National Patient Safety Improvement Programmes

NHS

Managing Deterioration

Going for Gold

7 October 2022

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Delivered by:

Wessex
Patient Safety Collaborative

The AHSN Network

Led by:

NHS England

Going for Gold

Today I want us to take a look at:

- What “Academic Health Science Networks” and “Patient Safety Collaboratives” do
- How Patient Safety Collaboratives can support you
- Adopting a Holistic approach to the management of Physical Deterioration and End of Life Care

The AHSN Network

There are 15 Academic Health Science Networks (AHSNs) across England:

- East Midlands
- Eastern
- Health Innovation Manchester
- Health Innovation Network
- Imperial College Health Partners
- Kent, Surrey and Sussex
- North East and North Cumbria
- Innovation Agency: Academic Health Science Network for the North West Coast
- Oxford
- South West
- UCLPartners
- Wessex
- West Midlands
- West of England
- Yorkshire & Humber

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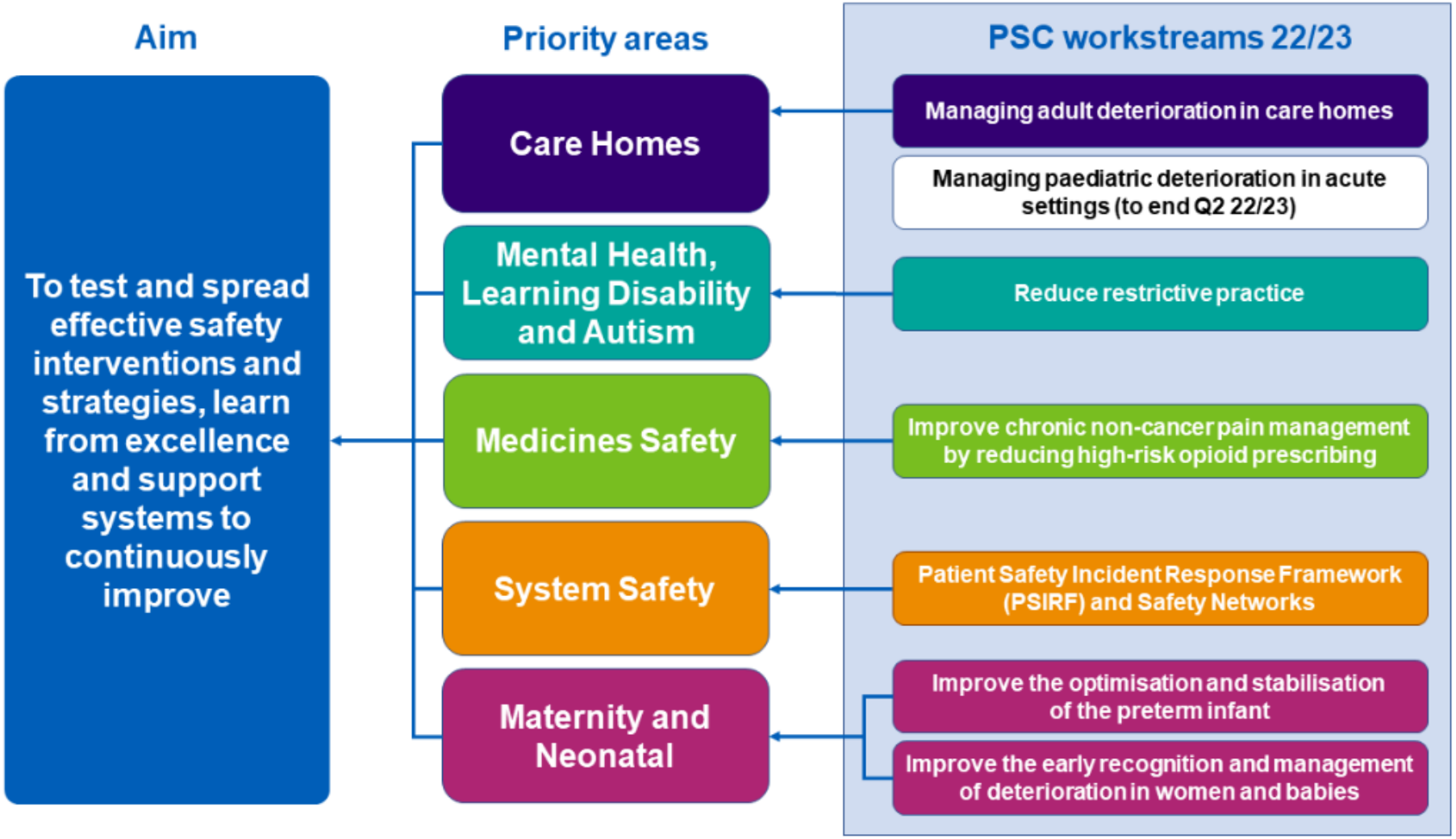

