these residents average 10 admissions in 6 months reduced to 2 • CHST follow up with current resident with Colorectal Surgeon has now reviewed this resident and he has been accepted on to this pathway. • Focus continues- follow through to evidence decrease in ED and more appropriate pathway in place

Workstream 4- Follow up from ED attendances related to aspiration/choking events

- ED attendances investigated by SLT from May 2021- present
- 22 ED attendances investigated to date for aspiration/choking
- 4 patients highlighted from these admissions who had a known aspiration risk and no Advance Care Plan in place regarding hospital escalation plans.
  - 4 x Best Interest Meetings and discussions with Home Managers & Family re plans to address aspiration risk and decisions regarding hospital escalation

SLT QI Input-NH 1



SLT facilitator Input

Intervention initiated from on site observations - SLT noted poor practice relating to sharing of information pertaining to IDDSI/dietary requirements

Intervention between May- October 2021

Aim to eliminate errors relating to dietary/IDDSI recommendations

- Documents reviewed and streamlined included handover sheet, dining room sheet, SLT care plan in file and kitchen records
- SLT worked with home manager and nurse in charge to help streamlining process and establish persons of responsibility for when changes occur.

Graph shows SLT visits and number of errors decreased from 12 to 0 over 6 month period with sustained reduction in errors from when intervention began.

SLT QI Input- New Nursing Home

- New Home opened early 2021,SLT input from May 2021-October 2021

- Intervention initiated from on site observations - SLT noted poor practice noted relating adherence to IDDSI requirements
- Interventions:
  - IDDSI Training carried out with 14 staff
  - Bespoke IDDSI kitchen training sessions provided to kitchen staff -2 chefs & 2 x assistants
  - Streamlining verbal/written communications of IDDSI recs within home and persons responsible when changes occur
  - Disseminated regional dysphagia posters for all staff areas
  - Mealtime audits carried out in dining rooms.
    - Baseline audit: 2 out of 4 residents in the dining room on incorrect IDDSI levels.
    - Post kitchen and staff training- 4/4 residents on IDDSI recommendations on correct consistencies.
  - Guidance given on referral processes with management and staff
  - Addressed poor practice with management and concerns as they arose within home including alerting staff to initiate best interest meetings when residents are non-compliant with SLT recommendations.
  - At 6 month monitoring review sustained improvements of all SLT input.

SLT QI Input Residential Home

- SLT input from June 2021-October 2021
- SLT inputted via as a Care Home on escalation via BHSCT Governance Framework
  - IDDSI Training carried out with 14 staff
  - Bespoke IDDSI training sessions for x1 kitchen staff
  - SLT worked collaboratively with CReST Senior Practitioner & Haypark staff on Food/Nutrition care planning for all residents
  - Liaised with Dietetics re: food fortification and co-ordinated training of same
  - Disseminated regional dysphagia posters for all staff areas
  - Meal time audits carried out pre and post training.
    - Initial lunch audit revealed 1 out of 3 residents on IDDSI recommendations being given inappropriate consistencies. Risk of choking identified with staff.
    - Post training 3/3 residents on IDDSI recommendations being given correct consistencies.
  - Established referral processes with management and staff
  - Sustained improvements at 6 month review

SLT SQB Project

Meals prepared for residents in X Nursing Home will have a minimum compliance of 60% with SLT/Dietetic recommendations by the end of May 2022

Chef/ catering knowledge of IDDSI is level appropriate

- **Skills in preparing a variety of modified textures/dietary specific meals on a large scale** → **Development and delivery of training pack aimed at catering teams understanding of IDDSI/Food fortification**
- **Skills in preparing a variety of modified textures/dietary specific meals on a large scale** → **Development of IDDSI appropriate/Food fortification snack menu**
- **Practical understanding and implementation of IDDSI/Food fortification** → **Audit Tool**

Strong communication processes in place

- **Clear communication processes within home to promote safety** → **Introduction of safety pause**
- **Facilitated access to other Chef/catering teams/ideas** → **Development of shared access platform**
- **Clear communication processes between AHPs/Home to promote support** → **Development of catering group learning sessions across service area**
- **Clear and consistent messaging in line with regional changes**

- Chef Questionnaire to understand knowledge base
- Chef and NH Manager interviews to understand challenges
- Process Mapping
- Audit of mealtimes, compliance
- Review of resident records to be completed

Workstream 5- Implementing Weekly MDT Virtual Care Home Reviews

- Representation:
  - NH-RN
  - CHST-RN
  - OT
  - Physio
  - SALT
  - Dietician
  - Pharmacy

- Commenced July 2020

  - Initially review of residents post COVID
  - Since March 2021-MDT's have also reviewed residents from Non-outbreak Homes

MDT Virtual Care Home Reviews-findings May 2020-December 2021

37 NH's received MDT Review

182 residents reviewed

Average age of resident 86 yrs.

