Bridgewater Community Healthcare NHS

NHS Trust

HALTON BOROUGH COUNCIL

NHS

Halton Clinical Commissioning Group

Halton Care Home Project

Investigation into Unmet Need

Interim Report

March 2014

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CONTENTS

1. Executive Summary

Public concern for the quality and standards in Care Homes (Residential/Nursing) has been much highlighted by the media. Care homes have become increasingly marginalised from health and social services and as a result transparency has been lost and quality standards can be variable (Boseley 2012, BGS 2011, AS 2013). Care home projects have taken place across the country. Some are specialised looking at one area of health such as mental health or strokes, others are more generalised looking at whole system approaches to the way in which Health and Social services provide services for their population such as the projects in Warrington, Manchester and Halton. To avoid overlap and to utilise different skill sets, the Halton care home project has established close links with the 5 borough partnership mental health team and have developed shared objectives and initiatives such as care home training provision, care home managers coffee afternoons and an integrated approach to standardisation of patient transfer forms.

The Halton care home project found that care within all Seven care homes that were visited displayed caring attitudes to the residents that they serve. We found lots of genuinely dedicated members of staff that work incredibly hard to provide good standards of care. The problems that we have identified were mainly due to unconscious omission and we have worked with the care homes to develop safe sustainable solutions.

The Halton care home projects, on-going work has so far identified 7 key issues these include:

- Communication;
- End of life Care;
- Physical Care;
- Pharmacy;
- Equipment;
- Primary care utilisation; and
- Activity

There are several next steps that need to be implemented to create sustainable solutions for the residents of care homes. Some of the solutions needed are relatively simple changes to current services and practices and other ideal solutions involve proposing new models of care which may prove a challenge to implement but worthwhile. System and cultural changes are needed to ensure that the standards required are achieved.

2.1 Rational for care home projects

The needs of the care home population (residential/nursing) have for along time been left unrecognised and unmet by both health and social services. (Boseley 2012, BGS 2011, AS 2013). Concern about the quality of provision that is provided by residential/nursing homes has been much highlighted by the media. While most care homes are trying to provide good quality care for the residents that they serve, it has shown that care homes can be isolated, leading to variation in quality and standards. YouGov public opinion poll commissioned by the charity Alzheimer's Society found that 70% of UK Adults questioned say they would be fairly or very scared of going into a care home.

Care home populations are increasingly frail and make up the neediest population in terms of healthcare, furthermore there is a rapid increase in numbers of older adults choosing to live and die in care homes (Hockley 2010). Research has shown that residents that have been admitted to homes have complex healthcare needs, multiple long-term conditions with significant frailty most of whom have dementia and will die within two years of admission (Katz 2003, BGS 2011). Halton Bough Council (HBC) and NHS Halton clinical commissioning group (CCG) have recognised that there could be potential gaps in services for this very vulnerable client group and therefore have commissioned the Halton care home project to investigate unmet need.

Relevant demographic information for Halton can be found at Appendix 1.

The Care Homes that the project has now had input into are: Widnes Hall, St Patricks, St Lukes Beechcroft, Croftwood, Halton view and Ferndale Mews.

The Care homes have a wide range of services from social services and NHS that provide care for the residents. These include:

- GP's;
- District Nursing;
- Social workers;
- Physiotherapy;
- Occupational therapy;
- Falls;
- Dietician;
- Tissue viability;
- Speech and Language;
- Podiatry;
- Dental;
- Opticians;
- Continence Services.

2.2 National/Regional Context

There is a comprehensive range of other care home projects occurring across the UK. They have some striking commonalities with each other even though they occur in different areas and some times specialising in services from strokes to dementia.

Most care home projects including Haltons found that care homes felt isolated and marginalised from the wider health and social services systems. The projects also highlighted problems in communication and collaboration between the care homes and services.

Some local examples of care home projects are explored below.

2.2.1 Manchester

Manchester developed the Community Health Nursing home improvement programme (Shine 2010).

The team's objectives were:

- To improve communications across organisational and professional boundaries;
- To reduce the number of emergency hospital admissions from care homes;
- To reduce residents length of stay in hospital;
- To increase the percentage of residents with end of life plans;
- To increase the numbers of residents dying in the home; and
- To improve residents' nutritional states.

The programme reported that the first 3 homes achieved a 40% reduction in length of stay of their residents in hospital and 80% of residents had documented conversations about end of life issues. The project members felt that they had succeeded in changing attitudes and improved the way things work within their homes; they also feel that the culture has changed within the care home; they no longer feel that they are working in isolation as they now view themselves as part of a wider multi-disciplinary team.

2.2. Warrington

Warrington developed a year long Care Home Enhancement Project (CHEP); which aim was to use a "preventative approach to enhance health and social care for older adults which could reduce the need for unscheduled admissions into hospital from care homes in Warrington."

They piloted the scheme to 5 care homes across Warrington; after the first 8 weeks one care home pulled out which was replaced by another. They found that a significant reduction in cost could be made by reducing the hospital admissions from care homes. They used the projection of a reduction of 200 admissions per month could save £5,990,400. It is difficult

to understand how these figures were reached and whether this would be an accurate picture of the savings that could be made. They also found solutions to streamline the system and process that could result in better patient care and reduced cost, these include: timely re-banding in the community, appropriate medication changes, reduction in Ambulance call outs, shortened hospital admission, preferred place of care, reduction in GP visits to care homes, reduction in falls and preventable fractures.

They have now finished this project and the NHS Warrington CCG has concluded that there is no further funding for the project. Although the CHEP project has not been rolled out across Warrington they do have an existing GP Liaison team. This team serves residents in care homes who are registered to a Warrington GP. All telephone calls to GP's are triaged through the care home team. The team filter the calls and refer to the right practitioner. The team consists of 4 Specialist practitioners (Former District Nurses), who will visit the homes to assess, and appropriately action sudden detrition in health to confirm or exclude illness when the history of illness is not specific such as chest infection, UTI, Mobility etc.

2.2.3 St.Helens

The care home project in St.Helens commenced on 1st January 2013. The aim is to improve the quality of care, health and well-being of the residents of care homes across St.Helens by supporting existing Care Home Staff with a specialist team of clinicians. The team consists of a consultant Geriatrician, 2 Nurse Practitioners, Advanced Nurse Practitioner and an administrator.

The team go into all the care homes in St.Helens by referral from the GP only. The team offer training and development to the care home staff. They provide advice on managing their resident's long-term conditions. The Consultant Geriatrician will be able to provide advice for that individual's on-going care, although the clinical responsibility remains with the GP. No data or reports are yet available for review.

