Norfolk & Waveney Care Home Manual

A collection of clinical guidelines and resources for managing patients in care homes.
**Introduction**

There are about 11,000 care home and nursing home beds in Norfolk. This is four to five times the capacity of our acute hospital trusts. Most residents are highly dependent and have many complex medical needs often including dementia.

Care/nursing home residents are among the most vulnerable of our patients and many would say among the most deserving.

Until now there has been no easily accessible clinical guide to help decision-making by those caring for residents. This is a collection of guidance aimed at the many different groups involved; GPs, district nurses, specialist nurses/community matrons, care assistants and care managers. Your levels of knowledge and experience may differ but we hope this guidance will help improve care for those that really matter, the residents.

I am indebted to Dr Richard Gilbert who originally compiled this guide for use at Bowthorpe Care Village.

The details may need to be altered to take into account differing clinical or referral guidelines that may be in use in different areas or when referring to different acute trusts.

Please feel free to share this electronic document widely with your colleagues, we would love it to be found on every computer in every care/nursing home and in use by GPs, district nurses and other members of the primary health care team.

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1. Management of suspected urinary tract infection in care home patients

“The diagnosis of UTI is particularly difficult in elderly people who are more likely to have asymptomatic bacteriuria as they get older…..Elderly institutionalised patients frequently receive unnecessary antibiotic treatment for asymptomatic bacteriuria despite clear evidence of no compensating clinical benefit”. (SIGN Guideline 88, 2012).

NICE Quality Standards 2015 on the management of UTI in adults include the following:

- QS1 – adults over 65y should have a full clinical assessment before a diagnosis of UTI is made. This should be a face-to-face review of symptoms and physical examination including temperature, pulse, BP and dipstick testing.

UTIs in elderly patients, especially those with dementia are important to diagnose because of the potential for sudden worsening of confusion (delirium) with associated agitation or withdrawal, reduced mobility and increased falls. UTI can lead to urosepsis and is an important cause of hospital admission in elderly patients. Diagnosis is however challenging because elderly frail patients may present with atypical signs and symptoms (SIGN 3.1), and also are more likely to have clinically insignificant bacteriuria (up to 50% of older people in residential care). Treatment of asymptomatic bacteriuria with antibiotics is associated with adverse events such as GI upset and rashes with NNH = 3. The SIGN guideline recommends that diagnosis of UTI in elderly people is not based on dipstick testing. A positive dipstick should not be taken to indicate UTI in the absence of clinical symptoms since it may reflect asymptomatic bacteriuria, which does not require antibiotic treatment. However a negative dipstick test has a negative predictive value of 100% in excluding UTI.

Key symptoms and signs of UTI

- Dysuria
- Frequency
- Urgency
- New urinary incontinence
- Suprapubic pain/tenderness
- Haematuria
- Fever
- Rigors
- New or worsening confusion/agitation
- Loin pain (upper UTI)
Guidelines for diagnosis of UTI (Eastern Pathology Alliance)

1. Do not use urinalysis on urine samples from patients >65y to diagnose UTI in the absence of clinical symptoms.
2. Do not send urine for —routine culture in asymptomatic patients.
3. Send an MSU if there are 2 or more features of UTI or features of pyelonephritis
4. Do not prescribe antibiotics to —treat bacterial growth from urine in asymptomatic patients.
5. Do not perform urinalysis on catheter urine samples.

Algorithm for diagnosis of Urinary Tract Infection in adults >65 years of age without a urinary catheter

In catheterised patients:
1. Do not perform urinalysis on urine of long term catheter patients to diagnose UTI – all will give positive dipstick for nitrite/leucocytes after catheter in place for >1 week due to colonisation.
2. Do not send catheter urine for routine culture
3. Do not prescribe antibiotics to treat bacterial growth from catheter urine in asymptomatic patients.
Treatment guidelines (Norfolk Antibiotic Formulary)

1. Women with acute lower UTI – use Trimethoprim or Nitrofurantoin as they have a low risk of C. difficile (the latter not to be used if eGFR<60). Send MSU to guide antibiotic choice if no response to first antibiotic. Usual course 3 days

2. Women with acute upper UTI – send MSU and treat with Ciprofloxacin (7 days) or Co-amoxiclav (7-14 days). Consider hospitalisation if signs of sepsis, unable to tolerate fluids or no response within 24h of starting antibiotics.

3. Men with acute lower UTI – seven day course of Trimethoprim or Nitrofurantoin (the latter not to be used if eGFR<60). If there is evidence of prostatitis use a quinolone.

4. Catheterised patients – consider UTI if fever, flank or suprapubic discomfort, systemic malaise or confusion. Treatment with a 7-day course of antibiotics should be commenced after a CSU is sent for culture.

Consideration should be given to changing the catheter when a patient diagnosed with a catheter associated UTI has a urinary catheter that has been in situ for more than 7 days and where continued use of a catheter is necessary. The catheter change should take place after the patient has completed 24 hours of antibiotic therapy, but before the end of the 3rd day of treatment. The patient should be referred to the community nursing team in a timely manner for a catheter change at a 24-72 hour interval following commencement of antibiotics. This will allow the
Community nurses to plan for the re-catheterisation in good time. (Norwich CCG newsletter Nov 2016).

Prevention of UTI

Care staff should be aware of the need to help residents maintain adequate hydration, and avoid constipation (see South Norfolk information sheets).

Key messages

- Do not use urine dipstick testing to diagnose UTI
- Negative dipstick testing rules out UTI
- UTI should be diagnosed on the presence of symptoms and signs and confirmed with MSU culture

References


http://www.sign.ac.uk/pdf/sign88.pdf

NICE Quality Standard QS90 (2015) *Urinary tract infection in adults*

https://www.nice.org.uk/guidance/qs90

UTI Resource Bundle (SNCCG) *UTI Resource Leaflets (includes patient leaflet, hydration guide, drinks diary, UTI professional checklist, HPA algorithms)*

http://nww.knowledgeanglia.nhs.uk/urology/uti_resource_bundle/uti_leaflets_tiers_1_2_3.aspx

Norfolk Antibiotic Formulary (NELCSU)

http://nww.knowledgeanglia.nhs.uk/prescribing_nhsn/formulary/antibiotic_quick_ref.pdf
NHS number: .......................................................... Patient: .................................................................... DOB: ...........................................................................
Date: ........................................Carer: ..........................................................

Older patients (>65) with suspected UTI (urinary tract infection)
Guidance for Care home staff
- Complete 1-6, complete symptoms and signs and send to GP surgery (original in residents notes)
- **DO NOT PERFORM URINE DIPISTICK** – NOT recommended in residents >65 years
- CLEAR URINE – UTI highly unlikely. If urine dark -Think dehydration and push fluids
- Collect a clean urine sample particularly if two signs of infection present (temp > 38.3°C or new incontinence)
- **UTI is a symptom THINK cause** such as: 1. Dehydration 2. Poor hygiene 3. Sore/dry itchy vagina 4. Not emptying bladder to completion 5. Faecal incontinence (E coli in faeces) 6. Urinary catheter 7. Constipation

1. Catheter  Yes/No  Reason for catheter: date of insertion: planned date of removal/change: Catheter passport  Yes/No
2. Any known antibiotic allergies? ....................... 3. Signs of any other infection source?  Yes/No  If Yes, circle any NEW symptoms:
- Cough  Shortness of breath  Sputum production  Nausea/vomiting  Diarrhoea  Abdominal pain  Red/warm/swollen area of skin  pressure ulcer
4. History of previous UTI  Yes/No  5. Number of UTI’s treated in the last year....................... 6. Were any of these UTI’s investigated  Yes/No

NEW ONSET SYMPTOMS What does it mean?  Tick if present
Loin pain  Lower lateral back pain (pain in side)
Urgency  Need to pass urine urgently/new incontinence
Frequency  Need to urinate more often than usual
Suprapubic tenderness  Pain in lower tummy/above pubic area
Haematuria  Visible blood in urine
Dysuria  Pain on passing urine
New fall or falling more  Maybe start of an infection

Signs (do clinical observations if able)  Record sign
- Temperature above 38.3°C or below 36°C or shaking chills (rigors) in last 24 hours (normal 36-37.5)
- Heart Rate >110 beats/min (normal 50-100)
- Respiratory rate >20 breaths/min (normal 9-14)
- Diabetic?  Y / N  If N - Blood glucose >7.7 mmols/L (normal 4-6mmol)
- Bloods taken?  Y / N  If Y - WCC >12/µL or < 4/µL
- **New onset or worsening** confusion agitation or delirium

GP/Health Care Professional (HCP) Management Decision –A full clinical assessment is recommended before a diagnosis of UTI is made. Do not use urinalysis on urine samples from patients >65y to diagnose UTI in the absence of clinical symptoms as up to 50% of older people in residential care have clinically insignificant bacteriuria (NICE QS90)
Circle all that apply:
(a) Uncomplicated lower UTI 
(b) MSU/CSU sent—particularly if more than 2 signs of infection or continuing symptoms after antibiotic treatment.
(c) Review in 24/48 hour with MSU/CSU results  
(d) Pyelonephritis  
(e) Antibiotic prescribed _______________________________
(f) cause of UTI found: _______________________________

(g) UTI preventative actions for carer: _______________________________


*Please note that 3 confirmed UTI’s in a year requires investigation – do not miss red flags*
Top tips to prevent a Urinary tract infection: advice for carers.

1. **Keep your resident well hydrated as dehydration is the main cause of UTI**
   - Aim for 1600mls per day, or push fluids until at least one clear urine per day.

2. **Ensure good hygiene.**
   - Female residents: wipe from front to back.
   - Male residents: ensure you clean under the foreskin and place it back once cleaned. (If resident is circumcised they will not have a foreskin so clean as normal)

3. **Avoid constipation**
   - A Normal bowel function: passing stools up to 3 times a day to 3 times a week; it should be sausage like and easy to pass (Bristol stool chart type 4)
   - The bowel is most active up to 30 minutes after main meal therefore when resident is finished each meal encourage to sit on toilet until a good bowel regime is maintained

4. **Cross contamination from faeces**
   - If resident is faecally incontinent a disposable containment product specifically for faecal incontinence may have been prescribed. Best practice indicates the product needs to be changed immediately following a bowel action as faeces will sit against the skin and track into bladder and can cause infection)
   - If resident is faecally incontinent or has overflow incontinence please contact continence nurse for assessment/advice.

5. **Not emptying bladder effectively (residual)**
   - Normal bladder capacity is 350-500mls. The bladder should empty to completion when you go to toilet, if the bladder leaves urine behind this stale urine can cause UTI’s.
     - (However quite a few individuals do not empty to completion – and may not sustain a UTI).
   - An enlarged prostate can cause the bladder not to empty properly
   - Medication such as antimuscarinics formerly termed as anticholinergics can relax bladder therefore the bladder may not empty properly
   - Vaginal prolapse can obstruct the urethra (pipe you pee out of)
   - Neurological conditions such as Parkinson’s, MS and dementia

6. **Vaginal Atrophy**
   - If resident has a history of dry sore vagina ask your health care professional for some cream (ovestin)

7. **Urinary catheter – All details should be written in Residents Catheter Passport**
   - If a resident has a urinary catheter they will have bacteria within their urine therefore never take a urine sample unless requested by a HCP. Monitor symptoms and change in symptoms and or two clinical symptoms.
   - Encourage 2000mls fluid per day and ensure good catheter hygiene, change leg bag every 7 days (or sooner if contaminated) night bags are usually single use and should be attached to a night stand.

If you are unable to collect a clean sample of urine due to incontinence, try a urinary sheath for male residents or a P-Bag for females. For patients wearing disposable containment products, the Newcastle urine collection system can be extremely effective in gaining an appropriate urine sample. If unable to do this discuss with your HCP for advice.

*Once completed, please fax Page 1 of this checklist to a health care professional at your GP practice or community nurses. This will enable the appropriate clinician to make a decision re treatments for your resident.*
**Professional UTI Prevention Checklist:**
Prevention for residents/patients
- Guidance for HCP/GP/DN/NP/Nurses in care/nursing homes
STOP – THINK! Are you sure you want to prescribe antibiotics?