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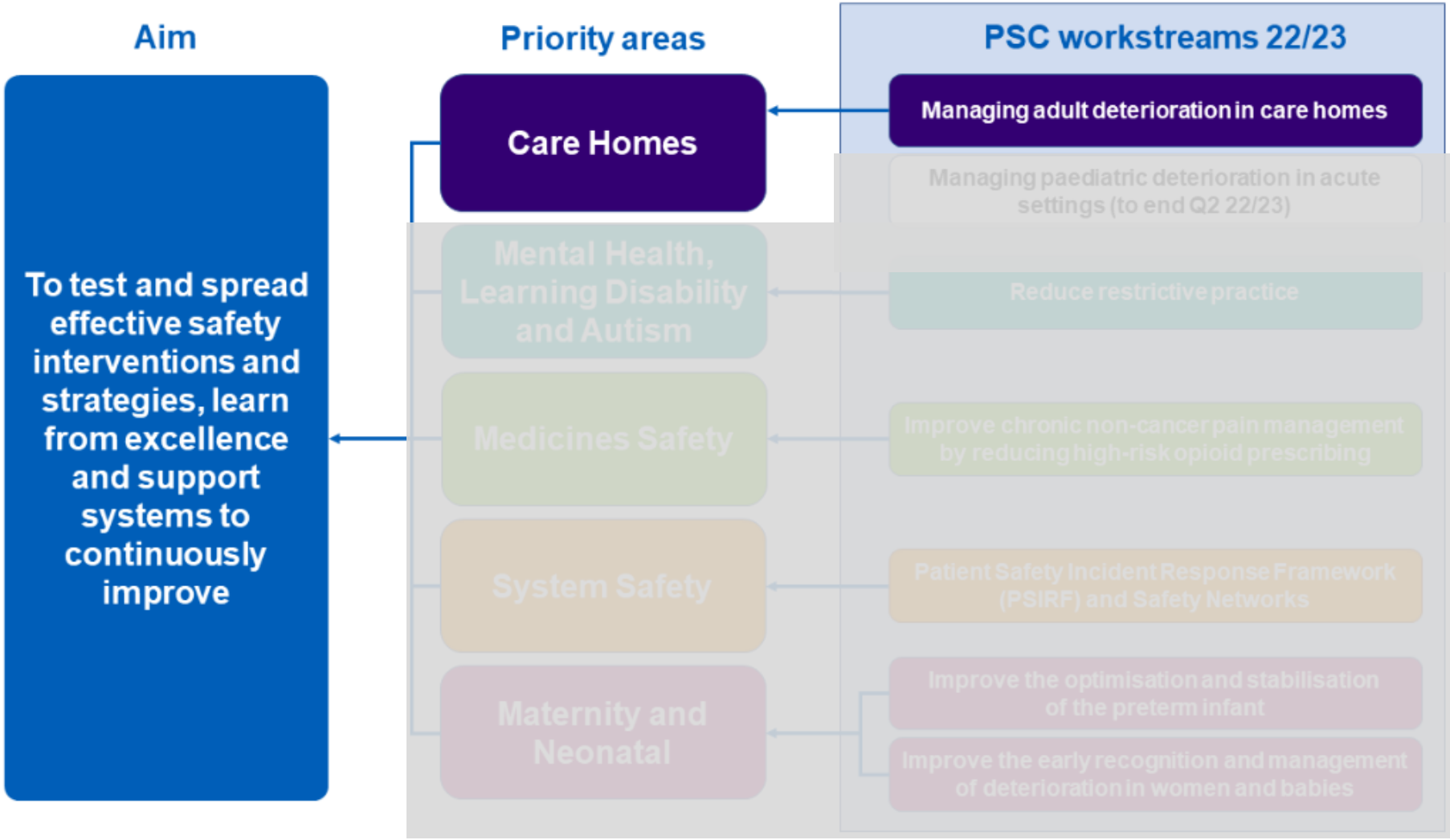