2.3 Local Context

2.3.1, 5 Borough Partnership (5BP)

The 5BP established a Care home Liaison team in January 2013. This was developed due to national and international concerns about the mental health care being provided to care home residents.

The aims were to:

- Keep residents in their current setting and reduce inappropriate hospital admissions;
- Reduce readmissions to hospital and the length of in-patient stays;

- Respond to urgent referrals within 24 hours and routine referrals within 10 working days;
- Reduce inappropriate 999 calls from care homes;
- Improve the quality of mental health care; and
- Reduce the cost of mental health care.

A dedicated multidisciplinary team was set up. The team provided timely assessments for mental health care.

- From January to May 2013, 703 referrals were received.
- 86% of referrals were assessed within the agreed time frame.
- The team found 83 patients that had a mental health problem that were previously undiagnosed (mainly dementia and /or depression).
- 136 patients had there medication reviewed, which resulted in 60 patients having there medication reduced.
- 223 review of antipsychotic medication took place in 89 cases, the medication was stopped or reduced.
- From January to May 2013, the service cost £583,301 to implement.
- The team estimate that they saved £347,571 on lower admissions; 23% lower on the same time period last year (Jan-May 2012).
- Estimated cost saving from the pharmacy reviews are £11,898.

The care home teams of Halton and 5 BP are taking an integrated approach to many of the tasks and projects surrounding care homes. The two team's compliment each other as the 5 BP team specialise in mental health and the Halton team specialise in physical health and social care. The care home liasion team have now been commisioned by Halton NHS CCG.

2.3.2 Halton Care Home Project

The care home project in Halton, was established in July 2013 and has been extended until August 2014. The projects main objective is to support care home providers to improve the quality of the care for residents and understand how the wider Health and Social Care System works for residents in Halton's care homes. This corresponds with the learning gained from the Francis report.

"People must always come before numbers. Individual patients and their treatment are what really matters. Statistics, benchmarks and action plans are tools not ends in themselves. They should not come before patients and their experiences. This is what must be remembered by all those who design and implement policy for the NHS." (Francis 2010.)

Firstly the team engaged with a wide variety of stakeholders that have input into the care homes and met the chosen home managers and visited their homes. As care homes work with a wide range of people it is important that we engaged with as many people as

possible. This has developed into a clinical reference group which is multiagency as well as multidisciplinary. We also decided to include the care home managers to strengthen the ethos of collaboration and transparency; this has created an open forum in which to discuss problems and solutions.

The project has now recruited seven care homes. All the patient case files, 410 in total, in each of the care homes have been reviewed. The care homes were visited by the team for a week per month. Each day started and ended by meeting the care home managers discussing any problems/issues that were found, as well as highlighting areas of good practice. Patients and notes were reviewed. Areas needing attention were highlighted as issues to both the care home managers and other agencies as necessary; to gain potential solutions as soon as possible.

It is important to note that all seven care homes that were visited displayed a caring attitude to the residents that they serve. We found genuinely dedicated members of staff that work incredibly hard to provide good standards of care. We were told that some of the staff were paying for courses themselves, to develop there own clinical competencies and have seen numerous small caring acts such as a hug for a resident that was upset, ensuring that the cup of tea was just right, taking time to sit and reassure a resident that was displaying anxious/confused behaviour, even though they were busy. The problems that we have identified were mainly due to unconscious omission. We have worked with the care homes to develop safe sustainable solutions.

3.0 Project Deliverables and Solutions

3.1 Issues Identified

On-going work has so far identified 7 key issues these include: Communication, End of life Care, Physical Care, Pharmacy, Equipment, Primary care utilisation and Activity.

- **Communication**

The team found good evidence of communication between other agencies that visit the home such as Dietician, Speech and Language Therapy (SALT), and the Falls Service. The care homes report good relationships and service from these agencies. **Appendix 2** shows the results of a questionnaire asking care home managers to provide feedback on services that they receive in their home. There seemed to be unnecessary delays caused to some services by the system of asking the GP to forward the referrals. This had been put in place to filter out unnecessary referrals and to inform the GP who was involved in the care. In reality the GP simply passed on the referral causing delay and more work for the GP surgery. Therefore we propose that the Care home refer direct, but inform the GP that the referral has taken place. Services that receive direct referrals have not had large amounts of inappropriate referrals.

The care homes have highlighted that GP surgeries like to be communicated with by different methods; some practices won't take telephone calls from care homes, for example asking if medication has been prescribed only like communication by fax. Others don't want them to fax repeat prescriptions; they have to take them in by hand. Registration of a resident to GP practice has been highlighted as being difficult. Registration at one single GP practice would help to ease the issues. This would provide continuity of care, develop relationships with the home and stop several different district nursing teams going in to the same care home at the same time to do tasks such as insulin's; therefore using multiple nurses when one nurse would be able to complete all the tasks. Better infection control at times when the home has an easily spread infection such a Norovirus and provide transparency residential home, for example 4 District Nursing teams dressing 1 pressure ulcer might not suspect a problem but 1 team dressing 4 pressure ulcers would.

Communication between the acute sector and the care homes have also been highlighted as an area of concern. Accident and Emergency state that they are often unaware of the base line for the patients such as if they usually present as confused or is it a new presentation; These problems can lead to the patient being admitted, while normal presentation is established. The care homes report similar confusion when the patients are discharged of not knowing what has occurred whilst they have been in hospital, as often the patient is unable to tell them, so they are unsure what the management plan for the condition is or if they have been discharged without medication, because it has been purposefully stopped or forgotten. Therefore we have set up a sub-project, which is multi agency and multidisciplinary. On the team are a discharge planning manager, 5 BP care home nursing manager, safeguarding nurse, Care home manager, Community Care Worker social services and clinical nursing lead for the Halton care home project to address this issue

The team decided to look at the information going in to and out of hospital. It was discovered that Warrington had uncovered the same problem and have developed a transfer/ discharge form. We utilized this form as a starting point and discussed with the care homes and A+E. Changes were made such as the addition of a body map, services involved with contact numbers. We also sent the form that needed to be completed for discharge with the resident attending A+E. Warrington's team highlighted the issue of the form being lost. After discussion with North West Ambulance Service it was decided to use a yellow form in a yellow folder to ensure it was as visible as possible; it was also decided to fax a copy of the form to the discharge liaison team so they could monitor the resident whilst in A+E and provide a further copy of the form if necessary.

