National Patient Safety Improvement Programmes

Managing Deterioration

East Midlands Patient Safety Collaborative care home survey 2021

How are care homes supporting the care of residents when they become unwell?

Regional report

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Delivered by:

East Midlands
Patient Safety Collaborative

TheAHSNNetwork

Led by:

NHS England
NHS Improvement

Contents

This report sets out the results of a survey of care homes in the East Midlands on their use of frailty and deterioration management tools and Advance Care Planning. It also presents opportunities for improvement and what recipients were proud of in the way care is provided.

The results of the survey for the locality area are shown first, then the results for the regional area, followed by a summary of information from a separate national survey, carried out by the national patient safety team.

1 Why a care home survey?

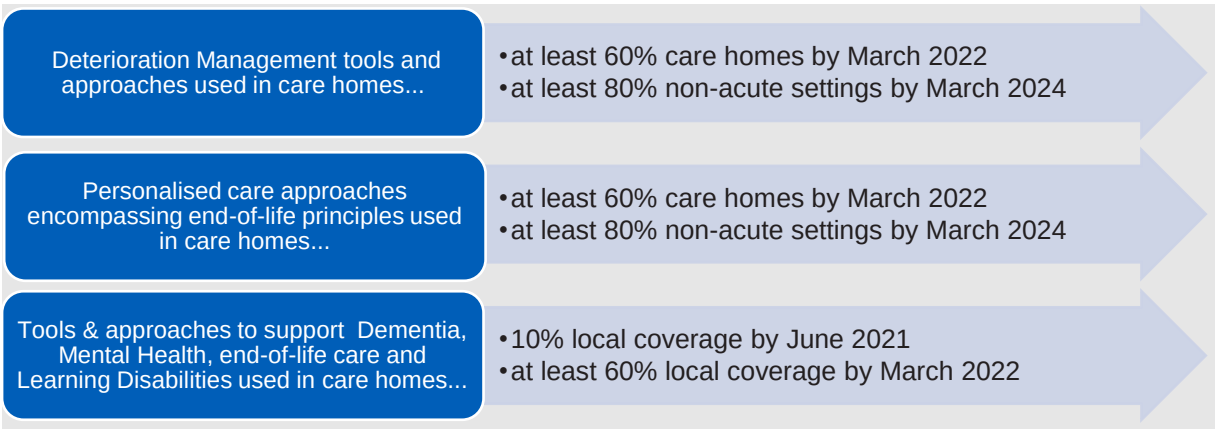
The East Midlands Patient Safety Collaborative (EMPSC) is funded and nationally coordinated by NHS England and NHS Improvement, to deliver **the National Patient Safety Improvement Programme** (NatPatSIP), a key element of **the NHS Patient Safety Strategy**. The programme's aim is to reduce error, harm, and death as a result of failures in the system, and to enhance safe, quality care.

> *Managing deterioration refers to spotting when a person's physical condition is worsening, and responding appropriately to keep them safe, and provide a positive experience of care.*

Part of the NatPatSIP is a **Managing Deterioration Safety Improvement Programme** (ManDetSIP), which includes a significant focus on the safety of care home residents. For a summary of the work the EMPSC is currently involved in to support resident safety and the quality of care in care homes, visit our website.

It is well-recognised that those living in care homes are predominately older adults with complex health needs, with the majority having multiple long-term conditions placing them at greater risk of becoming unwell and acutely deteriorating[1,2]. The ManDetSIP has a focus on safe prevention, identification, escalation, and response to physical health deterioration, in the care home setting.

The programme promotes and supports the adoption and spread of deterioration management tools and personalised care approaches to optimise safe, quality care of residents, with specific deliverables as shown below:



To build understanding regarding the current use of deterioration management and personalised care approaches in East Midland's care homes, the EMPSC carried out a

regional survey between May and June 2021. The intention is that localities will benefit from the insight this provides and alongside other locality data available, will apply it to shape locality plans for further adoption and spread.

1.1 Case studies: benefits of using deterioration management tools

Some East Midlands care homes are already using deterioration management tools and experiencing benefits for residents and carers, as demonstrated by the examples below:

Clifton View Residential Care Home, Nottingham

Care home staff felt they could recognise and understand when a resident was deteriorating but said it could be difficult knowing exactly how and where to escalate concerns. Once staff received training and implemented RESTORE2, they reported feeling more confident escalating concerns regarding a resident's condition.

"It creates an easy-to-follow plan which fills the staff with confidence."

Beech House Care Home, Worksop

"Betty was not her usual self, she was lethargic, leaning to her left side and looked very pale. We took our emergency procedure file and RESTORE2 documents to Betty's room and took a full set of observations - her NEWS score was 5.

"Betty had an Advance Care Plan in place which stated that she was not for admission to hospital and for us to liaise with her GP surgery. We took immediate action and requested an emergency visit.

"An Advanced Care Practitioner (ACP) attended and diagnosed Betty with a chest infection and antibiotics were prescribed. The ACP commented how helpful the documentation was in assisting her response.

"Due to using the RESTORE2 tool, a visit from a health professional was organised in a timely manner with the antibiotic sourced in few hours.

"We continued taking observations and noticed the difference in Betty over the space of 48 hours."

Wyngate Residential Care Home

“A couple of weeks ago, a gentleman fell ill. His observations were done and given to the staff on 999.

“Around 20 minutes later, his oxygen levels dropped drastically and when 999 were informed, they upped his category to urgent and ambulance crews were here shortly after. The staff felt they and Whzan had played an important role, the gentleman was in hospital for three weeks.”

2 The survey

The survey was co-designed with managers from four East Midlands care homes who completed the initial draft survey and gave feedback regarding ease of use and any improvements that could be made. The survey was updated in response and then the same managers completed the final version to ensure it was suitable for the intended audience.

Once the survey format was finalised, locality leads supported distribution utilising care home newsletters, social media channels, weekly care home bulletins and emails. The EMPSC provided content to highlight the purpose, process, and desired outcome for the survey and contact details for the EMPSC team, should care homes need any assistance in completing it. It also included a reminder email template, social media wording and images that could be used alongside any narrative.

This approach was positively received as it supported smooth and consistent distribution across the region. Each locality lead informed the EMPSC of the date of distribution and the number of care homes the survey was sent to.

The survey was initially open for four weeks from 24 May – 25 June 2021. An extension of one week was given due to some locality requests. The East Midlands PSC have worked together with analytics colleagues to produce this regional and individual locality report.

2.1 Survey questions

The survey was formatted into sections, each of which had an introduction to explain the domain being considered.