**PART 1** For residents with **new** symptoms to confirm UTI
Could this resident have a UTI? (Applies to catheterised and non-catheterised residents)

**Local symptoms:**
- New dysuria ☐
- New frequency ☐
- Suprapubic pain ☐
- Loin Pain ☐
- New incontinence ☐

**Systemic symptoms:**
- Delirium ☐
- Fever ☐
- Sepsis ☐

If one or more symptoms

**Perform urine dip & culture**
Dip and if positive for nitrates and leucocytes send a urine sample to GP
- See/ask an appropriate healthcare professional at your GP surgery
(Do not treat UTI based on urine dip alone!)
- Refer to local guidelines for diagnosis and management

**PART 2** for residents with a previously confirmed UTI

**URINARY CATHETERS:** Remove all unnecessary urinary catheters
According to local guidelines
Present ☐ No ☐
Removed ☐ Yes ☐ No ☐

**POST VOID RESIDUAL BLADDER SCAN:**
Performed ☐ Yes ☐ No ☐ (record PVR_________mls)......

**PR EXAM:**
Performed ☐ Yes ☐ No ☐

**PROSTATIC SYMPTOMS:**
- Obstructive symptoms ☐ Yes ☐ No ☐
- PR? Enlarged prostate ☐ Yes ☐ No ☐

**MEDICATION AND SYSTEMS REVIEW**
- Diabetes ☐ Yes ☐ No ☐
- Medication review (circle, see over for examples):
  - Anti-cholinergic/Opioids/Anti-muscarinic

**CONTINENCE:**
- Urinary incontinence ☐ Yes ☐ No ☐
- Faecal incontinence ☐ Yes ☐ No ☐
- Continence assessment ☐ Yes ☐ No ☐
- Known to community continence team ☐ Yes ☐ No ☐
- Known to urology team ☐ Yes ☐ No ☐
- Assessed by continence team for incontinence pads ☐ Yes ☐ No ☐

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Actions | Date
---|---

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Date: ..................................................
Name: ..................................................
DOB: ..................................................
Address: ..................................................
PART 3 further advice

URINARY CATHETERS:
Below are the NICE guidelines (March 2012) on prevention of infections in primary & community care
https://www.nice.org.uk/guidance/CG139/chapter/introduction

URINE SPECIMENS
- Urine dipstick alone is not an indicator to treat; therefore new clinical symptoms associated with a positive urine dipstick, send MSU/CSU before commencing antibiotics
- Urine dip from catheter samples will always be positive therefore await CSU before commencing treatment unless decision is based on new clinical symptoms

POST VOID RESIDUAL VOLUME (PVRV):
If PVRV >250mls then:
   a) Examine for and treat constipation
   b) Look for medial causes (e.g. anticholinergic medications, comorbidities)
   c) Consider obstruction (e.g. prostate or prolapse)

CONSTIPATION:
Rectal impaction: consider treatment with suppositories and macrogol 1 sachet b.d.

PROSTATIC SYMPTOMS:
If prostate feels abnormal:
BPH: Refer to CNS Continence nurse
Malignancy: Refer to urology urgently (2 week wait)

PV INSPECTION:
Perform PV inspection looking for
   a) Prolapse: consider gynaecology referral.
   b) Atrophic vaginitis: erythema, dryness, bleeding on contact: treat with estrodiol cream 0.01% o.d. for one month then maintenance twice per week.
   c) Candida: treat with clotrimazole.

MEDICATIONS:
Consider rationalising medications, examples include:
[1] opioid/codeine painkillers
[2] Bladder anti-muscarinic (e.g. oxybutynin, tolterodine, solifenacin, darifenacin, Mirabegron)
[3] Anticholinergic antihistamines/anti-emetics (e.g. promethazine, cyclizine)
[4] Anticholinergic antidepressants (e.g. amitriptyline)

CONTINENCE ASSESSMENT
- Non urgent referrals please refer to single point referral system at Wymondham hub
- For urgent referrals 2 week waits:
  • Norfolk and Norwich Hospital – refer to urology or gynaecology department
  • James Paget – refer to urology or gynaecology department
  • Queen Elizabeth – refer to urology or gynaecology department

ANTIBIOTIC TREATMENT
Appropriate clinical management and effective treatment of UTIs is important to prevent relapsing infections.
Please refer to local formulary and guidelines on appropriate use of antibiotics in UTIs.

ADVICE LEAFLETS
http://www.nhs.uk/pages/home.aspx
2. Management of cellulitis
(from NICE CKS revised July 2015)

Risk factors
- An identifiable break in the skin
- Leg ulceration
- Concomitant skin disorder
- Lymphoedema or leg oedema
- Venous insufficiency
- Obesity

Diagnosis

- **Typical features of cellulitis include:**
  - An acute onset of red, painful, hot, swollen, and tender skin, that spreads rapidly.
  - Fever, malaise, nausea, shivering, and rigors. These may accompany or precede the skin changes.
  - Unilateral presentation. The leg is the most commonly affected site, and bilateral leg cellulitis is very rare.

- **Examine the person:**
  - Look for a skin break where the infecting organism may have entered, such as a wound, macerated skin, fungal skin infection, or an ulcer.
  - There may be diffuse redness or a well-demarcated edge that can be marked with a pen in order to monitor progress.
  - If the infection is severe, the person may be systemically unwell; tachycardia, hypotension, tachypnoea, or confusion may be present.
  - Bullae and blisters filled with clear fluid, haemorrhage into blisters, bruising, petechiae, dermal necrosis, lymphadenopathy, and lymphangitis may occur.

- **Categorize the severity of cellulitis:**
  - The Eron classification system can help guide admission and treatment decisions.
    - **Class I** — there are no signs of systemic toxicity and the person has no uncontrolled co-morbidities.
    - **Class II** — the person is either systemically unwell or systemically well but with a co-morbidity (for example peripheral arterial disease, chronic venous insufficiency, or morbid obesity) which may complicate or delay resolution of infection.
- **Class III** — the person has significant systemic upset such as acute confusion, tachycardia, tachypnoea, hypotension, or unstable co-morbidities that may interfere with a response to treatment, or a limb-threatening infection due to vascular compromise.

- **Class IV** — the person has sepsis syndrome or a severe life-threatening infection such as necrotising fasciitis.

**Differential diagnosis**

- **Common conditions that present with unilateral redness and/or swelling include:**
  - Deep venous thrombosis — characterized by pain and swelling of the calves without significant erythema
  - Septic arthritis — involvement of the joint and disproportionate pain with joint movement.
  - Acute gout — swelling, redness, warmth, and pain on passive movement. The skin around the joint may be inflamed
  - Ruptured Baker's cyst — may cause unilateral calf swelling.
  - Thrombophlebitis — venous inflammation with thrombus formation. May cause redness, inflammation, and pain.

- **Chronic conditions** (these are usually bilateral but if worse on one side, it may be difficult to exclude superimposed cellulitis):
  - Varicose eczema/venous insufficiency — crusting, scaling, and itching.
  - Lipodermatosclerosis — a painful, red, tender, warm, hard, and sometimes scaly rash that occurs in the absence of significant systemic upset. It is most likely to occur in the lower leg in obese women with venous insufficiency..
  - Lymphoedema — swelling (especially in the subcutaneous tissues) that occurs as a result of excess accumulation of lymph due to inadequate drainage.
  - Oedema with blisters.

**Management**

- **Urgently admit to hospital, a person who:**
  - Has **Class III or Class IV** cellulitis.
  - Has severe or rapidly deteriorating cellulitis (for example extensive areas of skin).
  - Is very frail.
  - Is immunocompromised.
  - Has significant lymphoedema.
Consider admission for Class II cellulitis but may not be necessary if the facilities and expertise are available to monitor the person and possibly give IV antibiotics in the community.

- **Prescribe** oral antibiotics (Flucloxacillin or Clarithromycin) for a person who has Class I cellulitis. This should generally be a seven-day course with review after 48 hours. The extent of the erythema should be marked on the skin with a marker pen. If the patient has lymphoedema, then Amoxicillin 500mg tds should be added to Flucloxacillin, and the course extended to two weeks.

- **Identify and manage any underlying risk factors**, such as fungal skin infection or leg ulcer.

- **Identify and manage co-morbidities** (such as diabetes mellitus) that may cause the cellulitis to spread rapidly, or delay healing.

**Prevention of recurrence**

- Manage breaks in the skin which may become a portal of entry for organisms.
  - Treat eczema.
  - Treat tinea pedis. For further information.
  - Advise the use of emollients to prevent dry skin and cracking.
  - Treat any leg ulcer.
  - Manage venous insufficiency by using compression stockings after the acute cellulitis has resolved.
  - Consider referring people with lymphoedema to a specialist clinic.

- Advise weight management if the person is obese.

**References**

NICE Clinical Knowledge Summary *Cellulitis – acute* (revised July 2015)
https://cks.nice.org.uk/cellulitis-acute#!topicsummary

Norfolk Antibiotic Formulary (NELCSU)

http://nww.knowledgeanglia.nhs.uk/prescribing_nhsn/formulary/antibiotic_quick_ref.pdf
3. Identifying the Seriously Unwell Patient

Care staff need training in identifying residents with potentially serious acute medical problems, and the appropriate response both in-hours and out-of-hours. The response taken also needs to take into account any existing care plan, GSF status and preferred place of care. The guidelines given below apply in most situations; however in an end-of-life situation, a 999 call or transfer to hospital may not be the appropriate response. Care staff should apply the SBAR (Situation Background Assessment Recommendations) framework for providing information to a health care professional or the emergency services.

Key acute life-threatening presentations include the following:

1. Chest pain
   - Severe central chest pain with sweating, pallor, radiation to throat/left arm – suggests cardiac cause
   - Staff to ring 999. Less severe or non-central chest pain should generally be clinically assessed in-hours or consult 111 OOH.

2. Suspected stroke
   - Recognised by applying FAST (Facial weakness, Arm weakness, Speech problems, Time to call 999)
   - Usually staff to ring 999 and then if in-hours request urgent assessment by NP prior to ambulance arriving

3. Acute breathlessness
   - Consider whether resident has known underlying respiratory condition e.g. asthma, COPD, heart failure.
   - Have they taken their reliever medication (for asthma and COPD)?
   - Apply guidelines from patient’s own self-management plan if they have one
   - If breathlessness persists, request clinical assessment (in hours) or phone 111 (OOH).
   - For severe breathlessness, ring 999.

4. Possible sepsis
   - Consider in a resident with fever >38deg, confusion, drowsiness.
   - Request urgent medical assessment (in-hours, 111 OOH).

5. Fall with head injury
   - If the resident is unconscious following the head injury, or is taking warfarin or other anticoagulant, care staff should phone 999.
   - If the resident is not on warfarin, and is not knocked out or comes round rapidly, request clinical assessment (in-hours) or phone 111 (OOH).

6. Fitting
   - The resident should be put into the recovery position, and a 999 call made.
7. Choking
   - This usually occurs whilst a resident is eating.
   - Encourage the resident to cough.
   - If the resident shows signs of severe airway obstruction (unable to speak, very laboured wheezy breathing, can’t cough, reduced conscious level) then a 999 call should be made and Resuscitation Council guidelines followed, with administration of Back Blows and Abdominal Thrusts.

8. Profuse bleeding
   - For any resident with profuse bleeding (from stomach, lungs, nose or rectum), especially if on warfarin, call 999.
   - Mild bleeding should result in clinical assessment (in-hours) or a 111 call (OOH).

9. Collapse/unconscious
   - If a resident collapses and becomes unconscious, they should have an ABC assessment (Airway, Breathing, Circulation). It should also be identified whether the resident has a DNAR in place. Known diabetics should have a blood glucose measurement.
   - If they are unconscious but breathing and with a palpable pulse, put in the recovery position and call for assistance (999).
   - If they are unconscious with no detectable pulse, then commence CPR and call 999 unless a DNAR is in place.

10. Diabetic emergencies
    - Consider hypoglycaemia if known diabetic on insulin or sulphonylurea drugs becomes drowsy, confused or unconscious. Blood glucose measurement should be performed and if low (glucose < 4mmol/l) emergency glucose should be administered.
    - Consider hyperglycaemia in diabetic patient with breathless, vomiting and reduced conscious level. They should be urgently assessed by a clinician (in-hours) or OOH service, to include blood glucose and urine testing for ketones.
# Right Call, Right Care

## Urgent Call Communication Checklist

### Call 999: Do Not Delay
- Chest pain
- Suspected stroke - think FAST
- Cardiac arrest
- New or worsening breathing problems
- Fall with suspected injury
- Head injury
- Unconscious or new change in consciousness
- Choking
- Fits

### Call 111
For other urgent enquiries and advice when GP not available
Do not use 111 if it’s an emergency

### Call 111: Do Not Delay
- Chest pain
- Suspected stroke - think FAST
- Cardiac arrest
- New or worsening breathing problems
- Fall with suspected injury
- Head injury
- Unconscious or new change in consciousness
- Choking
- Fits

### Date: ____________________
### Time: ____________________

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<th><strong>Situation:</strong> say who you are and where you are</th>
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<td>What is the problem? e.g. I have found Mrs X on the floor or I can’t wake Mr Y up and his breathing has changed</td>
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<td>A brief history of the person e.g. She has dementia and falls frequently or Mr Y is normally alert and talkative with no breathing problems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Assessment:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you think has happened? e.g. I think Mrs X may have fractured her hip or Mr Y does not respond when I try to rouse him, he is making snoring noises</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Recommendation:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>What help do you want? e.g. I need someone to assess Mrs X and see if she has broken her hip or Tell me what to do to manage Mr Y’s breathing</td>
</tr>
</tbody>
</table>

### For your GP
- Unconscious or new change in consciousness
- Chest pain
- Suspected stroke - think FAST
- Cardiac arrest
- New or worsening breathing problems
- Fall with suspected injury
- Head injury
- Choking
- Fits

### For your GP: Do Not Delay
- Chest pain
- Suspected stroke - think FAST
- Cardiac arrest
- New or worsening breathing problems
- Fall with suspected injury
- Head injury
- Unconscious or new change in consciousness
- Choking
- Fits

### For other urgent enquiries and advice when GP not available
Do not use 111 if it’s an emergency

### Call 111: Do Not Delay
For other urgent enquiries and advice when GP not available
Do not use 111 if it’s an emergency

### You must have a phone beside the patient/resident
Use your mobile if needed
It is free

### Time to call 999
- Face - can they smile?
- Arm - can they lift both arms?
- Speech - is their speech muddled?

### Do Not Use 111 if it’s an emergency

### Time to call 999
- Can they smile?
- Does one side droop?
- Can they lift both arms?
- Is one weak?
- Is their speech muddled?