3 Care homes were chosen in Runcorn to pilot the form, these were Croftwood, Beechcroft and Simonsfield and we decided to use Warrington hospital A+E/UCC. We did a small scale audit before the forms were utilised. The results of the self reporting data for the month of October 2013 from the 3 care homes are as follows:

- 7 admissions to Warrington Hospital in October 2013.

- The care homes reported that all residents were sent to A+E with transfer records.
- 28% of residents were discharged the same month.
- 71% of the admissions needed telephone calls from the care home to A+E post discharge for further information.
- 29% of discharges were discharged home without any information.
- All patients were admitted to a ward; therefore no residents were treated and discharged from A+E.

The form was introduced on the 1/2/14. 7 forms (in one calendar month 28 days) were successfully sent with the resident and faxed to the discharge liaison team. The forms have been completed to varying degrees of success; however all have provided useful base lines for the residents. Two residents were treated and discharged from A+E and discharge information provided. Warrington report that no discharge forms in two years have ever been completed. One completed by a consultant and the other a Staff Nurse which allowed essential information to be provided to the care home upon discharge. Also the Advanced nurse practitionerfrom the 5 borough care home liaison team (mental health) was also contacted from A+E informing her that one of her patients had been brought in to A+E and discussing changes to the medication; this was the first time this has ever occurred and was delighted to be consulted. We will continue to audit the usage of the forms over the next 2 months period and if they continue to be successful we will recommend that they are used by all care homes in Halton transferring to both Warrington and Whiston Hospital A+E. We would also like to discuss the use of the form with other close areas such as Warrington and St Helens.

Care home managers have reported that they feel isolated, not only from social services and NHS but from each other. There is a chance to meet at the provider meetings held at Runcorn Town Hall, but this is a formal format; therefore it was decided, in conjunction with the 5BP care home team, to create informal coffee morning/afternoons that create a relaxed atmosphere and that feels like a safe place to meet, share success and problems and give care home managers the mechanism to support each other. At the time of writing this report two coffee mornings have taken place and the care home managers have reported that they find them very useful. The managers have decided to meet every 2 months and will take it in turn to host.

The resident's care files that we reviewed were very large and unwieldy, therefore difficult to navigate. The amount of information needing to be included to display person centred care is very large. Numerous problems with risk assessments such as Waterlow, Malnutrition Universal Screening Tool (MUST) being completed incorrectly and problems with written communications with frequent meaningless phrases being used such as "settled in lounge" or "un-witnessed fall", plus clearly wrong information being recorded such as wrong name and fields being completed wrongly such as Sex: Unknown, Religion: Ensure. Individual errors were reported through a communication book, to the managers.

However, these problems were so numerous that it was felt that education was needed. Therefore in conjunction with the 5BP care home team it was decided to hold education sessions. We have now completed 2 dates. The days were split into two identical sessions' morning and afternoon. The first training day Halton, the care home team trained on Waterlow and pressure ulcers, MUST, Record Keeping and Documentation. 5BP trained on dementia awareness, and drugs used in dementia. 94 care home staff attended. The second education day, 54 attended and had sessions from safeguarding, falls service, pain in dementia and Behaviours that challenge. The sessions were very well received with good feed back and comments (see appendix 4). The next training day is planned for the 11/3/14 and educational sessions include:- Recognising the Dying Phase, Dementia Friends, Behaviour, Psychological, Symptoms of Dementia and Medication issues in care homes.

Missing or wrong information has been documented on patients notes, for example on one resident's notes it had been recorded that a patient had had a Myocardial Infarction (heart attack), however when the GP summery was obtained, there was no record of this, furthermore they didn't know that their resident had COPD (a respiratory disorder) and had recorded on the case notes that she had no breathing difficulties. The team have recommended that a summary of medical records is obtained for each resident containing current medication, acute medical problems and past medical history, as long as the resident consents or if the patient lacks capacity to consent, it should be obtained in the patient's best interest and documented as such.

- **End of life Care**

The team witnessed a caring attitude to patients in the last few days of life and their relatives. We witnessed arelative providing thanks for the way his mother was being cared for and staff seemed keen to ensure that the patients and relatives were comfortable and had gained timely reviews from professionals such as GP's.

Training on the end of life programme '6 Steps' has started for the homes but due to the end of life facilitator leaving his post, the programme was suspended half way through. The care home team found that care homes understanding of end of life provision has been variable. The care homes report that they have completed 3 steps of the '6 step' end of life course, but as so much time has passed they would like to start the course again.

One home had put best interests about end of life care in place without assessing capacity on that decision; their understanding was that if a patient had a diagnosis of dementia they automatically put in place the best interest, however not being able to do some activities such as cross the road safely, is very different from not having a the ability to decide what you would like to happen when at the end of your life. Therefore this was passed to the safeguarding team to investigate and the new end of life facilitator will work with them, to ensure that capacity issues have been considered and implemented.

Do Not Attempt Resuscitation (DNAR) issues need to be further understood. We have found that some orders have been put in place over two years ago and not been reviewed although on some, indefinite, has been written on them. This is a subject that we have passed to the CCG and Advanced care planner (end of life care) to gain a better understanding, as Government guidance doesn't give clear instructions on reviews and GP's by law, don't need to review. However, most literature indicates that it is good practice, if a DNAR has been in place for two years, questions should be asked, such as was it put in place appropriately and how has the patient changed during that time. Northwest Ambulance Service will request a review after 90 days if a new unified document is registered with them; this is the newly implemented document that can be transferred and used in Hospital. Clear guidelines for the residential/ nursing homes should be developed as they seem to be using it as an advanced life directive, rather than a sensible precaution when it is clear that someone is reaching end of life.

One care home is very keen to be proactive with end of life care planning, however this has resulted in when residents are admitted into the care home, the relatives are being questioned on end of life care planning within 48 hours of admission. It was documented in one resident's notes that the relatives were not ready to discuss end of life plans yet and so the carer would ask them again the week after. This has been passed to the advanced care planner (end of life care), for clarification and advice to care homes on timing for end of life discussions.

Support has been highlighted as issues within the care homes when providing care for residents requiring end of life care. We found that one care home found it difficult to obtain a syringe driver in anticipation of a residents need. The manager has recently negotiated the purchase of a syringe driver with the owners of the care home; this has not yet been received. The district nurses were willing to loan a syringe driver, but after several calls didn't have one available and another district nursing team had to be contacted. This caused significant frustration for the staff in being unable to access the necessary resources in a timely manner. Fortunately on this occasion this didn't impact on patient care.