- Care home information
- Frailty scores
- Recognising and managing deterioration
- Advance care planning
- Challenges and successes

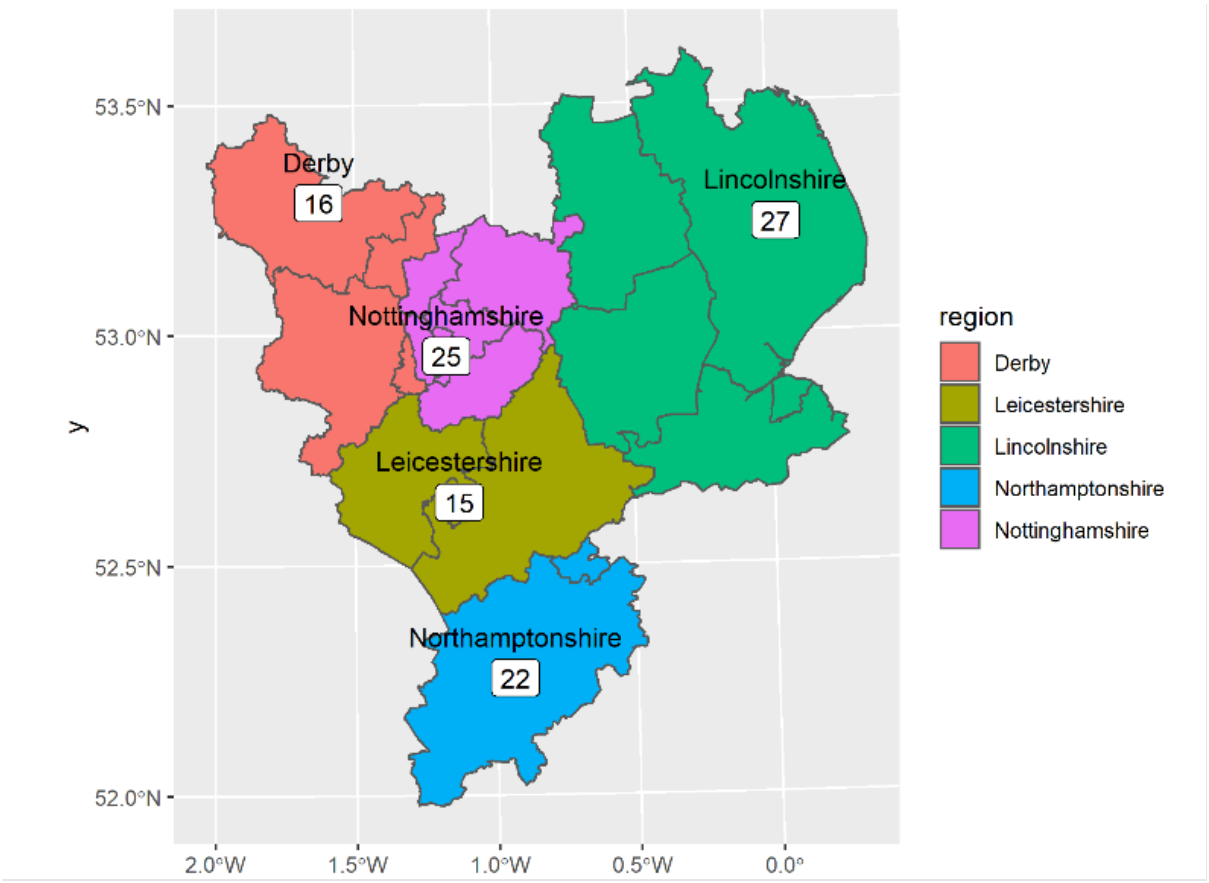
The questions are shown in Appendix 1.

3 East Midlands regional findings

3.1 Respondents

The East Midlands has approximately 1,448 care homes (CQC website, August 2021) including care homes with nursing and residential care. The EMPSC care homes survey was distributed to 1,119 East Midlands care homes for completion. 105 completed surveys were received, providing learning specific to 9.4% of survey recipients and 7% of East Midlands care homes overall.

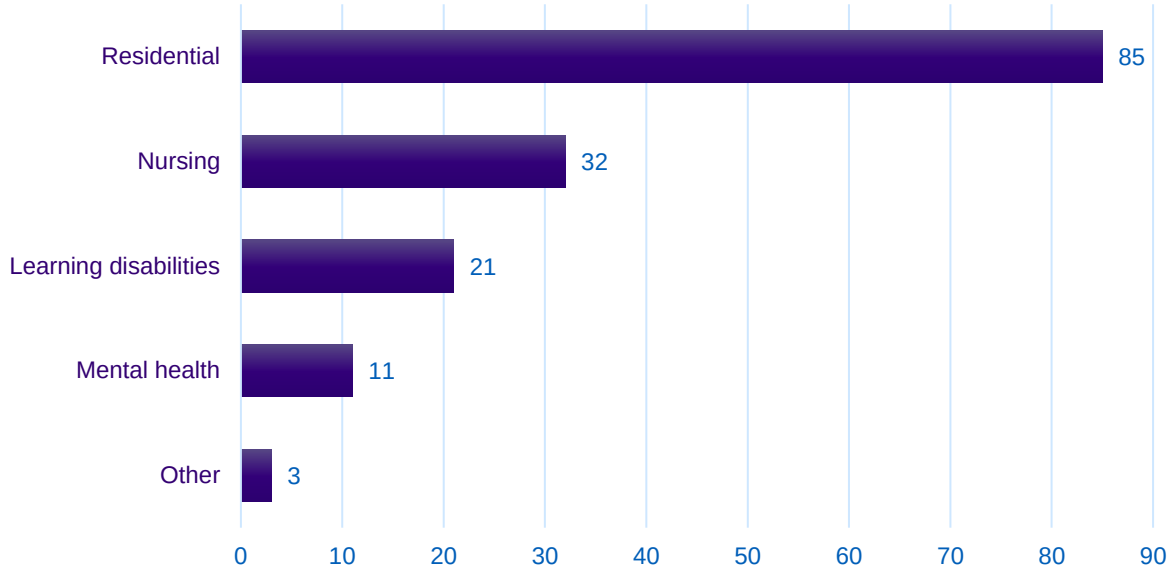
Of the 105 respondent care homes, 61 were part of a group. Each locality returned between 15-27 completed surveys, averaging a locality response rate of 22.



Number of locality survey responses from each area

A variety of care home types were represented, with some care homes noting more than one area of speciality as shown in Graph 1.

Graph 1: Respondent care home types



3.2 Recognising and managing frailty

The survey showed that 24 (23%) care homes routinely undertook frailty scores for their residents, with the Edmonton Frailty Scale most commonly used.