### Cardiac arrest
New or worsening breathing problems
Fall with suspected injury
Head injury
Unconscious or new change in consciousness
Choking
Fits

### Chest pain
Suspected stroke - think FAST
Cardiac arrest
New or worsening breathing problems
Fall with suspected injury
Head injury
Unconscious or new change in consciousness
Choking
Fits

### Fall with suspected injury
Head injury
Unconscious or new change in consciousness
Choking
Fits

### Head injury
Unconscious or new change in consciousness
Choking
Fits

### Unconscious or new change in consciousness
Choking
Fits

### Choking
Fits

### Fits

---

### Patient/resident name: ____________________
### Date of birth: ____________________

### Your name: ____________________

### Phone number you are dialling from (incl. options): ____________________
Now do your ABCD assessment; this will help the call handler make decisions

**Airway:**
Are they awake/speaking? (Alert)
Any snoring or gurgling noises?
Open the airway if you know how

**Breathing:**
Are they breathing?
Does it look normal?
Is it slow or fast?
If you can, count the breaths per minute

**Circulation:**
What colour are they?
Is there any bleeding?
If you can, do the BP and count the pulse
Are they cold? Take their temperature if you can
Have they passed urine in the last 4 hours? What colour was it?

**Disability including Diabetes:**
Has their conscious level changed?
Are they normally confused or agitated?
Are they normally verbal or nonverbal?
If diabetic, what is the blood sugar?
Have they fallen? If so, did anyone see them fall? (witnessed/unwitnessed)
Where is the site of the injury? New pain?
Are they getting worse?

Have you got:
MAR chart

If applicable:
Advanced Care Plan
DNR
Power of Attorney
DoLs

**Medical History:**

**Outcome of Call:**
5. Recognition of Frailty

(Based on British Geriatric Society “Fit for Frailty” consensus guideline, 2014)

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event, which challenges their health, such as an infection or new medication.

Frailty is not the same as multimorbidity or physical disability though they may frequently coexist.

Models of causes of frailty

1. Phenotype model – a group of patient characteristics (unintentional weight loss, reduced muscle strength, reduced gait speed, self-reported exhaustion and low energy expenditure) – patients with three or more of these features are said to have frailty.
2. Cumulative Deficit model – an accumulation of deficits occurring with ageing which combine to increase the risk of an adverse outcome (Rockwood) – can quantify using a frailty scale.

Frailty can vary in severity, it is not static but can improve or deteriorate, it is not an inevitable consequence of ageing but is a long-term condition in its own right.

Diagnosing frailty

1. Frailty syndromes
   - Falls (e.g. collapse, legs gave way, ‘found lying on floor’).
   - Immobility (e.g. sudden change in mobility, ‘gone off legs' stuck in toilet’).
   - Delirium (e.g. acute confusion, ‘muddledness’, sudden worsening of confusion in someone with previous dementia or known memory loss).
   - Incontinence (e.g. change in continence – new onset or worsening of urine or faecal incontinence).
   - Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants).

2. Consider use of the Rockwood Frailty Score Template.
3. Prisma 7 questionnaire – a score of > 3 indicates frailty

Prisma 7 questions:
   - Are you more than 85 years?
   - Male?
   - In general do you have any health problems that require you to limit your activities?
   - Do you need someone to help you on a regular basis?
   - In general do you have any health problems that require you to stay at home?
   - In case of need, can you count on someone close to you?
   - Do you regularly use a stick, walker or wheelchair to get about?
4. Edmonton Frailty Scale – 11 item questionnaire including the TUG test (see Ardens template)

0-5 not frail
6-7 vulnerable
8-9 mild frailty
10-11 moderate frailty
12-17 severe frailty

5. Walking speed – taking > 7.5 secs to walk 6m indicates frailty

6. Timed up and go (TUG) test – the time taken to get up from a chair, walk 3m, turn around and walk back to chair and sit down – cut-off indicating frailty >10 secs.

Managing frailty in an individual

- Carry out a comprehensive and holistic review of medical, functional, psychological and social needs based on comprehensive geriatric assessment principles in partnership with older people who have frailty and their carers.
- Ensure that reversible medical conditions are considered and addressed. Consider referral to geriatric medicine where frailty is associated with significant complexity, diagnostic uncertainty or challenging symptom control. Old age psychiatry should be considered for those with frailty and complex co-existing psychiatric problems including challenging behaviour in dementia.
- Conduct personalised medication reviews for older people with frailty, taking into account number and type of medications, possibly using evidence based criteria (e.g. STOPP START criteria).
- Use clinical judgement and personalised goals when deciding how to apply disease based clinical guidelines in the management of older people with frailty.
- Generate a personalised shared care and support plan (CSP) which documents treatment goals, management plans, and plans for urgent care which have been determined in advance. It may also be appropriate for some older people to include end of life care plans.
- Develop local protocols and pathways of care for older people with frailty, taking into account the common acute presentations of falls, delirium and sudden immobility. Ensure that the pathways build in a timely response to urgent need (see below).
- Recognise that many older people with frailty in crisis will manage better in the home environment but only with support systems which are suitable to fulfil all their health and care needs.

Holistic medical review – common problems which need to be addressed (see Ardens Frailty template):

- Falls
- Cognitive impairment and capacity
- Incontinence
- Weight loss and poor nutrition
- Polypharmacy – medication review
- Physical inactivity
- Low mood
- Alcohol excess
- Smoking
- Vision problems
- Social isolation and loneliness
Other long term conditions

Review should include thorough clinical including neurological examination.

Care Plan to include:

- Named care coordinator
- Health and social care summary
- Optimisation and/or maintenance plan (goals, actions)
- Escalation plan
- Urgent care plan (PPC, DNAR)

Assessment in an urgent situation

A clinician assessing an older person with frailty as an emergency, needs to strike a balance between being alert for serious underlying illness masquerading as a frailty syndrome, and over medicalisation of common problems such as falls and dementia. For example, over diagnosis of urinary tract infection as a single cause for falls, immobility and delirium in older people with frailty is common and a judicious clinical assessment is required. If in doubt (i.e. the patient is not febrile and appears to be otherwise well) then a set of bloods to look for raised inflammatory markers should be done without necessarily conveying the patient to hospital.

References

*Fit for Frailty*, British Geriatrics Society 2014
http://www.bgs.org.uk/campaigns/fff/fff_full.pdf

Edmonton Frail Scale
https://www.nscphealth.co.uk/edmontonscale-pdf
Clinical Frailty Scale*

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 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.

Suggested actions for patients with frailty score 7-9

Clinical Assessments:
- Undertake a medication review.
- Aspirin, warfarin, opiates, anti-cholinergics, antidepressants, ACE inhibitors and anti—hypertensives should be used with caution. Stop medications if indicated.
- Start any new medication at low dose with very gradual increments
- Consider need for calcium/vitamin D if housebound
- Avoid over treating hypertension and diabetes

Risk Assessment and Care Planning:
- Use advanced care plan when applying disease-based guidelines e.g. for diabetes, hypertension and CKD, dementia etc. outlining treatment goals/wishes with supporting anticipatory care plans for urgent care
- Discuss the patient’s preference for end of life and complete a DNACPR from if appropriate. Anticipatory care plans as part of advanced care planning
- Screen for falls and refer to NCH&C if required
- Check for postural hypotension if falling
- Ask about memory problems and refer on if indicated

Ongoing referral:
- Consider whether the right social care is in place considering carers support, signposting
- Refer to community matron if 3 or more long-term conditions
- Consider referral to geriatric medicine if significant complexity, diagnostic uncertainty or challenging symptom control
- Consider referral to Old Age Psychiatry if complex cognitive or behavioural problems
- Consider entering patient onto the GSF register
- GP practice to deliver a clinical review providing an annual medication review and where clinically appropriate discuss whether the patient has fallen in the last 12 months and provide any other clinically relevant interventions.
Suggested actions for patients with frailty score 5-6

**Clinical Assessments:**
- Undertake a medication review.
- Aspirin, warfarin, opiates, anti-cholinergics, antidepressants, ACE inhibitors and anti—hypertensives should be used with caution. Stop medications if indicated.
- Start any new medication at low dose with very gradual increments.
- Consider need for calcium/vitamin D if housebound.
- Avoid over treating hypertension and diabetes.

**Risk Assessment and Care Planning:**
- Use advanced care plan when applying disease-based guidelines e.g. for diabetes, hypertension and CKD, dementia etc. outlining treatment goals/wishes with supporting anticipatory care plans for urgent care.
- Consider the patient’s preference for end of life and complete a DNACPR form if appropriate.
- Screen for falls, check for postural hypotension and reduce medications accordingly. Refer to NCH&C if required.
- Assess nutritional status and skin integrity.

**Ongoing referral:**
- Refer to community matron if 3 or more long-term conditions.
- Discuss with HCP or at next planned MDT or as part of yearly review.
- Consider referral to geriatric medicine if significant complexity, diagnostic uncertainty or challenging symptom control.
- Consider referral to Old Age Psychiatry if complex cognitive or behavioural problems.
- Consider whether the right social care is in place considering carers support, signposting to other support services.
- Ensure good network and carer support.

---

**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.


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6. Delirium

Delirium is an impairment of cognitive function that is not progressive, but is reversible. The impairment of consciousness varies, often being worse at night. Delirium can be hypoactive (withdrawn, quiet, sleepy) or hyperactive (restless, agitated, aggressive).

Common causes of delirium mnemonic HIDE MAP:

- H - hypoxia
- I – infection
- D – drugs
- E – endocrine
- M – metabolic
- A – alcohol
- P – psychosis

Also – pain, bladder distension, faecal impaction/constipation, head injury.

Risk factors

- Over 65y of age
- Cognitive impairment (past or present) and/or dementia
- Current hip fracture
- Severe illness

Indicators of delirium

Recent changes (within hours or days) in:

- Cognitive function e.g. reduced concentration, slow responses, confusion
- Perception e.g. visual and auditory hallucinations
- Physical function e.g. reduced mobility, reduced movement, restlessness, agitation, changes in appetite, sleep disturbance.
- Social behaviour e.g. lack of cooperation with reasonable requests, withdrawal, or alterations in communication, mood and/or attitude.

Assessment

History and examination including vital signs
Drug history – any recent changes
Mental state examination
Glucometer blood glucose
Blood tests – FBC, U+Es, bone group, CRP
Consider ECG, MSU
Management

Whether the patient can be managed at the care home depends on whether a cause can be found for the delirium that can be treated or corrected, how much support is needed, and whether the patient is considered a risk to themselves or others. It is also dependent on any advanced care plan in place regarding the known wishes of the patient, and on discussion with immediate family or attorney. In general terms, it is preferable for the individual to be managed in familiar surroundings, as transfer to hospital will exacerbate their disorientation.

General principles:

- Treat and manage the underlying cause
- Provide effective communication, reorientation and reassurance
- Provide an adequate care environment
- Ensure adequate fluid intake to prevent dehydration

References

NICE Delirium overview

https://pathways.nice.org.uk/pathways/delirium

GP Notebook
7. Falls Assessment and Prevention

Management of residents who fall should be in keeping with NICE guidelines and quality standards.

Assessment for injury

- When a patient falls, care staff will follow their own procedures for assessing the severity of the fall, and whether a resident can be moved. If appropriate, urgent medical attention will be sought.
- When requested to see following a fall, the clinician should make an assessment of any injuries. Where appropriate, referral to hospital for an x-ray should be made if fracture is suspected. For minor lacerations, appropriate wound care should be given. If there is suspicion of a significant head injury, neurological assessment should be undertaken, and either head injury advice given with safety-netting, or the patient referred to A+E.