Managing Deterioration in a Care Setting

Supporting Care Homes across Dorset, Hampshire and the Isle of Wight

Wessex Patient Safety Collaborative at patient.safety@wessexahsn.net

Setting the context…

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Managing Deterioration in a Care Setting

Delivering safer care:

1. The NHS supports care home professionals to use well evaluated tools such as RESTORE2 and NEWS2. (CQC, DHSC, NHSE, PHE)

2. "If taking vital signs, care homes should use the RESTORE2 tool to recognise deterioration, measure vital signs and communicate concerns to healthcare professionals." (British Geriatric Society)

3. NEWS2, as used in tools such as RESTORE2 is adopted as a means to capture … signs of acute deterioration in physical health for people with learning disabilities. (LeDeR)

1. Admission and care of residents in a care home during Covid-19 CQC, DHSC, NHSE & PHE (31/7/20)
2. Covid-19: Managing the Covid-19 pandemic in care homes" British Geriatric Society (25/3/2020)
3. 2019 Annual report English Learning Disabilities Mortality Review (LeDeR) (16/7/20)

Care Quality Commission

"Providers should be aware of additional support available to them, such as diagnostic tools RESTORE2 and NEWS2."

Admission and care of residents in a care home during Covid-19. CQC. (31/7/20)

TELEMEDICINE
CLINICAL SUPPORT FOR CARE HOMES

Using Tools and Technology:

- NEWS2, Soft Signs and Safety Communication tools
- video consultations and virtual word rounds
- telemedicine support services
- technology enabled care
- digital records and clinical apps

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

Use of Deterioration Management Tools helps:

- improve care for residents and communication with families
- increase job satisfaction amongst carers resulting from increasing skills and knowledge
- Reduce inappropriate demands on healthcare e.g. GP visits, 111 and 999 calls, Ambulance conveyances, Emergency Department attendances and Hospital admissions.