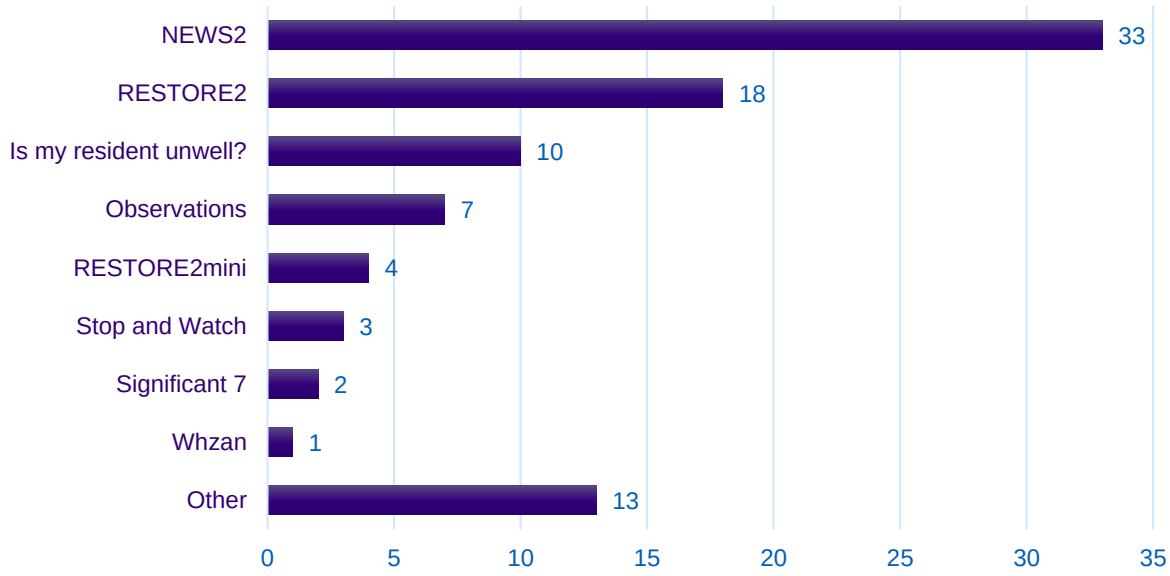
Of the homes who carried out frailty assessments, 17 did so on admission, 9, every six months, and 6 carried out the assessment after a resident returned from having been hospitalised (Graph 2).

Graph 2: Frequency of undertaking frailty assessments

3.3 Recognising and managing deterioration

Out of the 105 care homes that took part in the survey, 70 (67%) reported using deterioration management tools to aid the recognition and management of deterioration in residents. Care homes reported use of a variety of deterioration management tools (Graph 3).

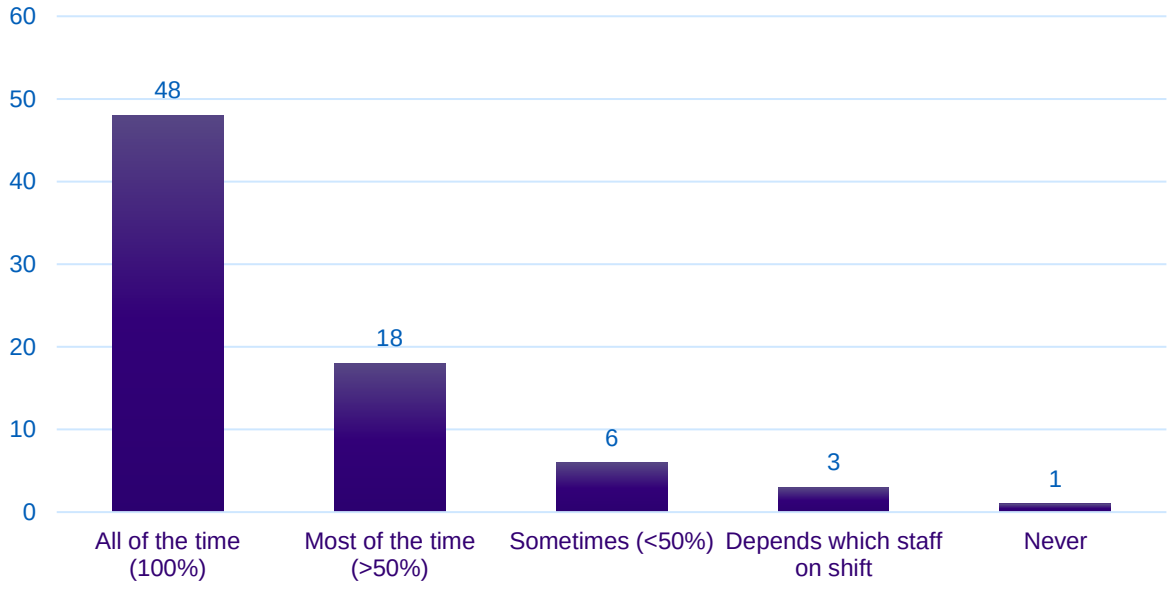
Graph 3: Deterioration management tools used in care homes



NB When care homes highlighted both RESTORE2 and NEWS2, this was re-classified as RESTORE2 only.

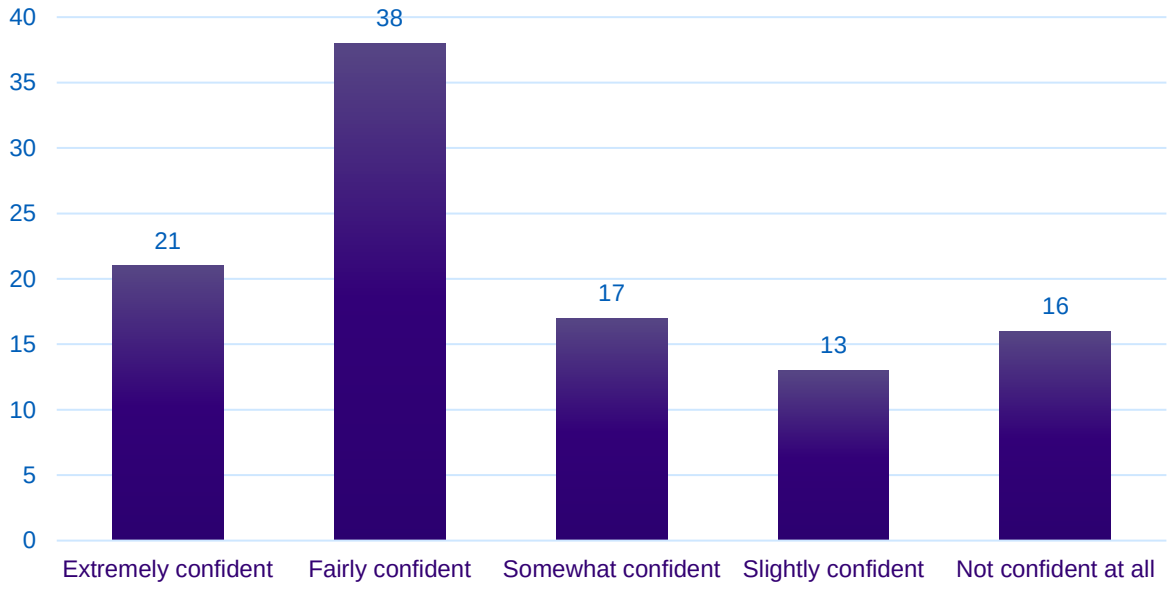
Of those that use deterioration management tools, 48 (46%) said they used them every time a resident became unwell, 18 (17%) most of the time and 6 (6%) less than 50% of the time (Graph 4).