Prevention

All patients who have fallen should have a basic assessment to include the following:

History

- Circumstances of the fall
- History of previous falls
- Symptoms associated with the fall
- Eye witness account if available

Identification of risk factors for falling

- Cognitive impairment
- Visual impairment
- Physically frail
- Incontinence
- Have a condition that affects mobility or balance e.g. Parkinson's disease, stroke, arthritis, diabetes, vertigo
- Are taking multiple drugs especially psychotropic drugs of those causing postural hypotension
- Have a fear of falling

Examination

- Cardiovascular examination including sitting/standing BP, pulse
- Assess gait and balance with the Timed Up and Go (TUG) test:

  *Time the person getting up from a chair, walking 3 metres, turning round, returning to the chair, and sitting down. If the person usually uses a walking aid, this can be used during the test.*
During the test observe the person’s postural stability, gait, stride length and sway.

A score of 12-14 seconds or more has been shown to indicate high risk of falls.

- Information can be recorded on the Falls Medical Assessment template.

Management

- Care staff will consider all correctable factors identified from the Falls Assessment Tool for Care Homes.
- A Clinical Pharmacist may undertake medication review with particular focus on stopping or reducing the dose of drugs associated with an increased risk of falling, or which are no longer clinically indicated.
- Patients experiencing a fragility fracture should be started on a bisphosphonate and calcium/vitamin D supplement unless there are clinical contraindications.
- Referral should be made to the Falls Prevention Service for those who have fallen 3 or more times.
- All patients who have fallen may be considered for other referrals as appropriate e.g. optician, podiatry, OT, dietician, assistive technology, MFE clinic.

References

NICE Quality Standard QS86, 2015 Falls in older people

https://www.nice.org.uk/guidance/qs86

NICE Guideline CG161, 2013 Falls in older people: assessing risk and prevention

https://www.nice.org.uk/Guidance/cg161

NICE Clinical Knowledge Summary Falls – risk assessment

https://cks.nice.org.uk/falls-risk-assessment

Timed Up and Go (TUG) Test (CDCP)

## Falls Assessment tool for care homes:

<table>
<thead>
<tr>
<th>Mobility/balance</th>
<th>Confusion/Mild Cognition impairment</th>
<th>Falls history</th>
<th>Medication</th>
<th>Continence</th>
<th>Foot health And footwear</th>
<th>Dizziness blackouts</th>
<th>Vision/hearing</th>
<th>Environment</th>
<th>Poor Nutrition/Bone Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the resident unsteady? Do they have muscle weakness or a fear of falling?</td>
<td>Does the resident have mild cognitive impairment/dementia? Are they more confused than normal?</td>
<td>Has the cause been identified? Have previous falls been discussed?</td>
<td>Is the resident taking 4 or more different medications?</td>
<td>Is the resident incontinent of urine or faeces? Any changes to normal habits?</td>
<td>Are there foot problems? Does the resident appear dizzy or have fainting attacks? “just went down”</td>
<td>Does the resident have impaired hearing or sight?</td>
<td>Is the environment safe and suitable for the resident?</td>
<td>Is the resident underweight or has poor nutritional intake? Think Osteoporosis prevention</td>
<td></td>
</tr>
</tbody>
</table>

### Consider?

- Supervision plan.
- Encourage appropriate physical activity.
- Walking aid
- Manual handling assessment.
- Support to build confidence.

### Consider?

- Health needs, for example pain, dehydration, constipation.
- Mood/emotion infection.
- Delirium.
- Medication effects.
- Advice from HCP.
- Promote exercise and activity.
- Environment.

### Consider?

- Blood pressure: lying/standing.
- Ask/look for symptoms of dizziness.
- Sleepiness.
- Hallucinations.
- Compliance issue.
- Annual medication reviews.
- HCP review.

### Consider?

- Toilet regime e.g. hourly.
- Lying & standing.
- BP.
- Heart rate.
- Medication.
- High or Low blood sugar.

### Consider?

- Good foot care regime.
- Liaise with resident & family regarding suitable footwear.
- Colour, sensation of feet.
- Compliance.
- Splints/orthotics.
- Referral to podiatry.

### Consider?

- HCP review.
- Lying & standing.
- BP.
- Heart rate.
- Medication.
- Good lighting.
- Check for ear wax.
- Sight loss.
- Friendly environment.

### Consider?

- Orientation of resident to environment.
- ADL.
- Clear & clutter free rooms.
- Good signage.
- Dementia friendly.

### Consider?

- Calcium & Vit D.
- Food fortification.
- MUST score.
- 1600mls intake in 24hrs.
- Referral to dietician.
- SALT if swallowing difficulties.
- Weight-bearing activity.
- Lifestyle advice e.g.: sunlight, smoking cessation.

---

### Risk factors identified | Action required | Date and signature | Actions completed | Date and signature
---|---|---|---|---

#### No change since last assessment

| No falls: continue regular assessment |

#### Change since last assessment

| New risk factor: inform senior |

#### Fall: inform manager update risk factors Discuss at next MDT|

Name of resident…………………………………………………………………………… DOB…………………………………..Room Number………………………………Date………………………………

Adapted from a tool developed by Lynn Flannigan, NHS Lanarkshire; authors: Care Home Practitioners SNCCG ; V1.5 Nov 2016
Falls Assessment tool for care homes:

Initial/routine falls assessment → Complete risk assessment tool → Falls prevention actions in individual care plan

MDT Assessment
- Falls diary
- Rehabilitation
- Medication review
- Change in needs
- Reassess social care needs

Single fall with no injury
- Yes
- Any falls?
- No

2 falls in 6 months or fall resulting in injury/hospital admission?
- Yes
- Referral to NCHC for falls assessment → Individual Care Plan
- No

Repeated falls? Has reason for falls changed since last review?
- Yes
- No
8. Immobility

“Gone off legs” is a common presentation in older people. It usually refers to older people who were previously mobile and active, having a sudden deterioration in their mobility.

Assessment

- Obtain history of problem – duration, progression.
- What aspect of walking is difficult? – unsteadiness, weakness, pain.
- History of recent falls – any fear of falling?
- Any features to suggest acute illness e.g. UTI, chest infection.
- Any features suggestive of cord compression – urinary retention, sensory changes in legs.
- Drug history looking for potential side-effects e.g. sedation.
- General observations including temperature, urinalysis, cognitive function, sedation.
- Cardiovascular examination including postural BP changes, peripheral pulses.
- Musculoskeletal examination – arthritis, signs of injury.
- Neurological examination – full examination of lower limbs including motor function and peripheral sensation – also balance, cerebellar and extrapyramidal dysfunction.
- Assess gait – asymmetrical, broad-based – TUG test.

Possible causes

- Acute illness – UTI, LRTI, dehydration, metabolic abnormalities, hypoxia.
- Acute injury – fractures including spontaneous, head injury.
- Drugs – sedatives, hypotensives, polypharmacy.
- Alcohol.
- Cardiovascular – hypotension, arrhythmias, PAD.
- Neurological – cauda equine syndrome, TIA, CVA, MS, MND, peripheral neuropathy, Parkinson’s disease, myopathy.
- Pain – back pain, knee and hip OA, foot pain.
- Balance problems – BPPV, labyrinthitis.
- Mental health problems – depression, fear of falling.
- Frailty.
- Dementia.

Management

- Guided by history and examination.
- Exclude and treat acute problems – may require blood tests and MSU.
- If manifestation of progression of frailty, consider multidisciplinary interventions (e.g. OT, physiotherapy).

Reference

Walking difficulty and off legs in adults

9. Chronic Disease Management

Residents in care homes are highly likely to have one or more chronic medical conditions. Multimorbidity becomes increasingly likely with increasing age.

Primary care is very used to providing monitoring and management of chronic diseases through the Quality and Outcomes Framework. In a care home population however, it becomes important to balance active management of risk factors and treatment of conditions, with the increasing risk of side-effects from polypharmacy in an elderly population, and the reduced benefits of treatments. In addition, the onset of frailty and/or the presence of dementia or other life-limiting conditions, means that discussion of the continuance of preventative treatments should be had with patients and their families.

Patients on the GSF register should also have review of their medication and the need for routine blood tests.

Approach to care taking into account multimorbidity

Focus on:

• Patient’s health conditions and their treatments and how these affect QoL.
• Person’s individual needs, preferences, priorities and goals.
• Improve QoL by reducing treatment burden, adverse events and unplanned care (don’t slavishly follow single condition guidelines).
• Review medicines and other treatments for likely benefits and harms.
• Discuss with patient, whenever possible and establish disease and treatment burden.
• Be aware of possibility of depression and anxiety.

Rationalising treatments

• Consider what is important to patient e.g. maintaining independence, reducing harms from medicines, reducing treatment burden, lengthening life.
• Use screening tool e.g. STOPP/START to identify medicine-related safety concerns.
• Assess benefits and harms of each treatment.
• Take into account possibility of lower overall benefit of treatments offering prognostic benefit especially in patients with limited life expectancy or frailty.
• Discuss with patients whether they wish to continue treatments.
• Consider stopping bisphosphonate after 3y treatment.

QOF – general principles

• All patients will generally have an annual review of their condition, with particular focus on the aspects of treatment and monitoring highlighted in the QOF regulations.
• Annual monitoring blood tests for each condition are indicated in the summary of Blood Tests.
• Annual review findings are entered onto computer systems via the appropriate disease template(s).
• Where preventative treatments are discontinued or treatment targets relaxed because of frailty, appropriate exception-coding for QOF should be made with clear reasons given in free-text.
QOF – specific considerations for individual conditions

- **Asthma**
  - Assess ability to use inhaler devices.
  - Consider use of spacers.
  - Step up or down according to symptoms.
  - Have in place action plan for dealing with exacerbations.

- **Atrial fibrillation**
  - Consider anticoagulation for stroke prevention with warfarin or a NOAC.
  - Only exclude from consideration of anticoagulation if the patient is palliative or very frail, or there are medical contraindications because stroke prevention is paramount.

- **Cardiovascular disease (CHD, CVA, PAD, CKD)**
  - Consider appropriateness of secondary prevention medications.
  - Consider reduction in anti-anginals with reduced mobility.

- **COPD**
  - Assess ability to use inhaler devices.
  - Consider use of spacer.
  - Consider reduced need for bronchodilators with reduced mobility.
  - Have in place action plan for dealing with exacerbations.

- **Dementia**
  - Importance of diagnosis and advance care planning.

- **Depression**
  - This is common in an elderly care home population with multimorbidity.
  - Identification and review as for younger adults.

- **Diabetes**
  - Adjust treatment targets to reduce the risk of hypoglycaemia.
  - Continue preventative care including retinopathy screening unless very frail or unable to cooperate.

- **Heart failure**
  - Balance treatments against risk of hypotension and worsening CKD.

- **Hypertension**
  - Routinely assess for postural drop.
  - Consider relaxing target for BP control.

- **Mental health**
  - Provide appropriate monitoring of lithium and antipsychotic treatment.

- **Osteoporosis**
  - Offer bisphosphonate and calcium/vitamin D supplements to all fragility fracture patients.
  - Consider limiting bisphosphonate treatment to three years.

- **Rheumatoid arthritis**
  - Provide appropriate shared care monitoring of immunosuppressant medications.

**References**

Quality and Outcomes Framework 2017/8

http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2017_18/201718%20Quality%20and%20outcomes%20framework%20summary%20of%20changes.pdf

NICE Guideline NG 56, 2016 Multimorbidity: clinical assessment and management

https://www.nice.org.uk/guidance/ng56

NICE Key Therapeutic Topic KTT 18, 2017 Multimorbidity and Polypharmacy

https://www.nice.org.uk/guidance/ktt18/resources/multimorbidity-and-polypharmacy. 58757959453381
# 10. Blood and urine tests

For all chronic disease blood tests, consider whether they are appropriate in elderly frail patients

<table>
<thead>
<tr>
<th>Recall</th>
<th>Blood tests</th>
<th>Urine tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD, Stroke/TIA and PAD annual review</td>
<td>U+E’s, LFT’s, diagnostic HbA1c, cholesterol+HDL</td>
<td></td>
</tr>
<tr>
<td>Diabetes annual review</td>
<td>U+E’s, LFT’s, glucose, monitoring HbA1c, cholesterol+HDL, B12</td>
<td>ACR</td>
</tr>
<tr>
<td>Hypertension/CKD annual review</td>
<td>U+E’s, LFTs, diagnostic HbA1c, cholesterol+HDL (if &lt;80y)</td>
<td>ACR (CKD only)</td>
</tr>
<tr>
<td>Mental Health annual review</td>
<td>If over 40y, FBC, U+E’s, LFT’s, cholesterol+HDL, diagnostic HbA1c</td>
<td></td>
</tr>
<tr>
<td>New Hypertension Diagnosis</td>
<td>Fasting lipids and glucose, U+E’s, LFT’s, diagnostic HbA1c</td>
<td>Urine dipstick, ACR</td>
</tr>
<tr>
<td>Pre-diabetes</td>
<td>Diagnostic HbA1c annually</td>
<td></td>
</tr>
<tr>
<td>Dementia New Diagnosis</td>
<td>FBC, U+E’s, LFT’s, TFTs, bone group, folate, B12 and glucose</td>
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<td>Thyroxine monitoring</td>
<td>TSH annually</td>
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<td>Amiodarone monitoring</td>
<td>U+E’s, LFT’s and TFT’s (six-monthly)</td>
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<td>Lithium monitoring</td>
<td>Serum lithium, U+E’s, TFT’s (3-monthly)</td>
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<td>Statin monitoring</td>
<td>Check LFTs after 3 months and at one year. Cholesterol+HDL annually</td>
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<td>If over 40y, FBC, U+E’s, LFT’s, cholesterol+HDL, diagnostic HbA1c</td>
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<td>Leflunomide monitoring</td>
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<td>Annual cholesterol+HDL</td>
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<tr>
<td>Vitamin B12</td>
<td>Annual FBC</td>
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11. Medicines Management

Acute Prescribing

- Acute items should be prescribed in the relevant quantity for the course required. The duration of the course of treatment should be specified on the prescription, or when the patient will be reviewed.
- Items which are likely to be required in the longer term should be prescribed as repeat items (see below).