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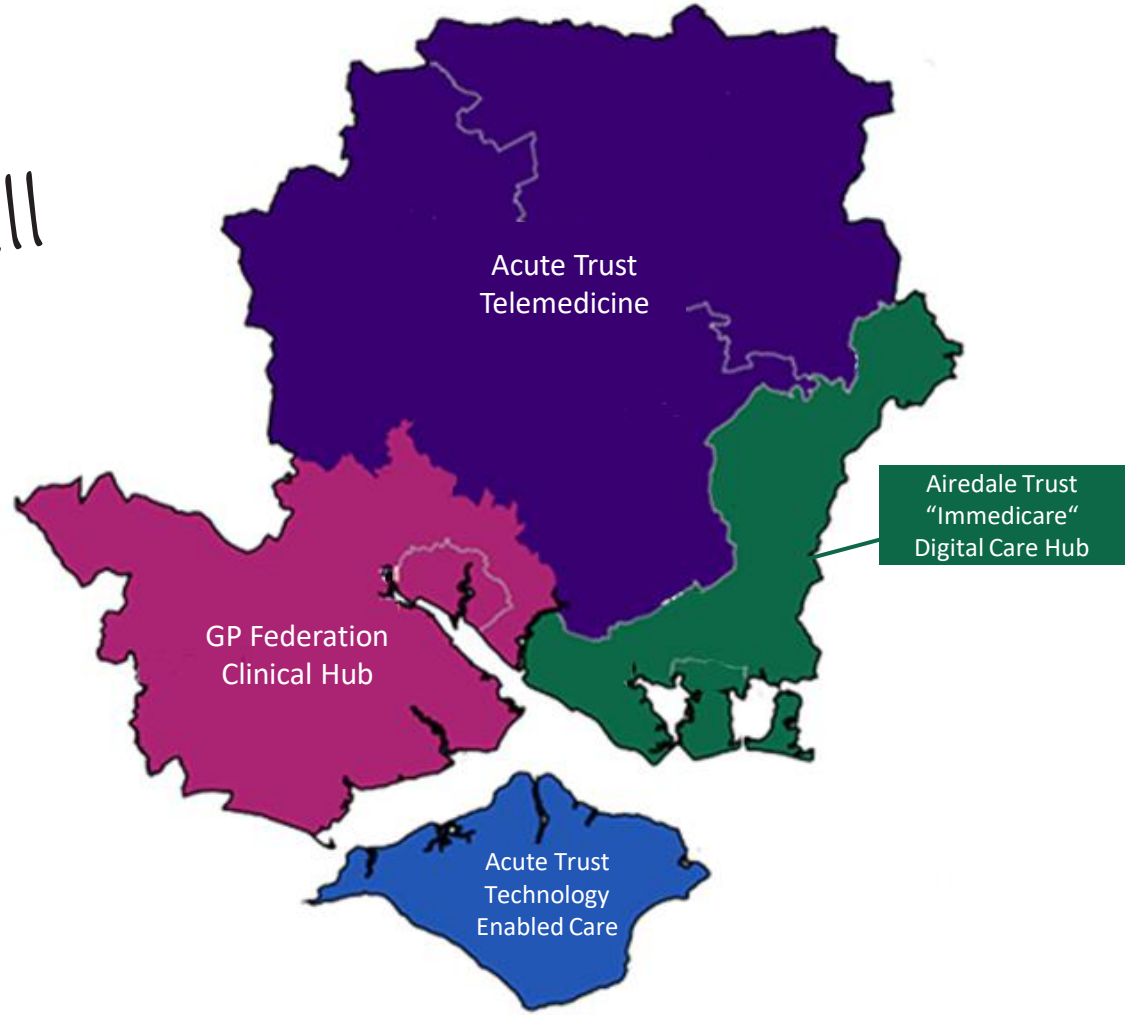
Complex - No one size fits all solution



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Working with…

Care Homes (Advice)

- Understand the role of Deterioration Tools
- Choose the most appropriate Deterioration Tool
- Understand Digital options
- Access help for unwell Residents
- Obtain support for Care Home staff

Care Homes (Resources)

- Paper based or on-line materials
- Free Training and Coaching in Deterioration management & Quality Improvement
- Signposting to useful organisations or resources
- Help with digital care solutions

Primary Care

Work with GPs to improve the management of Care Home residents experiencing physical deterioration

- Encourage effective communication between Care Homes, GPs and other healthcare professionals
- Help Care Homes implement the digital health solutions used across the Community, Primary Care and Care sectors

ICS and ICBs*

- Promote use of Deterioration Tools and Quality Improvement techniques in the Care Sector
- Improve the delivery of personalised care for residents
- Develop knowledge, skills and behaviours of carers
- Support implementation of digital strategies for Care Homes
- Reduce inappropriate demands on healthcare resources

Acute & Secondary Care

- Promote use of Deterioration Tools and Quality Improvement techniques in the Care Sector
- Reduce inappropriate demands for healthcare resources e.g. GPs, 111 and 999 calls, Ambulance conveyances, ED attendances and Hospital admissions.
- Support digital links between Health & Social care sectors