Graph 4: How often deterioration management tools are used



Of the 105 care homes that took part in the survey, 24 had received training on the use of deterioration management tools during the last 12 months. Reported levels of confidence in using deterioration management tools was variable, with 56% feeling extremely or fairly confident, while 44% reported lower confidence levels (Graph 5).

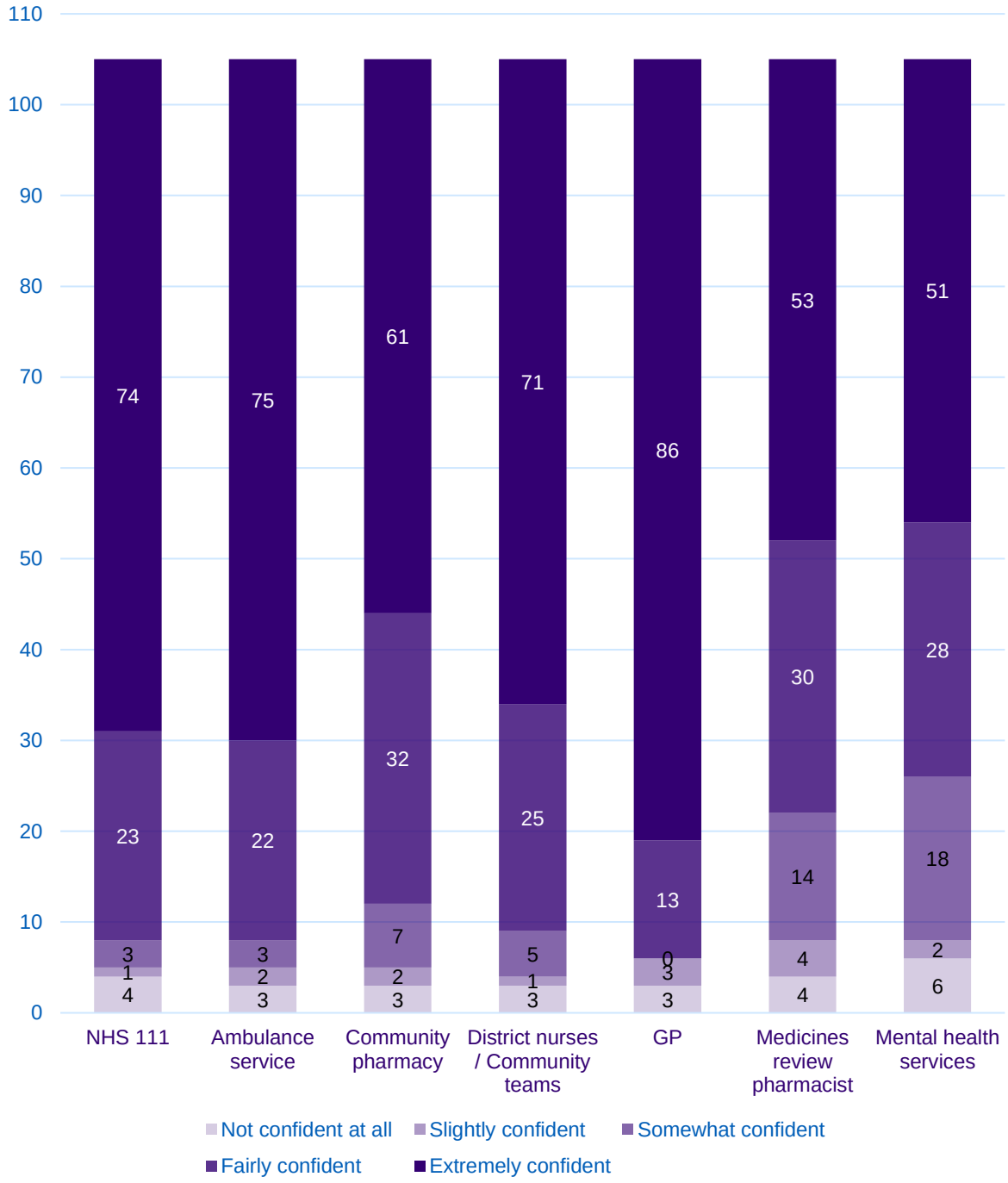
Graph 5: Confidence in using deterioration management tools



When residents become unwell and their needs require escalating outside of the care home, 56 care homes reported use of a communication tool with 38 using SBAR(D), 5 using RSVP and 13 indicating another tool, not listed.

Levels of confidence in escalating residents' deteriorating health needs varied across provider services, as demonstrated in Graph 6. The respondent group of care homes were most confident when escalating concerns to GP, Ambulance and 111 services, and least confident when escalating to the medicines review pharmacist and mental health services.

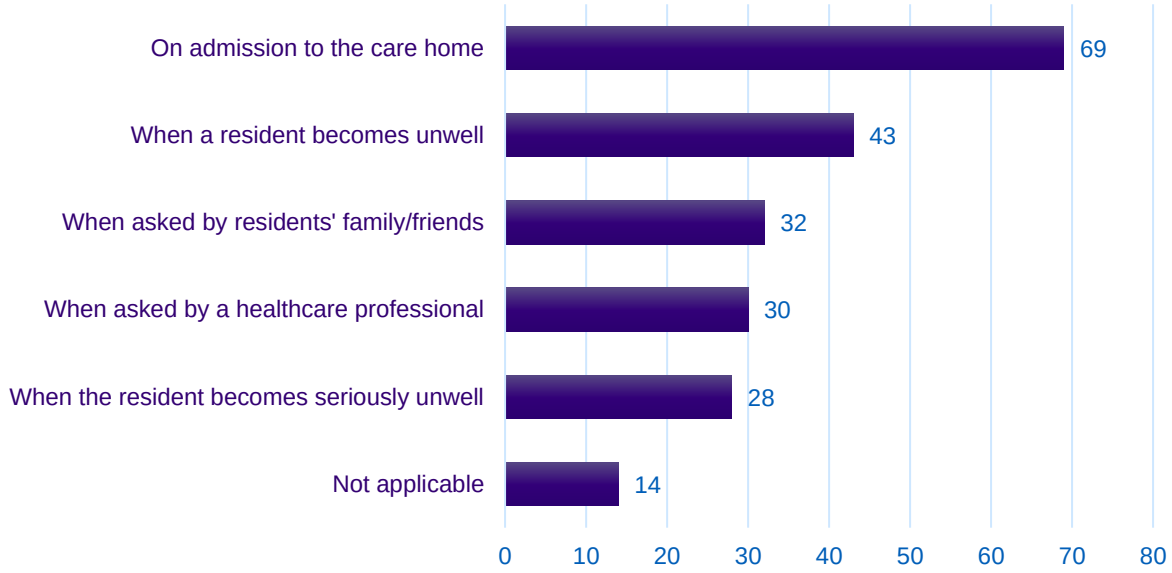
Graph 6: Staff levels of confidence when escalating residents' health needs to services