Repeat Prescribing

- Repeat prescribing will usually be for 28 day supplies of each medication.
- Ideally each medication should have a clinical indication Read-coded at the time of setting up the repeat template, or by a clinical pharmacist when new resident repeat templates are being entered.
- The default for repeat templates should be for six issues after which re-authorisation will be required. This can be over-ridden where appropriate for either more or less allowed issues.
- When patients are discharged from hospital with changes to their repeat medications, these should be updated from the discharge summary.
- Medication changes may also result from outpatient clinic letters.
- When clinicians change or add a repeat prescription, the following general principles apply:
  o Use generic formulations unless there is good reason not to (MR nifedipine, MR diltiazem, lithium, MR theophylline, anticonvulsants, inhaled beclomethasone).
  o Consider patient sensitivities and significant interactions.
  o Prescribe in line with the local prescribing formulary.
  o Give full details of dose and frequency with necessary directions — as directed should not be used and —as required should not be used alone.
  o For creams, directions should include location to be applied to, directions and duration of use.
- Changes to existing repeat prescriptions should be notified to care staff, written as an amendment on the MAR chart and the computer system updated.

Medication Review

- Medication review should include the following considerations (see STOPP START Toolkit and Clinical Medication Review, from NHS Cumbria):
  o Check that
- The medication is appropriate to the patient’s needs.
- The medication is effective.
- The medication is a cost-effective choice.
- Any required monitoring has been done or arrangements are in place.
- Dosage directions are clear and clinical indications are clear and appropriate.
  - Consider
    - Drug interactions.
    - Side effects.
    - Compliance.
    - Concordance.
    - Ability to take the medication.
- Actions undertaken following medication review:
  - Link unlinked drugs to clinical indication.
  - If an item is no longer needed, delete from list.
  - Consider if there are potential significant drug interactions.
  - Appropriate monitoring blood tests and clinical/QOF reviews should be arranged.
  - Consider if there are items which should be de-prescribed in view of patient frailty (see below), or in which the dosage can be stepped down.

12. Covert Administration and De-prescribing

Covert Prescribing

Administration of medication covertly should only be initiated providing the procedure laid out in the NELCSU Best Practice Guidance is followed. This should include a medication review to determine those medications which are essential, a mental capacity assessment, and a best interests meeting with clear documentation of the decision-making process.

Deprescribing

Clinicians should actively consider deprescribing medications when reviewing patients with increasing frailty.

Factors to consider when deciding if a medicine can be stopped include:

- The patient’s wishes and those of family if patient lacks capacity.
- Is the medication providing useful symptom relief?
- Is the medication essential? e.g. steroids in Addison’s disease, levo-thyroxine for hypothyroidism.
- Has patient’s condition changed e.g. less mobile = reduced need for anti-anginal.
- Is the patient experiencing side-effects?
• The risk of adverse reactions outweighs the possible benefits.
• The medication would not be reasonably expected to give benefit with the expectation of the patient’s lifespan – preventative treatments become less meaningful as patients with multi-morbidity age and become more frail.
• Duration of use e.g. discontinue bisphosphonates after three years of use.
• Adherence and ability to take the medication.

Particular caution should be exercised if considering stopping the following drugs (consider gradual withdrawal or specialist advice):

• ACEI and diuretics in heart failure.
• Antiarrhythmics.
• Anticonvulsants.
• Antidepressant, antipsychotic or mood stabilising drugs.
• Drugs used in Parkinson’s disease.
• Steroids, DMARDs and immunosuppressant drugs.

References


NICE Guideline ng 5, 2015 *Medicines optimisation: the safe and effective use of medicines to enable best possible outcomes.*

https://www.nice.org.uk/guidance/ng5

*STOPP START Toolkit Supporting Medication Review*, NHS Cumbria 2013


NELCSU Best Practice Guidance19 (November 2016) *Procedure for Initiating Covert Administration*


NELCSU Best Practice Guidance – Mental Capacity of the Patient and Covert Medication (May 2016)

http://www.knowledgeanglia.nhs.uk/prescribing_nhsn/covert_medication_patient_me
KEY MESSAGE: An appropriate process MUST be followed prior to the initiation of the covert administration of medicines.

See NEL CSU Best Practice Guidance - Mental Capacity of the Patient and Covert Medication for full information

It is important to clearly document the decision making process to implement covert administration to protect the patient against deprivation of their liberty (DoL) to make decisions about their health and welfare. All best interest decisions and documentation must be available in the patient’s care plan and copies made available in the Medicines Administration Chart (MAR) to ensure all those giving medication are aware of the need and the circumstances where it is necessary to give the medication covertly.

IMPORTANT: Remember to follow due process and clearly document decisions for:

- Mental Capacity Assessment
- Best Interest Meeting
- Risk Benefit Review of Current Medication

Mental Capacity Assessment

The person who can assess an individual’s capacity to make a decision about their medication will usually be the person who is directly concerned with the individual at the time the decision needs to be made. E.g. care home manager/ senior carer (residential care)/ nurse or in some cases the prescriber.

Remember that capacity can be regained therefore a review date must be made. ALL persons involved in the assessment must be recorded.

Best Interest Meeting

This is to discuss the residents’ refusal of treatment, their mental capacity and the consequences of their continued refusal and whether initiating covert administration is in their best interest to ensure their wellbeing.

A prescriber, the residents’ advocate (person with power of attorney for health matters or a social worker), care facility representative and pharmacist (where appropriate). Any living will/ advanced directive of the resident must be adhered to and every effort should be made to ask relatives/ friends if the person had any documented wishes prior to loss of capacity.

The outcome, evidence of advanced directive and names of those present MUST be documented.

Risk Benefit Review of Current Medication

ALL medication should be reviewed by the prescriber to determine those which are essential to their wellbeing and/or safety of others. A pharmacist should be consulted if oral medication is to be opened/crushed and added to food/ drink to advise if this is safe practice for the medications.

ALL medication to be given covertly MUST be listed and have written authorisation from the prescriber, have instructions added to their prescription and have full guidance given to the care home about WHEN covert administration is appropriate for the individual, i.e. continual, during a period of infection, an aggressive incident, or when refusing an open offer of medication. This should be kept with the MAR chart.
Patient is persistently refusing medication in any form

Complete a Mental Capacity Act Assessment
The person who can assess an individual’s capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. E.g. care home manager/carer (residential care)/nurse (nursing home)

HAS CAPACITY
Review medication and assess the reason for refusal. STOP or CHANGE of formulation may be required.
NO COVERT ADMINISTRATION ALLOWED

LACKS CAPACITY
Is AWARE medication is being administered, is refusing the medicines essential to their wellbeing and they will benefit from this intervention

Can decision be delayed? Is capacity likely to improve?

NO

YES
RE-assess when appropriate

If necessary contact friends and family OR Advocacy Service

Is there a CLEAR Advance directive from the patient? Is there a person with Power of Attorney/Deputy for Court of Protection or personal welfare?

NO

YES

Outcome of mental capacity assessment should be discussed by a multidisciplinary team – e.g. Care Home, Nurse Independent Prescriber, GP, Patient advocate/representative and where appropriate, a Pharmacist to make a decision in the patient’s best interest and/or for the safety of others.

Covert Administration of medication is necessary in the patient’s best interest and/or for the safety of others

Prescriber responsibility RISK/BENEFIT REVIEW
Review medication to determine those ESSENTIAL to the patient’s wellbeing and/or the safety of themselves or others.
STOP as least restrictive option and document

Complete ALL relevant paperwork.
Prescriber: Signed written authority: to administer covert medication – i.e. by letter to the care facility and to change the form of the medication (Medicines Act 1968) i.e. in dosage instruction on prescription MUST be issued to the Care Facility and the dispensing Pharmacy.
Care facility: Document change in care plan and add a copy of paperwork to MAR folder.

Care Facility Responsibility
Daily assessment of the patient after CA starts to determine continued need.
Weekly review in the care plan – extend review interval with continued need for CA.
Inform GP of any change – especially if the patient becomes wary of and refuses food/drink.
Administer medicines according to instruction.

Is there evidence of harm from the medication change i.e. Refusal of food?

NO

YES
CONTINUE
Ensure regular review
STOP and review needs

Pharmacist Responsibility
Advise on change in form of medication and appropriateness for covert administration.
Dispense in accordance with GP instruction adding all information to the dispensing label and MAR chart.
Inform the GP and Care Home of any supply problems with the medication to allow for immediate review of the patient

References
NEL CSU Best Practice Guidance - Mental Capacity of the Patient and Covert Medication June 2016.
**Version Control** (To be completed by policy owner)

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<td>To inform healthcare professionals</td>
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<tr>
<td><strong>Prepared by</strong></td>
<td>NEL CSU Prescribing &amp; Medicines Management Team - MS</td>
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A. based on national research-based evidence and is considered best evidence  
B. mix of national and local consensus  
C. based on local good practice and consensus in the absence of national research based information. |
| **Dissemination** | Is there any reason why any part of this document should not be available on the public web site? ☐ Yes / No ☑ |
| **Approved by** | Norfolk & Waveney Prescribing Reference Group |
| **Authorised by** | Norfolk & Waveney Drug & Therapeutics Commissioning Group |
| **Review date and by whom** | November 2018 Prescribing & Medicines Management Team |
| **Date of issue and by whom** | November 2018 |

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<td>October 2016</td>
<td>Marion Sully</td>
<td>Draft</td>
<td>To reword for the process using the flow chart as template. To highlight the important stages with further explanation.</td>
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<td>November 2016</td>
<td>MS</td>
<td>Final</td>
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Covert Administration of Medicines

KEY MESSAGE:
Covert administration of medicines should only be necessary and take place in exceptional circumstances and must follow an appropriate process. See NEL CSU Best Practice Guidance - Mental Capacity of the Patient and Covert Medication for full information.

- “Covert” administration is the term used when medicines are administered in a disguised format, e.g. in food or drink without the knowledge or consent of the person receiving them.
- Covert medication must NEVER be given to someone who is capable of giving informed consent to medical treatment.
- Administration of medication against a person’s wish may be unlawful.
- Every person has a right to refuse their medication, even if that refusal appears ill-judged to staff who are caring for them.
- Covert administration is only likely to be necessary or appropriate where a resident actively refuses their medication but is judged not to have the capacity to understand the consequences of their refusal and the medication is deemed essential to the patient’s health and wellbeing.
- The proposal to administer covertly should be discussed with the resident’s GP and with a relative, carer or patient advocate and Pharmacist.
- Administering medicines in this way can significantly alter their therapeutic properties and effect so that they become unsuitable – Pharmacist advice is necessary.

Caution! before considering covert administration
- Every reasonable effort must be made to give the medicine to the patient in the normal manner.
- Alternative ways of giving medication by normal means should be considered.
- In the event of regular refusal the patient’s medication regimen should be reviewed by their GP to consider reasons why they are refusing, e.g. unpalatable or adverse effects.
- There must be a clear expectation that it is in the patient’s best interest and/or for the safety of others and medication given is NOT solely for the benefit of others – i.e. to prevent nuisance behaviour.
- GP to confirm that the medication remains essential to the patient’s health and wellbeing.
- All the patient’s wishes prior to incapacity MUST be considered, e.g. living will.
- An assessment of the resident’s mental capacity to consent must take place.