*ICS – Integrated Care System
ICB – Integrated Care Board

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Delivering benefits for…

Residents and Families

- Early treatment of unwellness and prevention of further deterioration
- Avoidance of unnecessary hospital admission or reduced length of stay
- Care delivered in line with residents own wishes
- Increased confidence in care, better communication between resident, family and Home

Carers and Care Homes

- Improved job satisfaction regarding the ability to care for residents
- Greater appreciation of carers role by others
- Improved Communication Skills
- Agreed care protocols for unwell residents
- Relevant to CQC Care Safety criteria

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Delivering benefits for…

GPs

- Earlier identification of deterioration
- Improved quality of referrals
- Reduced complexity of care needs
- Reductions in missed opportunities to treat
+ Remote monitoring of frailer and unwell patients (Telehealth)
  + Improved communications /reduced admin (Digital system links)

Health & Care Systems

- Reduced 111 and 999 calls
- Fewer Ambulance calls / conveyances
- Less ED Attendances
- Reduced demand on Hospital beds with fewer / shorter Hospital Admissions

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Exploring questions…

To get help with all of these questions and more, contact the Care Home Team at patient.safety@wessexahsn.net

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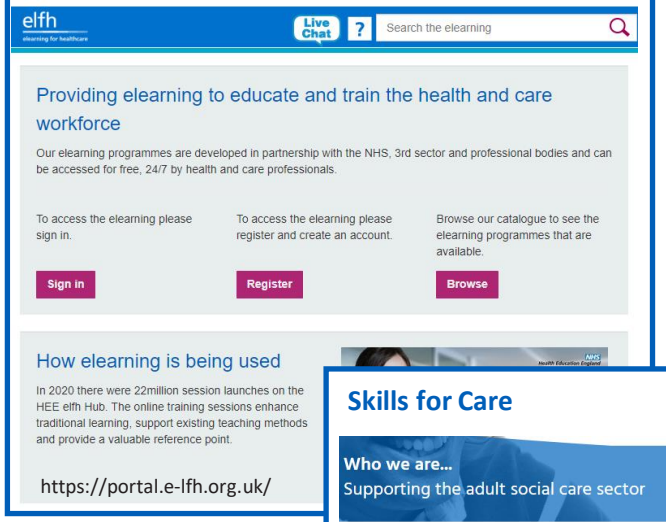
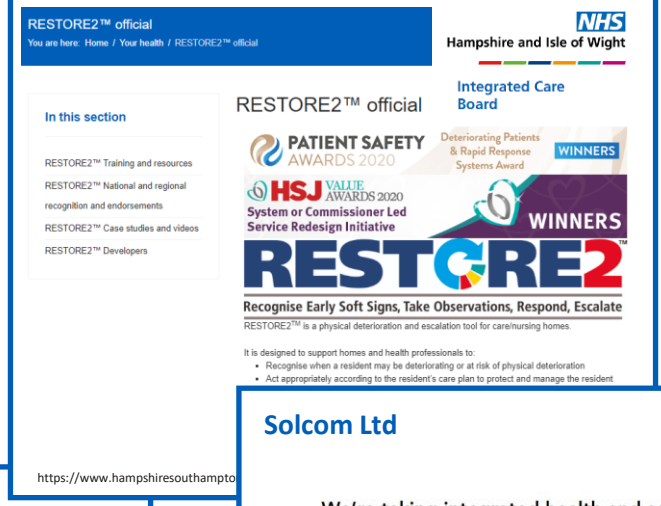
Engaging with Partners…

Health Education England eLfH



https://portal.e-lfh.org.uk/

Hampshire and Isle of Wight ICS



https://www.hampshiresouthampto

Skills for Care

https://www.skillsforcare.org.uk

Solcom Ltd

https://www.whzan.uk/

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Feedback

Improving Skills

- Increased confidence and empowerment of carers
- Decreased variation in the assessment, escalation and communication of concerns.
- More constructive communication and relationships between healthcare professionals
- Safer hand-offs
- Increased ability of healthcare professionals to monitor unwell residents rather than admit

Improving Care

- **68%** supported decision making and helped identify an individual's deterioration
- **100%** helped assessment and achieving earlier escalation of concerns
- **100%** helped to achieve earlier intervention from GP's, Out of Hours or Ambulance Service
- **93%** gave confidence when communicating with other healthcare professionals
- **25%** of staff who escalated residents using the tool would not have done so without it.