3.4 Advance Care Planning (ACP)

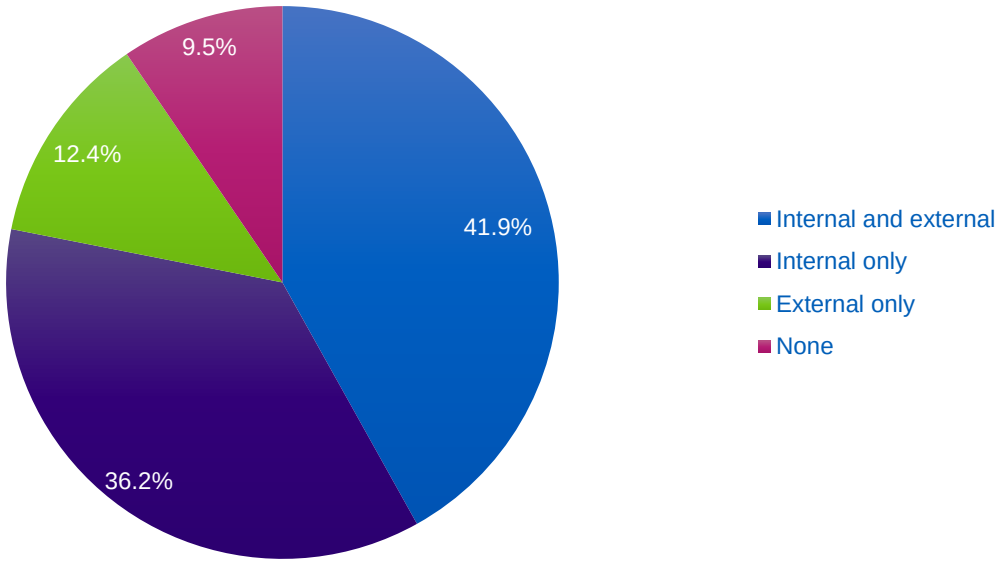
When asked, 75 (71%) care homes said they routinely undertook ACP, displaying a variety of occasions when this took place during a resident's stay. Of the care homes using ACP, the two most common times to do so were on admission or when a resident became unwell (Graph 7).

Graph 7: When ACP is completed for residents



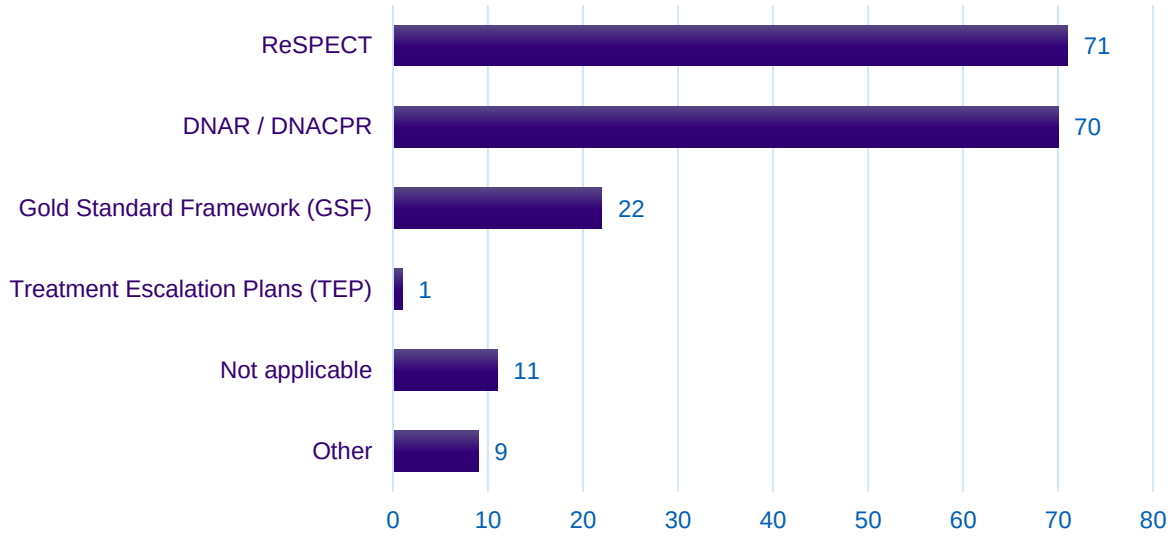
A variety of internal and external staff held responsibility for undertaking ACP, with 44 (41.9%) involving both internal and external staff to the care home, in Advance Care Planning (Graph 8).

Graph 8: Who has responsibility for undertaking ACP



When asked about what type of documentation was used to record residents' resuscitation decisions, the majority of care homes reported using ReSPECT and DNAR/DNACPR, with 22 care homes using the Gold Standard Framework (Graph 9).

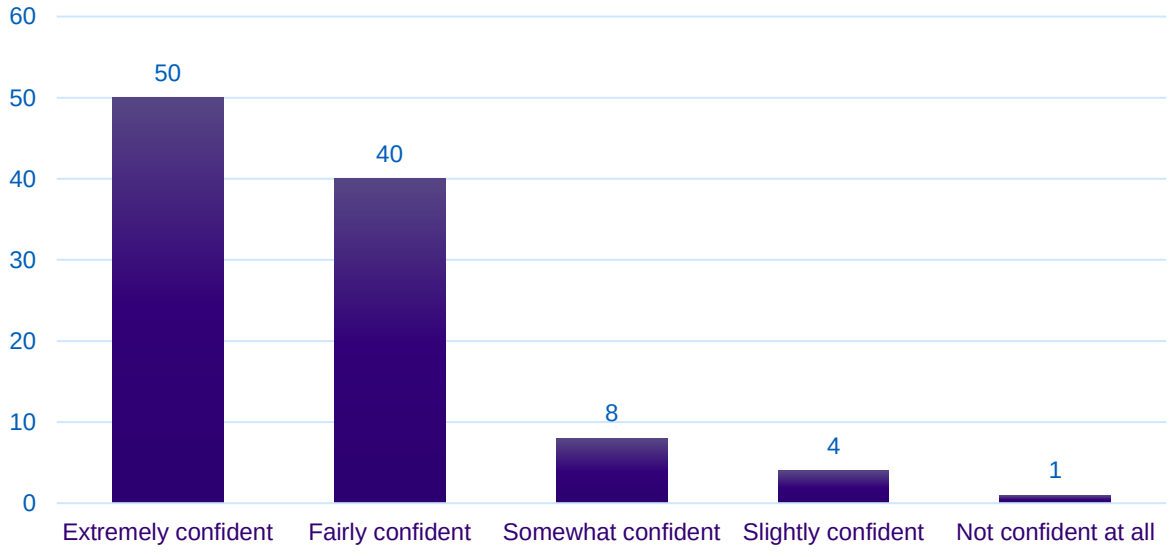
Graph 9: Type of documentation used to record residents' resuscitation decisions



NB Care homes may have specified multiple types of documentation. 50 sites selected both DNAR / DNACPR and ReSPECT.