- **Physical Care**

Several issues with physical care were noted. Some nurses were not confident in dressing wounds. One nursing home had asked the GP for advice and they said that they were told to redress the wound daily. Although the dressing choice was appropriate for the needs of that wound, dressing the wound daily was inappropriate as this increased risk of excoriation of the wound margins, increased risk of infection, and disruption of healing tissue from the wound bed; wound exudate levels were low, therefore daily dressings was not required.

One residential unit Case study detailed in Appendix 5, requested that the care home team's nurse review a resident that appeared to them to be visibly deteriorating. This patient

needed to be reviewed to many multidisciplinary teams to ensure appropriate treatment. The team were able to ensure that this occurred the same day.

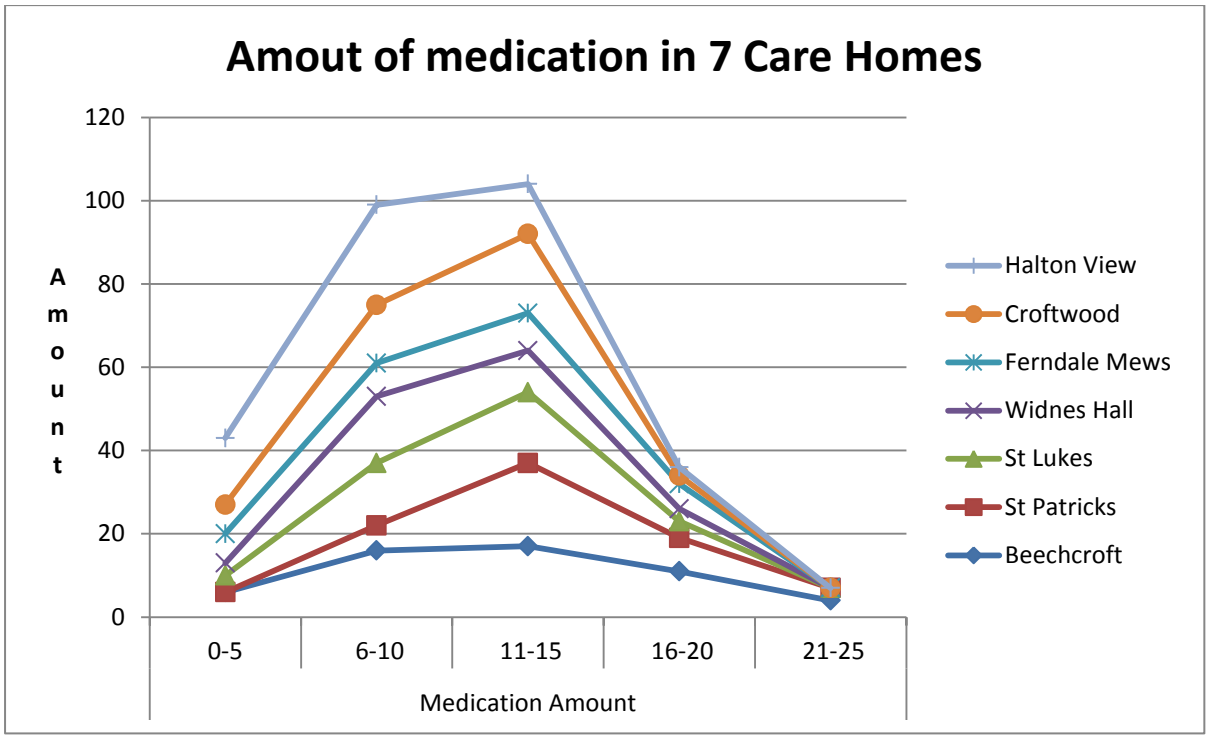
A safeguarding referral was raised for a patient with a false eye. Although the staff had noted that her eye was producing green discharge, they failed to identify that it was false and failed to provide any eye care.

The team found in one care home the optician had prescribed 20% of the resident's verifocals, for most of these residents it was inappropriate as they didn't read or do close work such as puzzles and therefore unnecessary; furthermore research indicates that there is a significant fall risk associated with adults over 65 years wearing Veri/Bifocals (Cambell, 2005). This issue was highlighted to the falls coordinator who has discussed the issue with the optician and has now reached a resolution. Now that the issue has been highlighted, the care home team will go back to all the care homes involved in the project and review the optical prescriptions.

The care home project discovered in two homes that the hairdresser's room and equipment hygiene standards were lacking. Equipment had been put away before cleaning; we found rollers/hairbrushes full of hair and skin. The drawers that they had been put away in also contained skin and hair. In one care home the floor and chair had also failed to be cleaned after use. Public Health Law requires that hairdressers and barbers operate hygienically. The hygiene standards required are listed in the bye-laws made under the local Government Miscellaneous Provisions Act 1982. Furthermore we felt that this preformed well below the standard of dignity and respect required. We advised both managers of our findings. However on return to one of the care homes, although we found the room to be overall cleaner, the equipment used was still in the same unhygienic state. This issue was then passed to Quality Assurance Team. The care home team will now inspect all hairdressing rooms in the 7 care homes involved in our project on return visits.

- **Pharmacy**

The chart below shows the numbers of medications that residents have per Care home.



The team found very high levels of medication amongst the care home residents. 84% of residents have over 6 medications, 50% of residents had over 11 medications, 12 % had over 16 medications and 7 residents were found to have over 21 medications. Polypharmacy starts to be a problem with 5 or over. This high level can produce many polypharmacy problems with drug to drug or disease to drug interactions and the older adult population tend to be more susceptible, due to the reduction in liver and kidney function, that are essential in the processing of drugs in the body. It is important to understand that polypharmacy may sometimes be necessary to control diseases but the residents should have regular medication reviews to monitor and control untoward interactions. The team found no evidence of regular reviews taking place. The problems resulting from polypharmacy can be numerous and systemic. Regular reviews particularly in the older adult population is crucial, because adverse drug reactions can often imitate other problems that are common in the older adult such as confusion, falls, incontinence, urinary retention and depression. These side effects in turn may cause a GP to prescribe further medication to treat them.

A pharmacist and a technician will soon be employed to review all patients in the 4 care homes and the pharmacy teams that are linked with the GP's are starting to look at residents that have over 15 medications. The project team have also requested that pharmacy investigate the use of Homely medications; these are products that can be obtained, without a prescription, for the immediate relief of a minor self limiting ailment. We have found that different homes have different usage and procedures. This needs to be understood and if possible standardised across the Halton care homes. A simple Google

search revealed that other CCG's across the country have recognised potential problems and have developed policies such as Oxfordshire, Gloucestershire and North Kirklees.