33% residents had increased frailty score from baseline

71 % of residents had lost weight
Range 0-11.4 kg
Average 2.3 kg

58 % of residents had Increased pressure ulcer risk

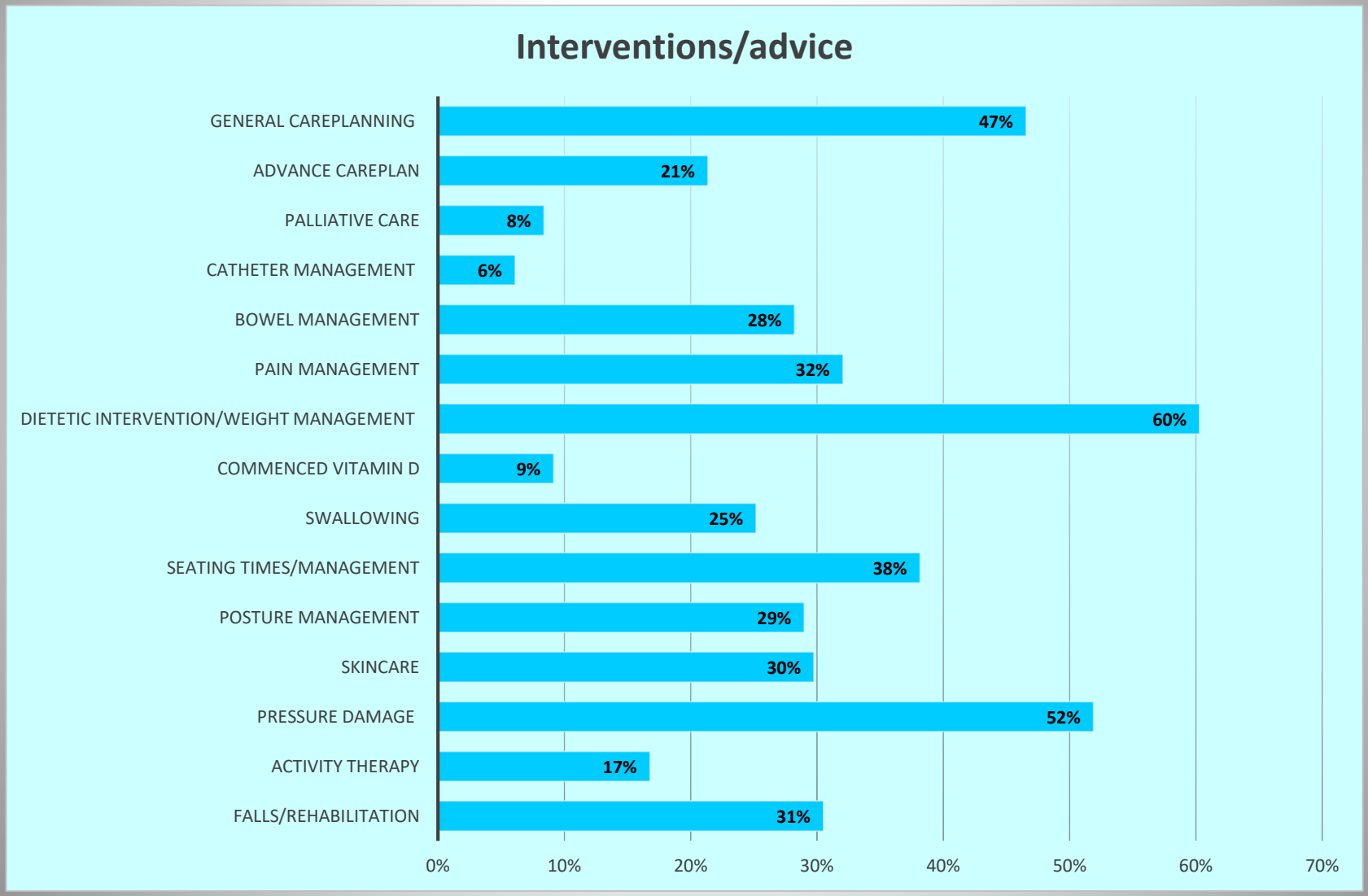
19% of residents were suffering low mood/anxiety

More than 950 recommendations

Average 7 recommendations per resident

On average 2.9 pharmacy intervention per resident

MDT Outcomes (May 2020-December 2021)



Workstream 6- Testing Elements of the Wellness Pathway

Implementation of Standardised Assessment Tools- Falls Bundle, Rockwood Frailty, Restore 2, Respect

21 Care Homes across region have agreed to participate in Pilot of implementation of ECCF

- BHSCT→ 6 Care Homes (5x NH & 1 RH)
- CH will pilot
  - Falls Bundle December 2021
  - New Pre-admission assessment document-this includes Rockwood Frailty Score
  - Restore 2/Restore 2 mini-to assist recognising deterioration, use SBARD to escalate concerns to the appropriate person/service (Jan 2022)
  - Training programme to be delivered by December 2021

NEW AHP- CHST Dietician

- 0.4 wte Dietician commenced in CHST December 2021
- Plan:
  - Based on learning from other AHP posts within team role:
    - Will be separate to work undertaken by core Dieticians
    - Will NOT include NH's where current dietetic project work is being undertaken
  - Scope-Initially small scale focusing on 2 out of 4 NH's (1 x Frail elderly, 1 x Dementia)
  - Initial baseline data collection Jan/Feb 2022-Dietician will undertake observation visits in 4 NH's
  - Analysis of data
  - Selection of 2 NH's
  - Interventions to be agreed based on baseline data collection
  - Post intervention data collection & review
  - Scale and spread

Data collection

1. Number of MUST sores completed monthly
   I. How many completed accurately (to include accurate recording of height)
   II. Evidence of appropriate action
2. Number of residents with weight loss
3. MUST Score info
   I. Number of residents with MUST scores of 1 or 2
   II. Number of these residents already known to dietetic service
4. Knowledge assessment of food fortification
   I. Theory v's practice
   II. Is food fortification standard in NH and is this evidenced in practice
   III. How many residents on fortified diet
   IV. Number of residents on modified diet
5. NH record accuracy
   I. Handover information
   II. Dining room & kitchen diet sheets
   III. Food record charts
6. Training data already accessed by NH staff

Provider Care Home Engagement