When care homes were asked, *'How confident are you that as a care home you are able to follow residents' wishes as recorded on their Advance Care Plan as much as you would like?'* most responses stated extremely or fairly confident (Graph 10).

Graph 10: Confidence of ability to follow residents' wishes as recorded on their ACP



Some respondents highlighted that it was made easier to follow residents' wishes when all care providers, were aware and supportive of care plans in place.

"Sometimes resident wishes are ignored by emergency services when they attend."

“My nursing team and I are irritated…
when ACP is seen as a tick box exercise…
and how individuals' wishes can be ignored.”

The importance of fully involving residents and their families in care planning was expressed:

“… care package was compiled with family and individuals wishes. This enabled the individual to be supported within the home as per the wishes of both family and individual so allowing staff to support right up to the end which was important for all concerned.”

Care homes were also asked what their priorities were for improvement and what they were most proud of in the way they provide care.

3.5 Priorities for Improvement

East Midlands care homes' priorities for improvement are represented in the word cloud below. Size of wording is reflective of the number of care home respondents that highlighted that theme.

When asked if they would like access to quality improvement (QI) training to support the delivery of safe and quality care in their care home, 80 respondents (81%) said yes.

3.6 Delivering care

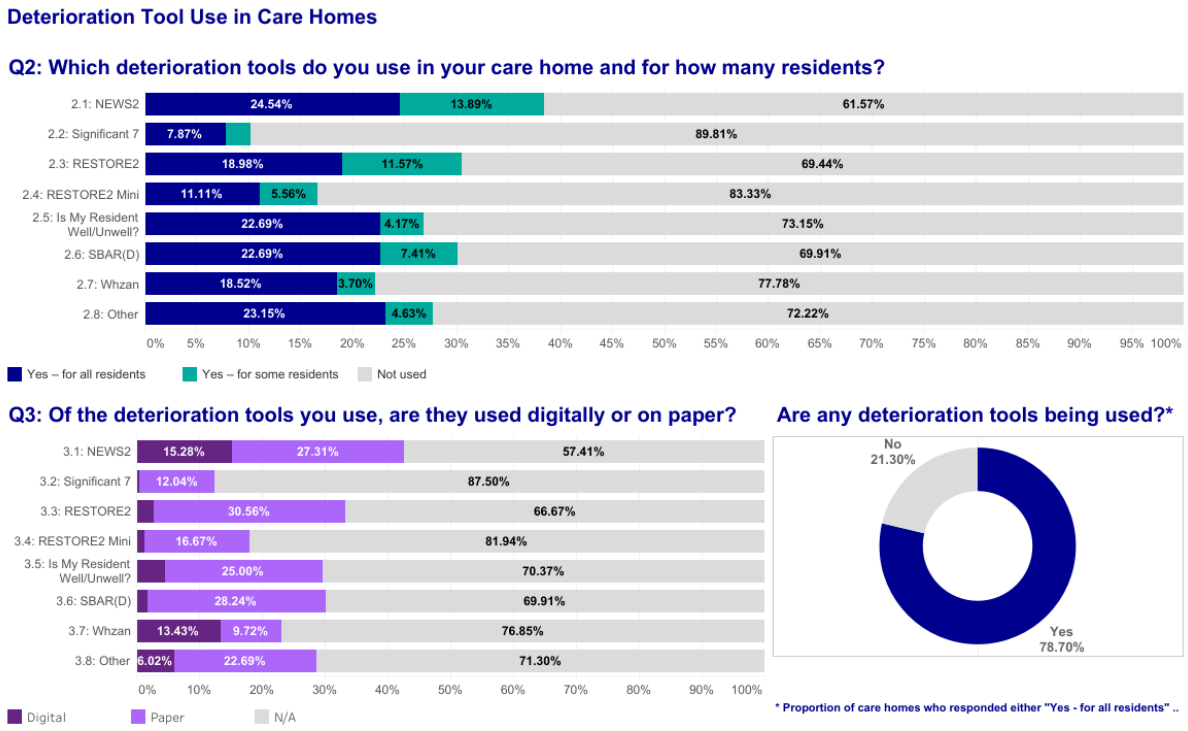
When asked about what they were proud of in the way care was provided, it was very clear from responses that care home staff felt very passionate about the care they provide for residents, with the top themes highlighted in the word cloud below:

4 National survey

In addition to individual surveys carried out by the 15 Patient Safety Collaboratives across England, the national patient safety team at NHS England and NHS Improvement also undertook a national survey of care home to understand how they are managing deterioration.

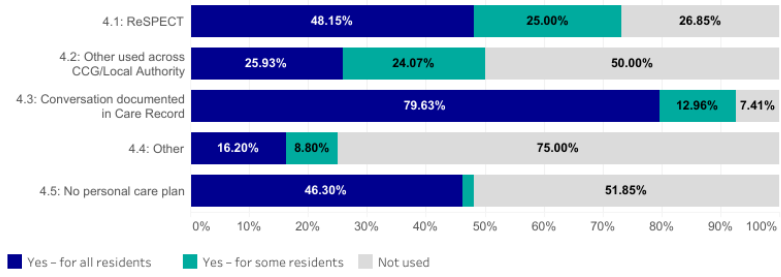
This is a selection of the findings, which we are hop are useful to add additional context to the local and regional data presented in this report.

East Midlands

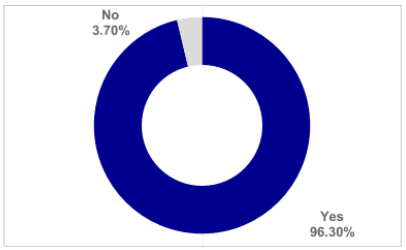


Deterioration Tool Use in Care Homes

Q4: When a resident deteriorates, please indicate which of the following personalised care plan(s) are/are not used when making decisions?

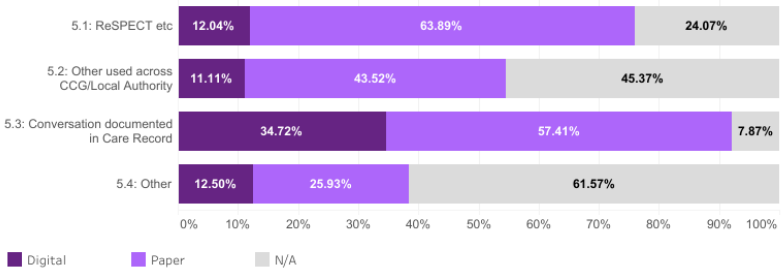


Q4: Is any form of personalised care plan being used?*

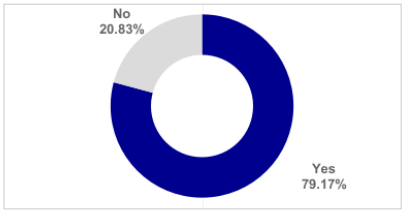


* Proportion of care homes who responded either "Yes - for all residents..