The homes also vary in the amount and type of stock that they hold. We found that although one care home use glass ampules, they didn't have any filter needles to filter out any glass shards. It was also found that very limited wound dressing stock was held; one home requested that a wound was assessed. There were no sterile dressing packs or dry dressings to put in place to help prevent infection while a prescription was generated, therefore this could cause further deterioration to the wound. We have asked the Pharmacy team to look into the amount and type of stock that is held.

- **Equipment**

The care homes have good relationships with physiotherapy and occupational therapy. They contract out maintenance and servicing. The care home team found that 16 residents on one unit in one care home had the slings left in place when they had been hoisted into a chair. We also found this practice in another care home on 5 residents. Leaving slings in place, especially on pressure reliving equipment can reduce the effectiveness and any folds or ridges can also cause pressure sores, as well as becoming uncomfortably hot, due to the material not being breathable. The manager explained that they were left in place due to the residents being combative or disease related contractive posture; they were therefore left in place for the protection of the resident and staff from being injured. These were valid reasons to keep the slings in place; however the risk assessments' recognising and supporting the practice had not been completed and the correct type of slings were not being used. The care home project, asked specialist Occupational Therapist (OT) to assess and advise the care home on the use of the slings and type of slings (see report appendix 6). The care homes, after the visit from OT proceeded to produce good risk assessment in the patient's notes and they were made aware of the need to replace some of the slings. The care home team asked to see the Lifting Operations and Lifting Equipment Regulations (LOLAR) reports for the slings in one care home due to the much worn nature of one of the slings; this was refused by the care home manager. This issue was then passed to the Quality Assurance Team.

The team also asked the Specialist OT to review a patient who had poor sitting balance in a chair; the lady was almost lying sideways and was unable to access drinks or reposition herself. The OT advised the Care home of a better chair to use, but couldn't find one that was perfect as the lady was small; therefore advice was provided detailing the correct size chair.

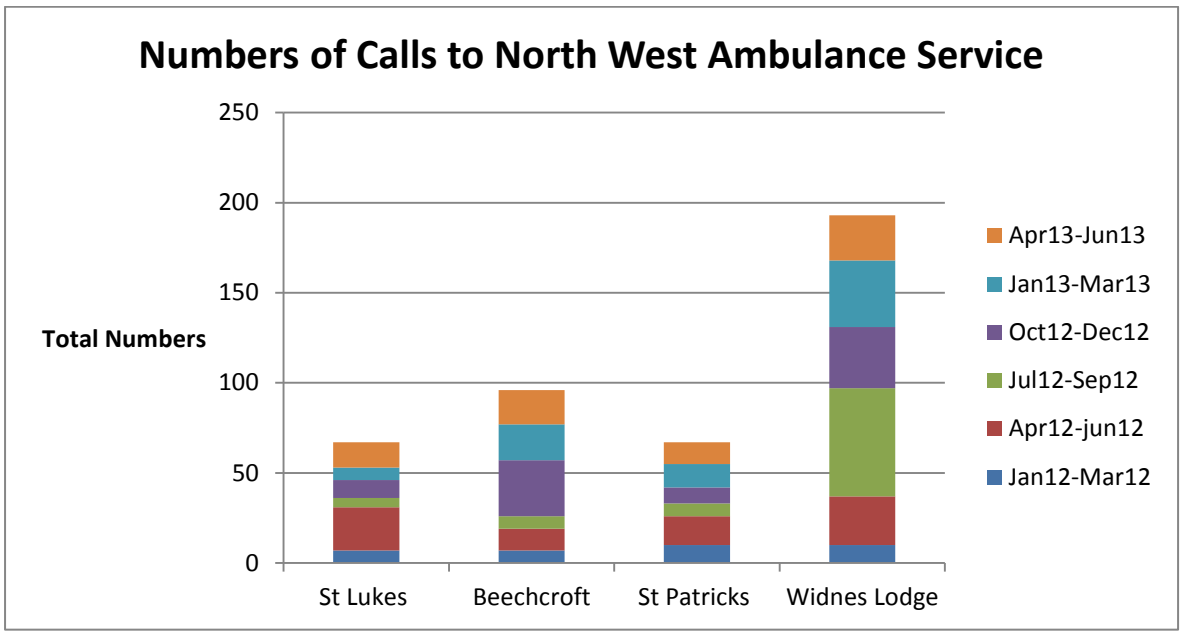
All air mattresses that we observed had been set on the wrong level for the weight of the patients. Having the setting set incorrectly can cause further problems with pressure. We found 5 set at the wrong level in one home, after discussing it with the care home manager it was decided to implement a chart with the patient's weight and the setting for the bed to

be checked each week to ensure that they remain correctly set. The same care home had also identified in residents notes that some of the residents should be using pressure reliving cushions. However when we located the residents in the lounge we found that they were not using cushions, furthermore they didn't have enough cushions for all the residents that needed them. We requested that the care home put this in place.