Assessment of mental capacity before covert administration
Every adult must be presumed to have the mental capacity to consent or refuse treatment\(^3\), unless they are:
- Unable to understand in simple language what the medicine is, its purpose and why it is necessary.
- Unable to understand the risks and benefits of the medicine, and whether there are any alternatives.
- Unable to understand in broad terms the consequences of not taking the medicine.
- Unable to retain the information long enough to make an effective decision

(This is most likely to be due to severe dementia or profound learning disability. Do not confuse communication difficulties with an inability to consent)
**Assessment and Responsibilities Governing Covert Medication Administration – Summary**

HAS CAPACITY
- Review medication and assess the reason for refusal. STOP or CHANGE of formulation may be required.
- NO COVERT ADMINISTRATION ALLOWED

LACKS CAPACITY
- Is AWARE medication is being administered, is refusing the medicines essential to their wellbeing and they will benefit from this intervention.
- Continue as before

LACKS CAPACITY
- Has NO need for covert administration as IS TAKING necessary medication

Covert Administration of medication is necessary in the patient’s best interest and/or for the safety of others.

**GP responsibility**
- Review medication to determine those ESSENTIAL to the patient’s wellbeing and/ or the safety of themselves or others.
- Signed written authority: to administer covert medication – i.e by letter to the care facility and to change the form of the medication (Medicines Act 1968) i.e in dosage instruction on prescription MUST be issued to the Care Facility and the dispensing Pharmacy.

**Care Facility Responsibility**
- Daily assessment of the patient after CA starts to determine continued need.
- Weekly review in the care plan – extend review interval with continued need for CA.
- Inform GP of any change – especially if the patient becomes wary of and refuses food/drink.
- Administer medicines according to instruction.

**Pharmacist Responsibility**
- Advise on change in form of medication and appropriateness for covert administration.
- Dispense in accordance with GP instruction adding all information to the dispensing label and MAR chart.
- Inform the GP and Care Home of any supply problems with the medication to allow for immediate review of the patient.

**References:**
2. Royal College of Psychiatrists statement on Covert Administration of Medicines http://journals.rcpsych.org/content/28/10/385.full [accessed 19/8/13]
4. Medicine Q & As, UKMI, What legal and pharmaceutical issues should be considered when administering medicines covertly? Q&A 365.2 [Accessed 19/8/13]
13. Nutrition

All residents should be weighed monthly, and their BMI and MUST scores calculated. Action should be taken in accordance with *Nutritional Support for Care Home Residents*.

**MUST score = 0 – Low Risk.** Do not require Oral Nutritional Supplements (ONS), and if being prescribed, consideration should be given to stopping.

**MUST score = 1 – Medium Risk.** Food fortification by care home. If weight not increased/stabilised after 2-4 weeks consider OTC supplements and refer to GP.

**MUST score = 3 – High Risk.** Food fortification and OTC supplements for 2-4 weeks, and refer to GP. If weight not stabilised then GP refer to dietician, with interim prescription for ONS (initial script for 7 days to ensure palatability and reduced waste).

**Oral Nutritional Supplements**

ONS may be prescribed on FP10 for indications approved by the Advisory Committee on Borderline Substances (ACBS). The usual indication applicable to care home residents is disease-related malnutrition.

Approved ONS for use before seeing dietician:

- Foodlink Compleat (milk-based powder shake)
- Altraplen Compact (milk-shake style sip feed)
- Fresubin Jucy (juice-style sip feed)

Patients prescribed ONS should have their prescription reviewed 3-monthly with the current BMI and MUST score recorded in the notes.

A useful resource for carers and care workers is: [http://nww.knowledgeanglia.nhs.uk/LinkClick.aspx?fileticket=PoTEle3LEJ4%3d&portalid=1](http://nww.knowledgeanglia.nhs.uk/LinkClick.aspx?fileticket=PoTEle3LEJ4%3d&portalid=1)

**References**

*Guidelines for food fortification, and use of Oral Nutritional Supplements in Adults*, NELCSU Anglia, November 2016


*Nutritional support for care home residents, Best Practice Guidance 21*, NELCSU Anglia, December 2016

Nutritional Support for Care Home Residents

Key Message: All care home residents should be screened for malnutrition and malnutrition (under nutrition) risk

- The Malnutrition Universal Screening Tool (MUST) may be used to assess nutritional status.\(^{(1)}\)
- MUST is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. It is available online at [http://www.bapen.org.uk/pdfs/must/must_full.pdf](http://www.bapen.org.uk/pdfs/must/must_full.pdf)
- Any assessment carried out using MUST should be interpreted with caution and with consideration to individual residents being assessed.

See below for local guidance on MUST score interpretation:

**Step 1+ BMI Score**

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**Step 2+ Weight Loss Score**

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<td>&gt;10</td>
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**Step 3 Acute Illness**

*If patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days Score 2*

Add scores together to calculate overall risk of malnutrition (N.B. Care required with interpretation if small build or obese).

**MUST score = 0 No risk factors**

Low Risk

Nutritional support is NOT required. If sip feeds are prescribed, review need and consider stopping.

**MUST score = 1 1 risk factor**

Medium Risk

Food First: Fortify food – see [Fabulous Fortified Feasts](#) booklet\(^{†}\). If weight has not stabilised or increased after 2-4 weeks refer to GP - complete assessment form.

**MUST score = 2 2 or more risk factors**

High Risk

Food first and refer to GP – complete assessment form – see appendix 1. Referral to dietitian may be required.

\(^{†}\) Available from NELCSU Prescribing and Medicines management team, GP surgeries and dietitians
**Food First!**

- **Food fortification** should be the first line approach for people identified as having a MUST score of 1 or greater.
- Food fortification is essential when trying to encourage weight gain: This involves increasing calorie and protein intake in people with weight loss, small appetites or people with or at risk of malnutrition.
- The ‘Food First’ approach is a daily consumption of:
  - 1 pint of fortified milk (in various forms including homemade shakes and sip feed recipes)
  - 2 nourishing snacks (people with small appetites prefer snacks to bigger meals)
  - 3 fortified meals (using full fat milk, cream and butter)
- Homemade sip feeds are drinks that do not replace meals but should be sipped between meals or as an alternative to eating a snack (see Fabulous Fortified Feasts booklet†). They are tastier than commercial sip feeds available to purchase or on prescription.
- If weight has not increased or stabilised after 2 – 4 weeks of food fortification, refer to GP for nutritional support.

**Referral to GP for Nutritional Support**

- Referral to GP for nutritional support should only occur when:
  - Weight gain or stabilisation has not been achieved after 2 - 4 weeks of Food Fortification
  - MUST Score = 2 or more
- When referring to GP for support with nutrition, care homes must complete the Assessment of Malnutrition Risk form and submit to GP: see appendix 1.
- It is at GP’s clinical discretion whether to provide oral nutritional supplements (ONS) on prescription or provide alternative recommendations prior to referral to a dietitian. This will be in the form of a powder shake which should be made in to a milk shake style drink with full fat milk.
- Food fortification should continue even though supplements have been prescribed.
- ONS should not replace meals but should be taken between meals – usually twice a day.
- Various flavours are available: an individual’s preference should be taken in to consideration in order to avoid wastage.
- Assessment by a dietician may be required if ongoing need for nutritional supplements is required.
- Prescriptions for ONS will only be re-authorised by the GP surgery if an up to date weight and BMI is provided every 3 months – complete Oral Nutritional Supplement Repeat Request form and submit to GP: see appendix 2.
- ONS should be stopped when adequate oral intake from normal food is established.

**Oral Nutritional Supplements (ONS)**

- ONS are considered ‘Borderline Substances’ for prescribing. They are only available on prescription if certain criteria are met, i.e. malnutrition is related to disease.
- Costs of providing ONS on prescription are significant: ranging between £93 - £123 ³ for a 28 day supply (based on 2 supplements daily).
- Compact (high calorie, low volume) ONS are preferred as they can provide 300kcal in 125mls, reducing wastage if large volumes cannot be consumed, particularly in patients with dementia.
- ONS can be consumed in portions divided throughout the day: once opened, store in refrigerator and consume with 24 hours. Discard unused contents thereafter.
- Prescribing of ONS should be reviewed if repeatedly refused by a resident.

**References**

2. Fabulous Fortified Feasts NHS PrescQIPP www.prescqipp.info
3. Based on cost of Altraplen compact vs Ensure Plus http://www.mims.co.uk/mims_monthly
### Care Home Assessment of Malnutrition Risk

To be completed by care home for referral to GP: Note incomplete forms will be returned for completion

<table>
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<th>To:</th>
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<td></td>
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### CARER ASSESSMENT OF MALNUTRITION RISK

Date resident admitted to home:

Reason for referral (e.g. change in resident’s condition, acute illness etc.)

Weight (include date): Height:

BMI: MUST Score:

Mouth (oral hygiene) assessment:

Frequency of bowel opening and stool consistency:

Swallowing difficulties (please describe):

Description of previous 72 hours intake of food and drink (describe food and drink offered and consumed and include volumes): *Include food log*

Has food been fortified and if so for how long?

Is help with feeding required? If so, please describe help offered:

Dietary restrictions (e.g. lactose or gluten intolerance, allergies etc.)
Appendix 2

Oral Nutritional Supplement Repeat Request - Guidelines For Carer

Malnutrition Risk Score
Add Step 1, 2 & 3 scores together to calculate overall risk of malnutrition or go to MUST calculator at:

http://www.bapen.org.uk/screening-and-must/must-calculator

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<td>Less than 18.5</td>
<td>More than 10%</td>
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If resident is acutely ill e.g. chest infection, UTI, flu, and there has been or is likely to be no nutritional intake for more than 5 days, add 2

What to do with a Malnutrition Risk Score

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<td>Repeat MUST score monthly</td>
<td>Repeat MUST score and monitor weight at least monthly.</td>
<td>Repeat MUST score and monitor weight at least monthly.</td>
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<td></td>
<td>Encourage small frequent meals and snacks with high energy and protein food and fluids. Aim for an additional 400-600 kcals per day (See overleaf for suggestions).</td>
<td>Encourage small frequent meals and snacks with high energy and protein food and fluids. Aim for an additional 400-600 kcals per day (See overleaf for suggestions).</td>
</tr>
<tr>
<td></td>
<td>Document food and drink intake for 3 days.</td>
<td>Document food and drink intake for 3 days.</td>
</tr>
<tr>
<td></td>
<td>Offer over the counter powdered nutritional supplements made up with full fat milk or homemade fortified milky drinks if still losing weight after two weeks.</td>
<td>Continue to offer homemade fortified milky drinks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If still losing weight after two weeks ask GP to refer to the dietitian.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Where prescribed, give oral nutritional supplements between meals until target weight is reached or until the 3 month GP review.</td>
</tr>
</tbody>
</table>

Please complete and detach the section below, for sending to the Surgery in addition to the normal repeat request

Oral Nutritional Supplement Repeat Request - Supporting Information

To: Surgery Name
From: Care Home
Requestor Phone Number

For: Patient Name
NHS Number
Today’s Date
GP Name

Dietician’s treatment goal
Current Measurements
Last Month’s Measurements

Target Weight (kg) Current Weight (kg) Last Month’s Weight (kg)

or

Target BMI Current BMI

Current MUST score

FOR GP PRACTICE USE ONLY

☐ RE-ISSUE ☐ TARGET MET DO NOT ISSUE ☐ REFER TO GP
Extra CALORIES can be added to food and drinks by adding high calorie ingredients – here are some suggestions: Fortified milk: 1 pint full fat milk whisked with 4 heaped tablespoons skimmed milk powder provides 580 kilocalories

<table>
<thead>
<tr>
<th>Cheese *</th>
<th>Skimmed Milk Powder</th>
<th>Sugar, Jam or Honey*</th>
<th>Extra Fats* (Butter, Margarine, Oils or Mayonnaise)</th>
<th>Double</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small matchbox size piece 125kcal</td>
<td>One heaped Tablespoon 50kcal</td>
<td>One heaped Teaspoon 20kcal</td>
<td>One heaped Teaspoon 35kcal</td>
<td>One heaped Tablespoon 70kcal</td>
</tr>
<tr>
<td>Sauces – aim for milky/creamy sauces</td>
<td>Breakfast cereals</td>
<td>Cereal or porridge</td>
<td>Mashed potato</td>
<td>Sauces and Soups</td>
</tr>
<tr>
<td>Pasta dishes</td>
<td>Porridge</td>
<td>Puddings</td>
<td>Toast and bread</td>
<td>Mashed potato</td>
</tr>
<tr>
<td>Pizza</td>
<td>Mashed potato</td>
<td>Hot drinks</td>
<td>Sauces</td>
<td>Puddings</td>
</tr>
<tr>
<td>Omelettes</td>
<td>Sauces and custard</td>
<td>Milkshakes or smoothies</td>
<td>Glaze vegetables</td>
<td>Cakes</td>
</tr>
<tr>
<td>Scrambled eggs</td>
<td>Milk puddings</td>
<td>Glaze vegetables</td>
<td>Cereal &amp; porridge</td>
<td></td>
</tr>
<tr>
<td>Mashed potatoes</td>
<td>Creamy soups</td>
<td>Ice cream</td>
<td>Milshakes or smoothies</td>
<td></td>
</tr>
<tr>
<td>Beans on toast</td>
<td>Milkshakes or smoothies</td>
<td></td>
<td>Fruit</td>
<td></td>
</tr>
</tbody>
</table>

*seek advice if previously advised to limit intake of fats and sugars.