Q5: How do you record the personalised care planning?



Q6: Is the personalised care plan available to others?**

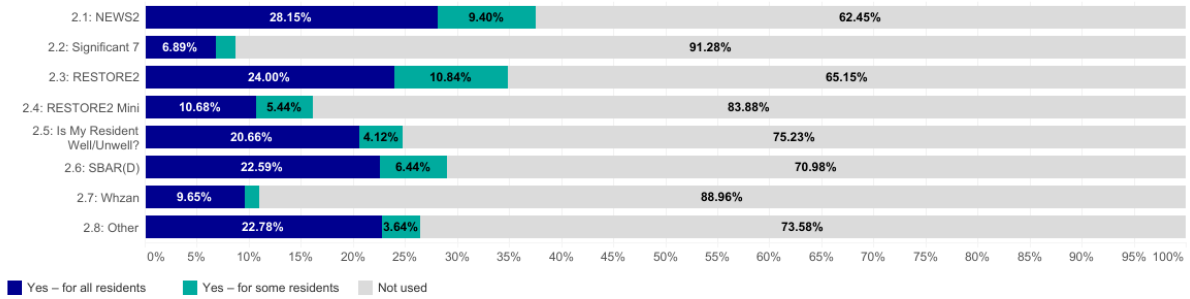


** Other health and social care professionals such as district nurses, GP's, an..

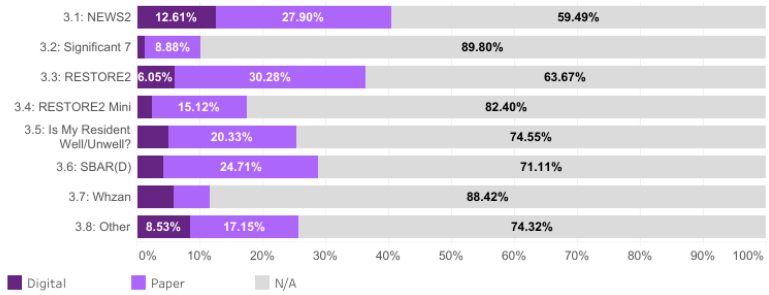
Nationally

Deterioration Tool Use in Care Homes

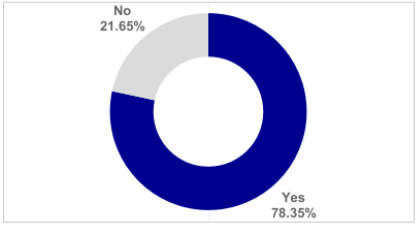
Q2: Which deterioration tools do you use in your care home and for how many residents?



Q3: Of the deterioration tools you use, are they used digitally or on paper?



Are any deterioration tools being used?*



* Proportion of care homes who responded either "Yes - for all residents" ..

Deterioration Tool Use in Care Homes

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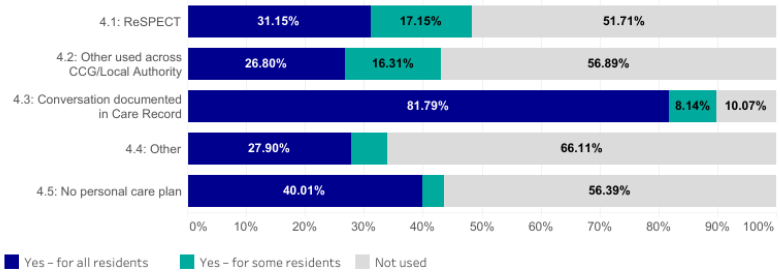

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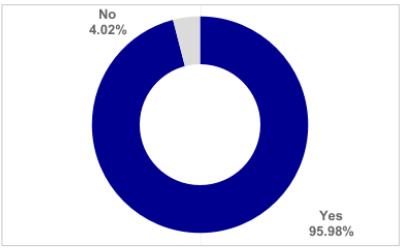

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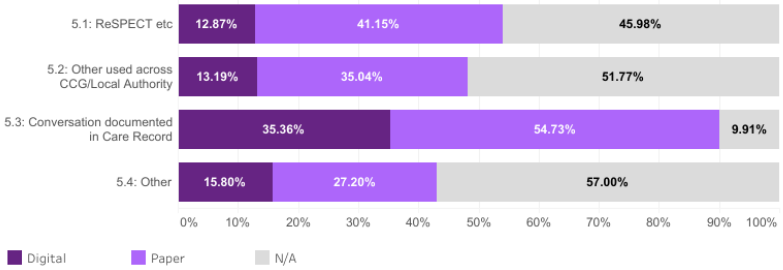
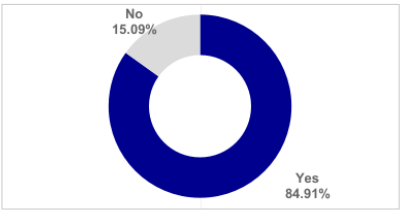


Q6: Is the personalised care plan available to others?**



** Other health and social care professionals such as district nurses, GP's, an..

5 Next steps

We acknowledge that this report reflects responses from 7% (105 out of 1,448) of the East Midlands' care homes, however we hope it remains a helpful snapshot of current practices and priorities and is useful in informing further work and locality plans.

Key areas that were highlighted by this survey, for regional consideration include:

- Use of frailty scores
- Confidence and use of deterioration management tools
- External collaboration: communication and co-ordination with other services
- Positive person-centred care

The EMPSC look forward to continuing in partnership with you in support of the aims and deliverables of the ManDetSIP and thank all those that distributed and/or completed the EMPSC care home survey 2021. To find out more about the support EMPSC offers care homes, please visit our website.

We hope that you have found this report of interest and that it will help inform planning and priorities for the important work of the care home sector.

6 References

1) *COVID-19: Managing the COVID-19 pandemic in care homes for older people* (British Geriatric Society, Nov 2020)

2) *Recognizing and responding to deterioration in care homes: a scoping review protocol* (Sevim Y. Hodge, Mohammad R. Ali; Adam L. Gordon, Feb 2021)

7 Definitions

Advance Care Planning	Offers people the opportunity to plan their future care and support. Including important decisions if they become ill or are dying, such as: care arrangements, funeral, and financial plans, while they have the capacity to do so.
Do not attempt cardiopulmonary resuscitation (DNACPR)	Cardiopulmonary resuscitation (CPR) is a treatment that aims to start breathing and blood flow in people whose heart has stopped beating. Some people, in conversation with their healthcare professionals, decide that they do not want to have CPR. This is called a 'do not attempt cardiopulmonary resuscitation' (DNACPR) decision.
ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)	A personalised recommendation for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. It includes a recommendation about CPR. (www.resus.org.uk/respect)
The Gold Standards Framework (GSF)	Supports health and social care teams to provide the highest standard of care for those they are caring for who are in the last years of life. Organisations can access GSF training and gain accreditation.
Treatment Escalation Plans (TEPS)	Provide the opportunity for the person and healthcare professionals to come to an agreement on the plan of care. It gives guidance on what treatments the person would receive, should their condition get worse.
NEWS2 (National Early Warning Score)	Based on six vital signs that aims to standardise detection of and response to clinical deterioration in adults.
RESTORE2	Physical deterioration and escalation tool based on nationally recognised methodologies, including early recognition soft signs, the national early warning score (NEWS2), structured communications (SBARD) and Treatment Escalation Plans (TEPS).