- **Primary care utilisation**

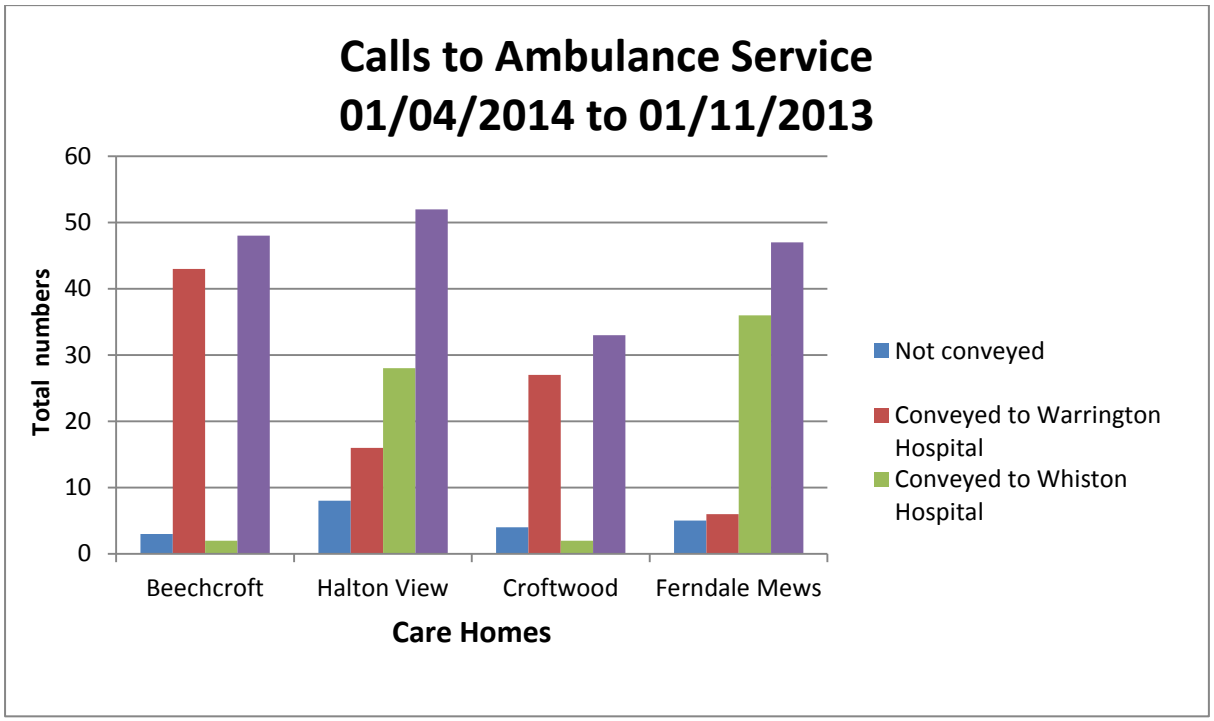
Whilst we have some data on the access to acute, primary and community care services we do not have a clear understanding of the use. Improving interventions in the community can prevent pressure on the rest of the healthcare system.

This chart below shows the number of 999 calls to the ambulance service over given time periods. It is important to note that the population size of each care home is different. Other variables that will have an effect are types of resident (nursing/residential) progression of disease and presence of nursing staff in the care home.



As patient identifiers weren't available with this data, it is difficult to know if all the patients were conveyed to hospital. Also, what happened to the patients in terms of length of stay, discharges and those that were readmitted; however, an audit of the care homes being involved with the previously discussed patient transfer form (see appendix 7) will provide further information and a clearer picture.

During phase two, NWAS were able to provide information on how many residents were conveyed to hospital.



- **Activity**

There was a lack of activity in all the care homes we visited. The team only observed one care home having regular activity; regular and additional programmes of activity are necessary for resident's wellbeing. One to ones observed were not utilised to the full capacity and often just involved sitting in front of the television with the resident that they were tasked to care for. Physical activity such as yoga for the more capable residents and Chair based exercises would be useful and training for care home staff to be able to provide these sessions for their residents. Exercises for the brain need to also be catered for such as bingo, board games, animal therapy, crafts along side the usual aromatherapy, beauty therapy etc. Education for residents (for those cognitively able) and care staff on bone health, healthy diets and smoking cessation advice for those willing and able to participate would be helpful. Quite a few of the care homes have offered rooms and venues for meetings.

The project approached the Health and Wellbeing Service Steering board to see if any of the members had any ideas and resources to aid in further enrichment activity. It proved to be a very favourable meeting with several people coming forward with offers to help.

We have started working with the intergenerational project (health improvement team) linking care homes with schools for mutually beneficial activities; it is starting with a pilot at one of the care homes we have suggested and a school the health improvement team have approached. Furthermore, the health improvement team have offered to work with two of the care homes, that have residents with some of the most challenging needs, to provide

some training to the staff on activities and/or to provide some resilience training for the staff.

We will be looking to find further activity solutions for the care homes as this seems to be the area that needs vast improvement. Sadly the activity co-ordinator is often used as a carer when care homes are short staffed and therefore leaving any planned activity abandoned.

4.0 Conclusions

4.1 Next Steps

There are several next steps that need to be implemented to create sustainable solutions for the residents of care homes. Some of the solutions needed are relatively simple changes to current services and practices and other ideal solutions involve proposing new models of care and difficult cultural changes. These are summarised below:-

- Streamline referral process of direct referrals to professionals.
- All residents should have a GP summary detailing past medical history, current problems and medication, providing the residents consent or following the principles of best interest.
- Create a rolling care home training programme, utilising multi agency and disciplinary teams.
- Invest in individual training for some of the care home staff, such as tissue viability, and V150 prescribing, so that they can prescribe dressings, laxatives, Catheter equipment. Although the initial outlay would have some cost, this would be off set by the improved quality and the reduction in community professional time. This would provide the means for the care homes to have further skills to care for their residents. It would reduce the pressure on tissue viability service and the GP's prescribing the dressings. It would also provide recognition and skills for the nursing staff and hopefully improve retention levels. Care home nursing staff should be at a similar skill level to community nursing staff, to be able to care for this very vulnerable population.
- It should be contracted that the nursing homes providing end of life care should have there own Syringe driver and should have on going education and training to support the use.
- Improve communication between Care Home and hospital using standardised patient transfer forms.
- Proactive reviews:
    - Pharmacy, reviewing medication 6-12 monthly.
    - Mental Health; all residents to be reviewed by the mental health team on admission to the care home and yearly.

    - Physical Health; reviewed by a dedicated care home nurse, Physiotherapist O.T. and Doctor on admission to the care home and 6monthly.
- Change the way we consider Care Homes. Ensure that processes that would be put in place for someone in their own home are the same that would put in place in care homes.
- Improve transparency, by ensuring the Care Homes feel comfortable and confident in when and how to seek advice and help.
- Ensure that other adverse incidents such as pressure sores (grade 2 >) are analysed using route cause analysis, so that lessons are learnt and incidences are recorded and reduced.
- Create a more embracive culture between social and healthcare. Utilise meetings such as the, clinical reference group referenced earlier in this report.
- Create meetings, such as the coffee morning to allow care managers to provide support to each other to reduce isolation.
- Encourage registration at one single GP practice.
- Place a larger focus on activities within the home.
- Larger clinical input into the reviews of quality standards within the Care homes.
- The creation of one integrated care home team to liaise between all the agencies and professionals to ensure that the needs of the care home population remain clearly in focus.

4.2 Conclusion

Care homes arguably care for the most vulnerable population in this country. The homes have become marginalised from the relative safety of Social Services and Health. System and cultural changes are needed to ensure that the standards required are achieved. It is no longer an excuse to stand by because they are private companies and hope that the standards are reached. Failure to provide good quality care for an individual is not just an indictment on that care home but a shared failure of the health and social care system that should have provided and ensured the quality of care for that individual. It is anticipated that the developments already undertaken in addition to those outlined will provide Halton with transparent, collaborative, quality services that the vulnerable care home population require and deserve.