---

**SNACKS**

<table>
<thead>
<tr>
<th>Nutritious Snacks to Encourage (over 200kcal)</th>
<th>Less Nutritious Snacks to Avoid (under 200kcal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mini pack of biscuits (e.g. bourbon 40g)</td>
<td>Plain biscuits (2 x 20g)</td>
</tr>
<tr>
<td>Thick n’ creamy yoghurt (115g)</td>
<td>Small individual trifle (105g)</td>
</tr>
<tr>
<td>Two slices hot buttered toast (each 27g bread &amp; 7g butter)</td>
<td>Jam tart (35g)</td>
</tr>
<tr>
<td>Two crumpets with butter (2 x 40g)</td>
<td>2 Cocktail sausage rolls (30g)</td>
</tr>
<tr>
<td>Handful of peanuts (50g)</td>
<td>7 boiled sweets or half packet fruit pastilles</td>
</tr>
<tr>
<td>Small block of chocolate (50g)</td>
<td>Small sandwich 1 slice bread &amp; butter with ham, cheese spread or pâté.</td>
</tr>
<tr>
<td>Matchbox size piece of cheese with 14g butter and two crackers</td>
<td>225kcal</td>
</tr>
</tbody>
</table>
## 14. Best Practice Nutritional Support for Care Home Residents

**Version Control** (To be completed by policy owner)

<table>
<thead>
<tr>
<th>Title</th>
<th>BEST PRACTICE GUIDANCE for CARE HOMES – Nutritional Support for Care Home Residents</th>
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<td>Description of policy</td>
<td>To inform healthcare professionals and care home staff</td>
</tr>
<tr>
<td>Scope</td>
<td>Primary Care setting</td>
</tr>
<tr>
<td>Prepared by</td>
<td>Prescribing &amp; Medicines Management Team – LB</td>
</tr>
<tr>
<td>Dissemination</td>
<td>Is there any reason why any part of this document should not be available on the public website? Yes / No</td>
</tr>
<tr>
<td>Approved by</td>
<td>NEL CSU Anglia Prescribing &amp; Medicines Management SMT</td>
</tr>
<tr>
<td>Authorised by</td>
<td>NEL CSU Anglia Prescribing &amp; Medicines Management SMT</td>
</tr>
<tr>
<td>Review date and by whom</td>
<td>Dec 2018 Prescribing &amp; Medicines Management Team</td>
</tr>
<tr>
<td>Date of issue</td>
<td>Dec 2016</td>
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<table>
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<th>Date</th>
<th>Author</th>
<th>Status</th>
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<td>0.1</td>
<td>Dec 2016</td>
<td>PMMT</td>
<td>Final</td>
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<td>0.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
15. ONS Pathway

Guidelines for Food Fortification & Use of Oral Nutritional Supplements (ONS) in Adults – Summary Pathway

**Step 1: Screen for malnutrition**
Use MUST
http://www.bapen.org.uk/pdfs/must/must_full.pdf
Ensure weight / BMI is documented in patient records

- **MUST score = 0**
  - No risk factors
  - Low Risk

  If taking ONS review need and consider stopping

- **MUST score = 1**
  - 1 risk factor
  - Medium Risk

  *Step 2: Food First*
  Give Food First Advice [Click here for resources](#) on fortifying food
  Review after 2-4 weeks. If weight has not stabilised or increased proceed to **Step 3**.
  Ensure weight / BMI is documented in patient records

- **MUST score = 2**
  - 2 risk factors
  - High Risk

  *Requests for ONS for care home residents*
  Cares should complete assessment form to inform GP of malnutrition risk and for repeat request for ONS (see [Best Practice Bulletin 21](#)). ONS should not be prescribed to care home residents as a substitute for food.

**Step 4: Refer to Dietitian***
Ensure steps 1 – 3 have been followed
A prescription for ONS may be initiated by GP for the interim period – ensure 1st prescription for max. 7 days to ensure palatability and reduce waste – see recommended products.
*May not be appropriate for palliative care patients: GP should use clinical discretion in prescribing appropriate, short terms ONS

**Step 5: Prescription of ONS on advice of Dietitian**
Check patient preference for flavours as per Dietitian examples. Continue fortified food.

---

**Key Points:**
- ONS should only be prescribed if ACBS criteria is met see [Drug Tariff Part XY Borderline Substances](#)
- Weight/BMI must be recorded prior to initiation of ONS
- Starter packs with various flavours are available
- Prescriptions should only be re-authorised and re-issued if current weight is recorded
- Usual quantity is one supplement twice a day between usual meals – ensure directions are specific
- Desserts and yogurt style drinks are not recommended

---

**Step 3: Food First & Over the Counter Supplements**
These can be purchased in most chemists and supermarkets – sachets which need to be mixed before use so are only suitable for patients with carer support or who can make it up themselves
Review after 2-4 weeks
If weight has not stabilised or increased go to **Step 4**.
Ensure weight / BMI is documented in patient records

---

**Review after 3 months:**
Ensure weight / BMI is documented in patient records
Current weight should be provided by patient – carer every 3 months before a prescription for ONS can be re-authorised and re-issued by GP Once discharged from Dietitian care, continue to assess malnutrition status and review ongoing need for ONS every 3 months – stop if patient has resumed adequate dietary intake and weight maintenance
18. ONS pathway

**Step 3: Over the counter supplements not for FP10 prescriptions**

These can be purchased in most chemists and supermarkets. The most common ones are listed below and typically less than £1 per sachet.

<table>
<thead>
<tr>
<th>Supplement</th>
<th>Volume per serving when made up</th>
<th>Approx. calories per serving when made up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meritene Energis soup (made with water)</td>
<td>150ml</td>
<td>207kcal</td>
</tr>
<tr>
<td>Meritene Energis shakes (made with full fat milk)</td>
<td>200ml</td>
<td>240kcal</td>
</tr>
<tr>
<td>Meritene Energis shakes (made with fortified milk)*</td>
<td>200ml</td>
<td>330kcal</td>
</tr>
<tr>
<td>Complan (made with water)</td>
<td>200ml</td>
<td>250kcal</td>
</tr>
<tr>
<td>Complan (made with semi-skimmed milk)</td>
<td>200ml</td>
<td>320kcal</td>
</tr>
<tr>
<td>Complan (made with full fat milk)</td>
<td>200ml</td>
<td>380kcal</td>
</tr>
<tr>
<td>Complan (made with fortified milk)*</td>
<td>200ml</td>
<td>450kcal</td>
</tr>
</tbody>
</table>

*Fortified milk is made by whisking 4 tablespoons of milk powder into 500ml or one pint of whole milk.

**Step 4: ONS Supplements suitable for prescribing before referral to dietitian as per ACBS criteria**

<table>
<thead>
<tr>
<th>Formulary Choice</th>
<th>Comments</th>
<th>Flavour</th>
<th>Volume per serving</th>
<th>Calories per serving</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First line: Milk based powder shake</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foodlink Gluten-</td>
<td>Free. Contains lactose. Various nutritionally complete. 200ml</td>
<td>57g whole</td>
<td>386kcal (made with milk)</td>
<td></td>
</tr>
<tr>
<td>Complete Not</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Second line: Milk based sip feed</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Altraplen Compact</td>
<td>Milksheke style. Nutritionally complete. Gluten free.</td>
<td>Various</td>
<td>125ml</td>
<td>300kcal</td>
</tr>
<tr>
<td><strong>Juice style sip feed: Option where milk based supplements are not acceptable to patient. Not suitable for diabetics. Contain 30% less protein than milk based.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fresubin Jucy</td>
<td>Lactose, gluten and fat free. Minimum pack size 4x200ml</td>
<td>Various</td>
<td>200ml</td>
<td>300kcal</td>
</tr>
</tbody>
</table>

**Step 5: ONS Supplements suitable for prescribing on recommendation of dietitian only**

High calorie supplements containing ≥2kcal/ml should be prescribed on recommendation of a dietitian. **Modular supplements** such as Calogen, Fresubin 5kcal shot, Procal shot are either high fat, high carbohydrate or high protein supplements and are not nutritionally complete, therefore should only be prescribed on recommendation of a dietitian.

<table>
<thead>
<tr>
<th>Product</th>
<th>Comments</th>
<th>Flavour</th>
<th>Volume per serving</th>
<th>Calories per serving</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Calorie Supplements</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fresubin 2kcal drink</td>
<td>Nutritioally complete Gluten- and lactose free in neutral flavour.</td>
<td>Various</td>
<td>200ml</td>
<td>400kcal</td>
</tr>
<tr>
<td>Altraplen Protein</td>
<td>Milksheke style. Nutritionally complete. 20g protein</td>
<td>Vanilla or Strawberry</td>
<td>200ml</td>
<td>300kcal</td>
</tr>
<tr>
<td><strong>Thickened supplements for patients with dysphasia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fresubin Thickened Stage 1</td>
<td>Syrup consistency. Nutritionally complete. Gluten- and lactose free.</td>
<td>Vanilla, Strawberry.</td>
<td>200ml</td>
<td>300kcal</td>
</tr>
<tr>
<td>Fresubin Thickened Stage 2</td>
<td>Custard consistency. Nutritionally complete. Gluten- and lactose free</td>
<td>Vanilla, Strawberry.</td>
<td>200ml</td>
<td>300kcal</td>
</tr>
</tbody>
</table>
16. Palliative Care Protocol

Ambitions for End of Life Care

Care should be based on the 6 National Ambitions for End of Life Care:
(see references)
- Each person is seen as an individual.
- Each person gets fair access to care.
- Maximising comfort and well being.
- Care is co-ordinated.
- All staff are prepared to care.
- Each community is prepared to help.

Advance Care Planning

Advance Care Planning is a structured discussion with patients and their families/carers about their wishes and thoughts for the future. It includes:

- What they want to happen (DNAR, allow natural death).
- What they don't want to happen (refuse specific treatments).
- Who will speak for them (proxy or legal LPA).

Advance care planning for patients with capacity should ideally begin when the patient first arrives potentially even before they develop unstable end-stage disease.

If not completed previously, an ACP should certainly be created when the patient is added to the GSF Register. The -Thinking Aheadl documentation should be used as the basis of Advance Care Planning. A copy of the ACP should be scanned into the patient record, and the code —End of life advance care planll (Xabq2) recorded as a summary item. If changes are made to the care plan, or the patient's medical condition changes significantly, the code —End of life care plan reviewedll () can be recorded.

Advance care planning for a patient without capacity requires discussion with those who know the patient best and the Lasting Power of Attorney for Health (LPA) if there is one. The principles of Best Interests decisions on behalf of patients without capacity are set out in the Mental Capacity Act 2005 Section 4.

Consideration should be given as far as reasonably ascertainable to:

- The person’s past and present wishes and feelings (and in particular any relevant written statement).
- The beliefs and values that would be likely to influence their decision if he had capacity.

Account must be taken if practicable and appropriate to consult them, of the views of:

- Anyone named by the person as someone to be consulted on the matter in question, or on matters of that kind.
- Anyone engaged in caring for the person or interested in their welfare.

In some cases an Independent Mental Capacity Advocate may need to be involved.

In all cases, a record of the discussion and decision-making should be made using the NCC Record of Best-Interest Discussions

**Identification of patients for the Palliative Care Register** (based on GSF Prognostic Indicator Guidance, 4th Edition)

Triggers indicating that a patient is nearing the end of life:

- The surprise question — Would you be surprised if this patient died in the next few months/weeks/days
- General indicators of decline and increasing needs – decreasing function, general physical decline, advanced disease with reduced response to treatment, progressive weight loss, repeated unplanned admissions,
- Specific clinical indicators – metastatic cancer, organ failure, frailty/dementia

**GSF Needs Based Coding**

B – Green – unstable/advanced disease – months prognosis (Read code XaZbA)

C – Yellow – deteriorating – weeks prognosis (Read code XaZbD)

D – Red – final days/terminal care (Read code XaZbE)

**The Register**

Patients considered appropriate to include on the register should have the Read code XaEJE — Palliative Care added to their summary as a major item. This can be done using the Palliative Care template. They can also have the code for their GSF staging added (see above). A high priority reminder may be added to the patient home screen — On GSF Register II. The Register should consist of all patients identified with the above codes.