	(www.hampshiresouthamptonandisleofwightccg.nhs.uk/your-health/restore-official)
RESTORE2*mini*	Condensed version of the full RESTORE2 tool consisting of soft signs and SBARD structured communication.
Significant 7	Identifies signs of deterioration specifically related to skin, toilet habits, mobility, and levels of confusion.
Soft Signs	Early indicators that someone might be becoming unwell. Often evidenced by staff and family members who are familiar with a person's usual behaviour and habits.
Is my resident unwell?	12-point checklist to record changes in a person's condition and escalate concerns.
Stop and Watch	Includes prompts of what to watch out for to check if a person's condition is worsening.
Whzan	Portable monitoring equipment that measures vital signs, records photos, and performs assessments and questionnaires including NEWS2. (www.whzan.uk/blue-box)
SBARD (Situation, Background, Assessment, Recommendation, Decision) and RSVP (Reason, Story, Vital Signs, Plan)	Communication tools to raise concerns in a structured way, ensuring information is transferred between healthcare professionals to get the support needed for the patient. (www.england.nhs.uk/wp-content/uploads/2021/03/qsir-sbar-communication-tool.pdf)

Appendix 1 Survey questions

1. Name of care home

2. Which regional locality is your care home in? Tick all that apply.
- Nottingham and Nottinghamshire
- Derby and Derbyshire
- Leicester, Leicestershire and Rutland
- Lincoln and Lincolnshire
- Northampton and Northamptonshire

3. Type of care home. Tick all that apply.
- Nursing
- Residential
- Mental Health
- Learning Disabilities
- Extra Care Housing / Housing with Care
- Other

4. If your care home is part of a group of care homes, please advise the name of the group?

Frailty Scores

When we say Frailty Score, what do we mean?

The term frailty or 'being frail' is often used to describe a particular state of health often experienced by older people. It refers to a person's mental and physical overall resilience, and how this relates to their chance to recover quickly following health problems.

A Frailty Score is used to identify residents who are at increased risk of poor outcomes and who may not benefit from certain medical and care interventions. This then allows individual care planning to take place.

5. Do you routinely undertake Frailty Scores for your residents? Yes / No / Not sure

6. If yes which frailty assessment tool do you use? Tick all that apply.
- Clinical Frailty Scale (CFS)
- Edmonton Frailty Scale
- Electronic Frailty index (EFI)
- FRAIL score
- N/A

7. How often do you undertake frailty assessments? Tick all that apply.
- On admission
- Every 6 months
- After a resident is hospitalised?
- N/A

Recognising and managing deterioration

When we say Deterioration, what do we mean?

Deterioration in a resident is any signs or indication that a resident is becoming unwell.

8. Do you use any tools to aid the recognition and management of deterioration in residents? Yes/No

9. If no, is there something else you use? Please explain below.

10. If yes, how often do staff use this tool when residents become unwell?
- All of the time (100%)
- Most of the time - (more than 50%)
- Sometimes - (less than 50%)
- Depends on which staff are on shift
- Never
- N/A

11. Which tools are used in your home to help recognise and manage deterioration in residents? Tick all that apply.
- Is my resident well?
- NEWS2
- RESTORE2
- RESTORE2 mini
- Significant 7
- Stop and Watch
- Other
- N/A

12. If other, please specify below.

13. Has your care home received training on the use of a managing deterioration tool in the last 12 months? Yes/No

14. If yes, which tool has the Care Home received training on?

15. When using a managing deterioration tool, how confident would you say most staff are in general? Extremely / Fairly / Somewhat / Slightly / Not at all

16. If a resident becomes unwell and you need to escalate this outside of the care home,

which communication tools do you use to do this? Tick all that apply.

- FREED – Frailty Recognition, End of life, Escalating Deterioration
- RESTORE2 (includes SBARD)
- RSVP – Reason, Story, Vital signs, Plans
- SBAR(D) – Situation, Background, Assessment, Recommendation, (Decision)
- RESTORE2*mini* (includes SBARD)
- Other
- We don't use any formal process or tool

17. Using the scale below, how confident would you say staff are when escalating to the following services? Extremely / Fairly / Somewhat / Slightly / Not at all

- 111
- Ambulance service
- Community
- Pharmacy
- Medicines review
- Pharmacist
- District nurses / Community teams
- GP
- Mental health services

<u>Advance Care Planning</u>

Advance care planning offers people the opportunity to plan their future care and support, including medical treatment, while they have the capacity to do so.

Not everyone will want to make an advance care plan, but it may be especially relevant for:

- People at risk of losing or with variable mental capacity linked to their health condition.
- People diagnosed with a life-limiting or life-threatening health condition.

18. Do you routinely undertake Advance Care Planning in your care home? Yes/No/Maybe

19. When do you complete an Advance Care Plan for residents? Tick all that apply.

- On admission to the care home
- When a resident becomes unwell
- When the resident becomes seriously unwell
- When asked by a health care professional
- When asked by residents' family/friends
- N/A

20. Who has the responsibility of undertaking Advance Care Planning in your care home? Tick all that apply.

- All care home staff
- Care home nursing staff
- GP
- District Nurse
- Advanced Nurse Practitioner (ANP)
- N/A

21. What type of documentation is used to record residents resuscitation decisions as part of Advance Care Planning in your care home? Tick all that apply.

- DNAR / DNACPR (Do not attempt resuscitation/cardiopulmonary resuscitation)
- ReSPECT (Recommended summary plan for emergency care and treatment)
- Combination of TEP / ReSPECT
- FREED
- Gold Standard Framework (GSF)
- Other
- N/A

22. How confident are you that as a care home you are able to follow residents wishes as recorded on their Advance Care plan as much as you would like? Extremely / Fairly / Somewhat / Slightly / Not at all

23. Please provide further comments if needed to explain your answer above.

<u>Challenges and successes</u>

24. What are the three key priorities you would like to focus on for improvement?

25. What three things are you most proud of in the way your home provides care?

26. Would you like access to Quality Improvement (QI) training to support the delivery of safe and quality care in your care home? Yes/No

27. If yes, please provide contact details below.