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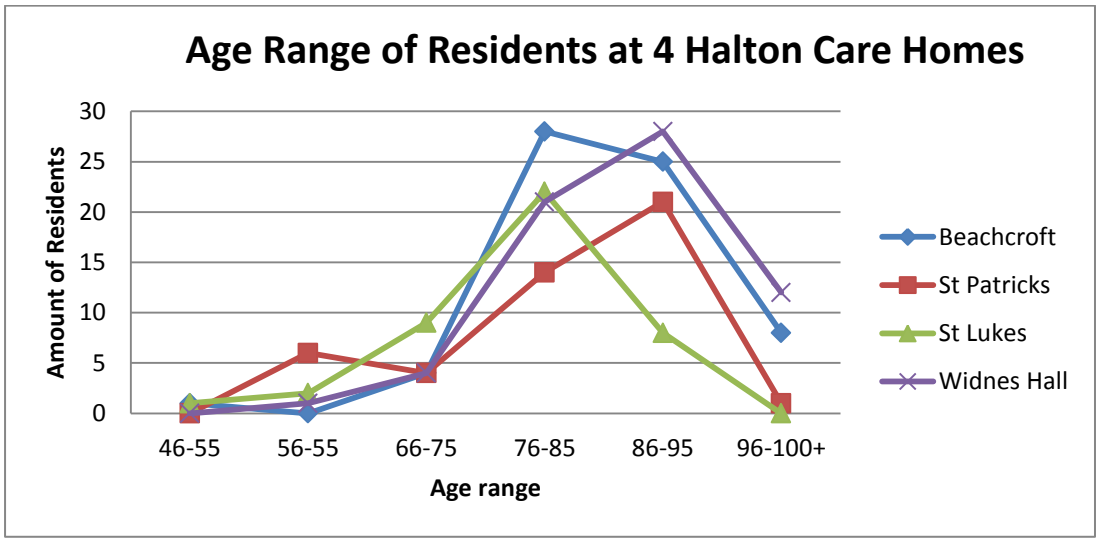
Appendix 1: Halton Care Home Demographics.

In Halton 2012 there was estimated to be is 19,600 Older Adult (over 65 years). There is estimated to be a population increase in Older Adults of 33% from 18,600 in 2011 to 24,700 in 2021 (Halton.gov). This also corresponds with a rise in life limiting illness in this population from 10,782 in 2012 to 13,300 in 2020 (poppi). Care Home provision is not spread equally across the area Widnes has 67% and Runcorn 33%. In Halton there are 716 beds, in 16 care homes there are approximately 8% of beds that are vacant each week. This breaks down into categories depending on the needs of the population, Residential beds 297 Nursing 84 and Dementia/EMI (Residential and Nursing) 412 these are approximations as some of the beds are interchangeable depending on the individual need of the person.

There are 12 providers that serve the Care home population these are:

Company Name	Number of Care Homes in Halton	Number of Beds
CIC	2	88
HC-One LTD	3	157
Minster Group	1	41
Hill Care	2	122
Madeline McKenna	1	23
Four Seasons	1	44
Ideal Care homes	1	66
Cartref	1	24
Ryan Care	1	15
Lily Cross	1	60
Trewan House	1	44
Norton lodge	1	32



Appendix 2: Results from care home managers questionnaire regarding services that they receive into the home.

Name of Service	St Luke's Care Home	Widnes Hall Care Home	Beechcroft Care Home	St Patrick's Care Home
Dietitian	Referrals usually via GP, usually very good	Fax, GP, Telephone, usually good		Fax form to dept. - Usually good reponse time
Falls Team	Referrals usually made via the phone or fax, usually very good	Fax, GP, Telephone, usually good		Fax form to dept. - Usually good reponse time
SALT	Referrals usually made via fax/phone, no problems	GP referral usually good		Fax form to dept. - Usually good reponse time
GP-general	Calls via telephone vary from good to very poor	Usually good		Telephone rquest usually same day
GP - review on admission to home	Calls via telephone vary from good to very poor	Average		Telephone rquest usually same day
GP review on discharge from hospital	Calls via telephone, review usually within one week	Average		Telephone rquest usually same day
Equipment	Do Not Request Equipment	Equipment good		Purchase own equipment, no problems
Mental Health	Phone, referral via fax, GP, generally good response	Usually good		Telephone request response variable due to case worker
Social Worker	Phone, referral via fax, GP, can vary depending on Social Worker availability	Average		Telephone request response variable due to case worker
Support/Care plan	Completed in house, or can come after admission			Named nurse responsilble and action taken
Out of Hours	Phone - out of hours GP form, can vary up to 3 hours plus	Average	`	Telephone request, can be a time lapse before visit
Hospice	Phone/email, response time very good	Not applicable		Not used at pesent
CHC	Phone/email	Usually good		Telephone request, variable response time
OT	Via GP or Kate Dutton if required	Via GP, variable		Requested by GP, usually good response time
Physio	Via GP or Kate Dutton if required	Via GP, variable		Requested by GP, usually good response time
Pharmacy	Phone/fax, generally quite good	Usually good		Requested by GP, usually good response time
Other - Continence Service	Phone, fax/email, varies due to re-faxing because of fax problems			Fax referral, can take up to six weeks
Are you aware of:	**Record use i.e. often, sometimes, now aware of them**	**If no why not? What are the barriers? Do you use an alternative?**		
Frat/Frac	Aware but have our own forms	Aware but use own policy		Not aware
Oral assessment tool	Aware but have our own forms	Aware but use own policy		Forms part of pre-admission plan
MUST	Yes in use - Generally done monthly or if required sooner will be done e.g. some residents on fortnightly weights.	Yes, routinely		Yes - Weekly or monthly depending on the score
Waterlow	Yes in use - Generally done monthly or if required sooner will be done e.g. some residents on fortnightly weights.	Yes, routinely		Yes - Weekly or monthly depending on the score
LCP	Yes - working to GSF as required	Yes - working to GSF as required		Yes - GP ,family members, and staff involved
Any other comments				
Do you refer all Falls to CQC? Evidence	No - only those as per CQC guidelines	Witnessed falls are recorded		No only those with srious injuries as per CQC guidelines
Do patients on 4 or more meds. get a review?	Residents meds. are reviewed but not all residents are reviewed routinely.	Occasionally		Meds are under constant review by MHT
Falls register - what does it capture	Unit, time and type of accident/incident			When and how and preventative actions
Audit of 999's - actions?	None undertaken	In place		Audited
Records of incidents reported to safeguarding.	Always recorded	Monthly		All incidents are recorded and logged with CIC quality

Appendix 3: Feedback from the training day.