**Ongoing Care**

- All Red and Yellow GSF patients should be discussed at the regular MDT meeting. Clinicians should revise the GSF stage coding as the patient’s condition changes.
- A DNAR form should be completed if this has not already been done following discussion with patient/family/carers.
- Unnecessary repeat medications should be discontinued as oral intake diminishes.
- Clinical and care home staff should discuss and prepare for possible scenarios for the patient as they deteriorate.
- GSF Red patients should be seen at least fortnightly by a GP, but more often if needed. Anticipatory drugs should be prescribed for all GSF Red patients and Yellow patients near to becoming Red. The drugs recommended by the NCHC End of Life Care Guidelines will generally be used unless there are supply problems. Anticipatory medication will be written up on the NCHC Syringe Driver and Anticipatory Medication Chart.
- All patients prescribed anticipatory medication should have a care plan submitted to IC24 (Out of Hours provider) and communication to the NCHC Hub.
All staff need to be aware of the signs that someone may be approaching the end of life, and if there is any doubt advice should be sought from a more experienced colleague. Once the possibility that a person may die within the next few days or hours is recognised, this needs to be communicated clearly to the patient if appropriate, staff members and those who are important to the patient. The GP should also be informed. All decisions should be taken in accordance with the patient's current or previously expressed needs and wishes, and should be regularly reviewed and revised as circumstances necessitate.

All care should be given according to the Five Priorities of Care:

The Five Priorities of Care of the Dying Patient (from —One Chance To Get It Rightl, 2014)

Priority One – RECOGNISE The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, these are reviewed regularly and decisions revised accordingly.

Priority Two – COMMUNICATE Clear and sensitive communication needs to take place between staff and the person who is dying and those identified as important to them. This includes identifying the extent of the person’s need for information and allowing them to decline discussions regarding the possibility that they may be dying.

Priority Three – INVOLVE The dying person and those identified as important to them are involved in decisions about treatment and care to the extent that the dying person wishes.

Priority Four – SUPPORT The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

Priority Five – DO An individual plan of care is agreed, coordinated and delivered with compassion. (Including: food and drink, symptom control, psychological, social and spiritual support).

Sources and References


Thinking Ahead – My Wishes for my Advance Care Plan (NCC/SCC) http://www.greatyarmouthandwaveneyccg.nhs.uk/_store/documents/thinkingahead_informationforyou.pdf

17. Mental Health Care

Depression

Depression has a prevalence of 10-20% in elderly people in general, and up to 40% in those aged over 85y and in care home populations (National Institute for Mental Health, 2005). Risk factors for depression include:

- Social isolation
- Bereavement
- Previous episodes of depression
- Life events including moving into care home
- Cognitive impairment
- Sensory impairment
- Pain
- Disability
- Recent major illness or hospital admission
- Chronic diseases and multimorbidity
- Alcohol misuse

Diagnosis of depression in older people may be made difficult by presentation with non-specific symptoms (tiredness, insomnia, general malaise) or by predominance of physical symptoms (pain). Symptoms of depression may be attributed to —just old age! Forgetfulness as part of a presentation for depression may be misdiagnosed as cognitive impairment.

Screening for depression may be done using the two screening questions:

- During the past month have you been bothered by feeling down, depressed or hopeless?
- During the past month, have you been bothered by having little interest or pleasure in doing things?

Assessment of depression should include the following:

4. Focused physical examination if appropriate.
5. Investigations – FBC, haematinsics, TFTs, U+Es, LFTs, bone group.

Treatment of depression

- Non-pharmacological measures (see NICE Quality Standard on Mental wellbeing of older people in care homes QS 50, 2013)
  - Appropriate exercise.
  - Encourage participation in meaningful activity (quality statement 1).
  - Be enabled to maintain and develop their personal identity (quality statement 2).
• Psychological therapy
  o Consider referral to the Wellbeing Service for CBT.

• Antidepressant therapy
  o Usually SSRIs are used first-line (be aware of risk of GI bleeding and hyponatraemia).
  o Mirtazepine is a suitable second choice or if insomnia is a major problem.

• Consider referral to specialist mental health services for:
  o Psychotic depression.
  o Significant suicide risk.
  o Unclear differential from cognitive impairment.
  o Non-response to treatment.

References

Management of depression in older people: Why this is important to primary care, RCGP 2014
https://www.rcgp.org.uk/clinical.../97B6C76D1B1F4FA7924B7DBD2044AEF1.ashx

NICE Quality Standard QS50, Mental wellbeing of older people in care homes, 2013
https://www.nice.org.uk/guidance/qs50

Dementia

Disease Register

The dementia disease register will be considered to be all patients with a read code within the Dementia QOF diagnosis group. An appropriate disease code will be recorded for all patients diagnosed by secondary care and shown in the summary as a major item.

All patients with a dementia diagnosis will have at least annual review of their condition with review of their care plan.

Dementia Diagnosis

Some frail patients with obvious advanced dementia in care homes have never had a formal diagnosis made in secondary care. A diagnosis of dementia can be made with a high degree of certainty if the following criteria are met:

1. Functional impairment. The patient is no longer fully independent in relation to basic activities of daily living such as washing, dressing, feeding and attending to their own continence needs. The requirement for prompting or supervision constitutes a loss of full independence.
2. Cognitive impairment – GPCOG score <5 indicates impairment.
3. Corroborating history – staff confirm that in their opinion, the patient consistently demonstrates both functional and cognitive impairment.
4. Exclusion criteria – the patient's presentation cannot be explained in relation to the presence of acute confusional state, mood disorder or psychosis.
It is reasonable in this situation for a GP to make the diagnosis after screening bloods. Brain imaging is not necessarily required in those presenting with moderate to severe dementia (NICE Dementia Guideline). Professor Burns, the National Clinical Lead advocates a common-sense approach to GPs diagnosing non-complex advanced dementia in Care homes.

The benefits for the patient of having a dementia diagnosis include:

- Dementia annual review with review of the advanced care plan.
- Enabling the patient and family to consider whether a Lasting Power of Attorney should be applied for.
- Being aware of the risk of delirium especially with infections, hospital admission and the use of some drugs.
- Appropriate management of behaviours and provision of care support.

Dementia Referral

Patient being referred to the Memory Clinic for assessment will have screening blood tests (FBC, U+Es, LFTs, bone group, TFTs, B12 and folate, glucose) and a baseline ECG may be required.

An ECG is only indicated if the likely diagnosis is Alzheimer’s and there is a possibility that medication may be commenced.

The list below is not exhaustive but includes those patients who may need referral to Secondary Care:

- Parkinson’s Disease (PD) and suspected Lewy Body Dementia. Dementia in PD can be an extremely challenging clinical problem (the balance of Dopamine and Acetylcholine can be very tricky.
- Suspected Fronto-Temporal lobe dementia (see above).
- An atypical presentation or course.
- High risk situations, such as difficult to manage behaviour, psychosis or other risks.
- Safeguarding concerns.
- Potentially contentious legal issues.
- Associated significant psychiatric morbidity or history.
- Patients with Learning Disability (LD) (especially Down’s Syndrome patients, who have a particularly high risk of developing dementia). Assessing dementia in patients with LD requires specialist psychological input.
- Suspected alcohol related dementia.

Dementia Screening

All new residents over 75y without a previous dementia diagnosis should have Mini-Cog screening as part of their new resident assessment. Patients who score 2 or less may be further assessed by a GP using GPCOG.

Behavioural and psychological symptoms in dementia (BPSD)

BPSD include psychosis (delusions/hallucinations), depression, apathy, aggression, agitation/anxiety, sleep disturbances, vocalisations and sexual disinhibition.
The Newcastle Challenging Behaviour Team 5-stage model provides a framework for determining interventions for challenging behaviour:

- Background information (about the person, other health problems)
- Triggers
- Facts about the behaviour
  - Identifying the person’s needs
- Devising interventions

Management of BPSD should include the following:

1. Exclude delirium e.g. UTI, chest infection
2. Consider possible causes:
   - Pain
   - Anti-cholinergic burden
   - Undiagnosed underlying illness
   - Environmental factors
   - Depression and anxiety
3. Treat any underlying cause
4. Apply watchful waiting and non-drug interventions (e.g. distraction, one-to-one care, activity, leave and return, music, etc)
5. Consider pharmacological therapy for psychosis, depression or severe distress, or where there is immediate risk of harm to the person or to others.

Drugs to consider for treatment of BPSD include:

- SSRIs (depression, anxiety, apathy)
- Risperidone (psychosis, aggression, severe agitation/anxiety)
- Hypnotics (poor sleep)
  Antipsychotics should be avoided where possible in Alzheimer’s disease, vascular dementia or mixed dementias. Discuss risks vs benefits (sedation, risk of stroke, worsening cognition) and consider other cerebrovascular risk factors.

Risperidone is the only antipsychotic licensed for use in dementia. Initiation should take place using the lowest dose, ideally after specialist advice and be titrated up after 2-4 days according to response. Treatment should be reviewed after no more than six weeks. If symptoms are controlled, then stepping down may be attempted cautiously after 6-12 weeks. Patients on longer periods of treatment should be reviewed every three months.

References


Managing behavioural problems in people with dementia, NELCSU
http://nww.knowledgeanglia.nhs.uk/prescribing_nhsn/antipsychotics_dementia.pdf
Mini-Cog™
Instructions for Administration & Scoring

ID: __________________ Date: __________________

Step 1: Three Word Registration

Look directly at person and say, “Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now.” If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies. For repeated administrations, use of an alternative word list is recommended.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Banana</td>
<td>Leader</td>
<td>Village</td>
<td>River</td>
<td>Captain</td>
<td>Daughter</td>
</tr>
<tr>
<td>Sunrise</td>
<td>Season</td>
<td>Kitchen</td>
<td>Nation</td>
<td>Garden</td>
<td>Heaven</td>
</tr>
<tr>
<td>Chair</td>
<td>Table</td>
<td>Baby</td>
<td>Finger</td>
<td>Picture</td>
<td>Mountain</td>
</tr>
</tbody>
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Step 2: Clock Drawing

Say: “Next, I want you to draw a clock for me. First, put in all of the numbers where they go.” When that is completed, say: “Now, set the hands to 10 past 11.” Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: “What were the three words I asked you to remember?” Record the word list version number and the person’s answers below.

Word List Version:________ Person’s Answers: ____________________ ________________

Scoring

<table>
<thead>
<tr>
<th>Word Recall: ______ (0-3 points)</th>
<th>1 point for each word spontaneously recalled without cueing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clock Draw: ______ (0 or 2 points)</td>
<td>Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.</td>
</tr>
<tr>
<td>Total Score: ______ (0-5 points)</td>
<td>Total score = Word Recall score + Clock Draw score. A cut point of &lt;3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of &lt;4 is recommended as it may indicate a need for further evaluation of cognitive status.</td>
</tr>
</tbody>
</table>

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References


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18. Mental Capacity

The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The Act makes the presumption that an adult has the capacity to make decisions for themselves unless it can be shown that they lack capacity to make a particular decision at the time a decision needs to be made.

The five statutory principles in the Act are:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made in his best interests.
5. Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

There is no such thing as "general lack of capacity." Capacity must be assessed in relation to making a particular decision at the time it needs to be made.

Assessment of capacity

Two-stage test of capacity:

1. Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (This can be temporary or permanent).
2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Components of the assessment:

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to the decision?
- Can the person communicate their decision?

An assessment that a person lacks capacity to make a decision must never be based simply on:

- Their age
- Their appearance
- Assumptions about their condition
Any aspect of their behaviour

Lack of capacity to make a particular decision at the time it needs to be made needs to be demonstrated on the balance of probabilities.

A person must be able to retain information in their mind for long enough to use it to make an effective decision. If it can only be retained for a short while it must not automatically be assumed that they lack the capacity to decide.

Recording the assessment:
- Be clear about the decision being assessed
- Evidence each element of the assessment
- Ensure concrete details of choices are available
- Identify the salient details the person needs to understand
  - Demonstrate measures taken to promote the person’s ability to decide
- Indicate why this is a lack of capacity rather than an unwise decision

Best interests

Any act for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person’s best interests.

Checklist for best interest’s decision-making:

1. Encourage participation of the person
2. Identify all relevant circumstances that the person themselves would take into account if they were making the decision themselves
3. Find out the person’s views (including past and present views, any beliefs and values, previous written statements)
4. Avoid discrimination (on the basis of age, appearance, condition or behaviour)
5. Assess whether the person might regain capacity, and if so, can the decision be delayed?
6. If the decision concerns life-sustaining treatment, it should not in way be motivated by a desire to bring about the person’s death, or make assumptions about the person’s quality of life.
7. Consult other people for their views (family, close friends, carers, attorney appointed under LPA). If no one is available fitting these categories, and the decision is about major medical treatment, or where someone should live, then an Independent Mental Capacity Advocate (IMCA) must be consulted.
8. Avoid restricting the person’s rights (are here less restrictive options?)

An exception to the best interest’s principle is where someone has made a previous advance decision to refuse medical treatment.

The decision-maker for best interest’s decisions can be:
- The carer most directly involved with the person for day-to-day actions or decisions
- The doctor or other member of the healthcare staff for provision of medical treatment
- The LPA for decisions within the scope of their authority