MUST, Waterlow and Documentation training - Thursday 10th October 2013							
1. Poor 2. Below Average 3.Satisfactory 4. Good 5. Excellent							
MORNING SESSION						**TOTALS**	
	1	2	3	4	5		
ENVIRONMENT	NIL	NIL	10	20	1	31	
CONTENT	NIL	NIL	13	21	2	**36**	
RELEVANCE	NIL	NIL	11	18	6	**35**	
AFTERNOON SESSION							
	1	2	3	4	5		
ENVIRONMENT	NIL	NIL	6	11	10	27	
CONTENT	NIL	NIL	2	12	12	26	
RELEVANCE	NIL	NIL	2	12	8	22	
GENERAL COMMENTS							
1. Handouts?							
2. Very good has been interesting							
3. Too much reading from slides							
4. Very repetitive							
5.Too much to take in							
6. Lots of jargon							
7. Funny in parts -enjoyed it							
8. Interesting better with handouts							
9. Very interesting							
10. Learnt more and feel more confident							
11. Very interesting and useful - Thankyou							
12. Very well presented/ very useful							
13. Could have shown comparison of pressure ulcers							
14. Very interesting							
15 Very well presented							

28/11/13 Falls and Safeguarding					
1 poor- 5 excellent					
	1	2	3	4	5
How did you rate the overall venue?			4	7	12
How did you rate the overall presentation?			1	6	16
How accessible was this presentation to you?			1	3	19
How did you rate the experience, knowledge and skills of the presenter?				2	21
How did the presentation suit your learning needs?			1	5	17
Very Interesting Very well presented and informative Very good presentation Very well presented key points were given and explained well in a short time. I enjoyed Paula's session it is very important to remember any vulnerable adult can be at risk of abuse in any form financial, sexual emotional ect					

Appendix 4

Case Study

The team was requested to review this lady by a social worker, who was concerned that Mrs A had lost weight.

The care home reported that she was very withdrawn and spent most of the day lay on her bed in her room.

On examination it was found that she had lost 8.4% weight in one month. She stated that she had pain to her sacrum, lower back and hip. This was very painful and not being controlled. These areas were examined and a grade two pressure sore was found to her sacrum which was dressed with a temporary dressing.

The care home had referred her to a dentist as she had painful gums and didn't want to use her dentures the dentist has tried to visit last week but the care home reported that She was busy and unable to see the dentist.

The care home noted that she struggled with diet and therefore were giving her a mashed diet.

The team referred her to:

- GP for pain management and to review weight loss.
- District Nursing Service for wound management and Pressure reliving equipment. Bloods.
- Dietician for weight loss.
- Speech and language to assess swallow and food consistency.
- Dentist.

We requested that the Care Home provided an enriched diet and to weigh her weekly.

Discussing with the GP surgery it was also noted that she had had two previous pelvic fractures following a fall therefore, a referral to the fall prevention service was all so completed. The GP surgery also noted that a pelvic mass has been found but as she had moved out of the area for a short time before moving back in. The referral to the consultant and follow up appointments had been lost. Therefore the GP followed up on this.

Appendix 5: Report from the specialist Occupational Therapist.

Bridgewater Community Healthcare NHS
NHS Trust

Halton and St Helens Division
Occupational Therapy for Assistive Technology

Occupational Therapist Report

Report on a joint visit with Jenny Theodore and Donna Pickavance to St Patricks Nursing Home, Crow Wood Lane, Widnes on 7th August 2013.
Reason for visit: To provide advice and information on suitable slings for residents who have slings left in situ.

St Patricks has a number of residents requiring hoisting who remain sitting on their slings in specialist seating during the day. Not all slings are suitable for leaving in situ, and could be detrimental to the user's skin integrity and comfort. Slings designed to be left in the chair are made of either a very fine soft fabric like parachute silk or a 'comfort' fabric which is soft, breathable and has a 2 way stretch so that it moulds around the user and does not wrinkle into stiff folds. These slings are often called 'All-day slings' or 'in-seat slings' Polyester slings are not ideal to leave in situ as the fabric is not breathable and the user can become very hot and sweaty. They ruckle up easily into uncomfortable folds, causing discomfort and risk of pressure areas. Mesh slings are usually used when bathing and showering. They are breathable so are slightly better than the polyester for leaving in situ, but still ruckle and cause discomfort.

A brief visual check was made of the residents in the Ashley Unit who were sitting on slings. The majority of residents were sitting on general purpose polyester or mesh slings, some of which were very worn and should be replaced. We saw one person sitting on a parachute silk sling.

We also looked at the information contained in the Moving and Handling Risk Assessments. Although they specified the hoist and the size of sling, they contained few other details to ensure the correct equipment and techniques were used. E.g. did not specify the type of sling, which loops to use, whether it is left in situ or removed.

Recommendations:
Ideally, all slings left under residents whilst in their chairs should be designed for this purpose. As it is not feasible to replace all the slings currently in use, more specific individual risk assessments would identify those at highest risk of injury or discomfort and detail the appropriate equipment and techniques to use to reduce risks to an acceptable level.

I recommend that the worn slings are replaced immediately with more suitable 'all day' slings, then the remaining slings replaced as appropriate when possible. As 'All-day' slings will be more comfortable and supportive, they may cause less distress when hoisting for some of the residents.

Helen Reed, Dip COT,
Occupational Therapist, Halton Independent Living Centre.

Appendix 6: Audit for care homes regarding transfer and discharge information.

Audit Data for Care home pilot October 2013

How many admissions to Warrington Hospital in October?
How many residents were discharged from Warrington hospital in October?
How many residents, in October, went with transfer records to Warrington Hospital?
How many residents that went in to Warrington Hospital October, have not been discharged?
How many discharged in October, form Warrington Hospital were admitted in a previous month?
How many discharges, in October, from Warrington Hospital, did you receive written information for, when the resident returned home?
How many discharge information contained all the essential information?
Did you have to make any phone call to the hospital to gather more information?
If phone calls were needed, how many phone calls did you make?
How many admissions were generated by a GP?
How many emergency admissions?
Numbers of rapid discharges?
In those residents that were admitted in October, to Warrington Hospital, how many had a previous admission in the preceding 4 weeks?