Staff Feedback

Care Homes:

"Definitely gives me confidence, I am able in short words to say what is concerning me, my reporting is clear and in order". (Carer)

"The paramedics were grateful for having information ready and provided. Personally feel we have a better response and working relationship with paramedics especially" (Carer)

GP's, Ambulance and Acute Care:

"We are really grateful when the charts follow patients into the hospital, as they provide excellent background and baseline information" (Consultant Acute Physician)

"I've seen the staff using the tools, they have been far more prepared when we have gone to visit a patient who is unwell, with observations ready etc." (GP)

"Where before GP's would come and do observations and may say that the resident is ok to monitor, we can now monitor them, which has decreased the GP visits." (Care Home)

Outcomes

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Background

4 Projects of differing designs working with

- over 116 Care Homes (Nursing and Residential)
- Primary Care Teams
- Commissioning Groups

Dis-benefits of Hospitalisation

- Hospitalised patients are **61** times more likely to develop disability in Activities of Daily Living (than those not hospitalised)
- **17%** of older patients walking independently 2 weeks prior to admission needed help to walk on discharge
- **50%** of patients experience functional decline between admission and discharge
- Deconditioning contributed to delayed discharge in more than **47%** of older patients
- Only **39%** of those with a new or additional ADL disability were back to their usual level of function after one year

Ref: NHSEI Tour de East of England: How to get involved booklet (From Mid/Sth Essex Report Jul 2022)

Benefits of using Deterioration Tools

The projects varyingly reported reductions of:

- **35%** Unplanned GP visits (1 Prj)
- **50%** 111 Calls (1 Prj)
- **8.4% to 31%** 999 Calls (2 Prj)
- **15.8%** Ambulance Conveyancing (1 Prj)
- **49.2%** Hospital Bed Days (1 Prj)

No Serious Incidents involving unmanaged deterioration (1 Prj)

Care Quality

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Care Quality Commission

Key Question	Topic Area	Quality Statement
Safe	Safe systems, pathways and transitions	We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.
	Safeguarding	We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.
	Involving people to manage risks	We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.
	Safe environments	We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.
	Safe and effective staffing	We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.
Effective	Assessing needs	We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.
	Delivering evidence-based care and treatment	We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.
Caring	Independence, choice and control	We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.
	Responding to people's immediate needs	We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.
	Workforce wellbeing and enablement	We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person centred care.

Care Quality

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Care Quality Commission

Key Question	Topic Area	Quality Statement
Responsive	Person-centred care	We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.
	Equity in access	We make sure that everyone can access the care, support and treatment they need when they need it.
	Planning for the future	We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.
Well led	Shared direction and culture	We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.
	Governance, management and sustainability	We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
	Partnerships and communities	We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Principal Relevant Regulations

Regulation 12: Safe Care and Treatment (Health and Social Care Act 2008)

The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe.

Regulation 9: Health and Social Care Act 2008 (Regulated Activities)

The intention of this regulation is to make sure that people using a service have care or treatment that is personalised specifically for them. This regulation describes the action that providers must take to make sure that each person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences.

Providers must work in partnership with the person, make any reasonable adjustments and provide support to help them understand and make informed decisions about their care and treatment options, including the extent to which they may wish to manage these options themselves.

Integrated Cross-Boundary Care

the gold standards framework

HOME

GSF Primary Care and Domiciliary Care

CARE HOME

GSF Care Homes

HOSPITAL

GSF Acute Hospitals

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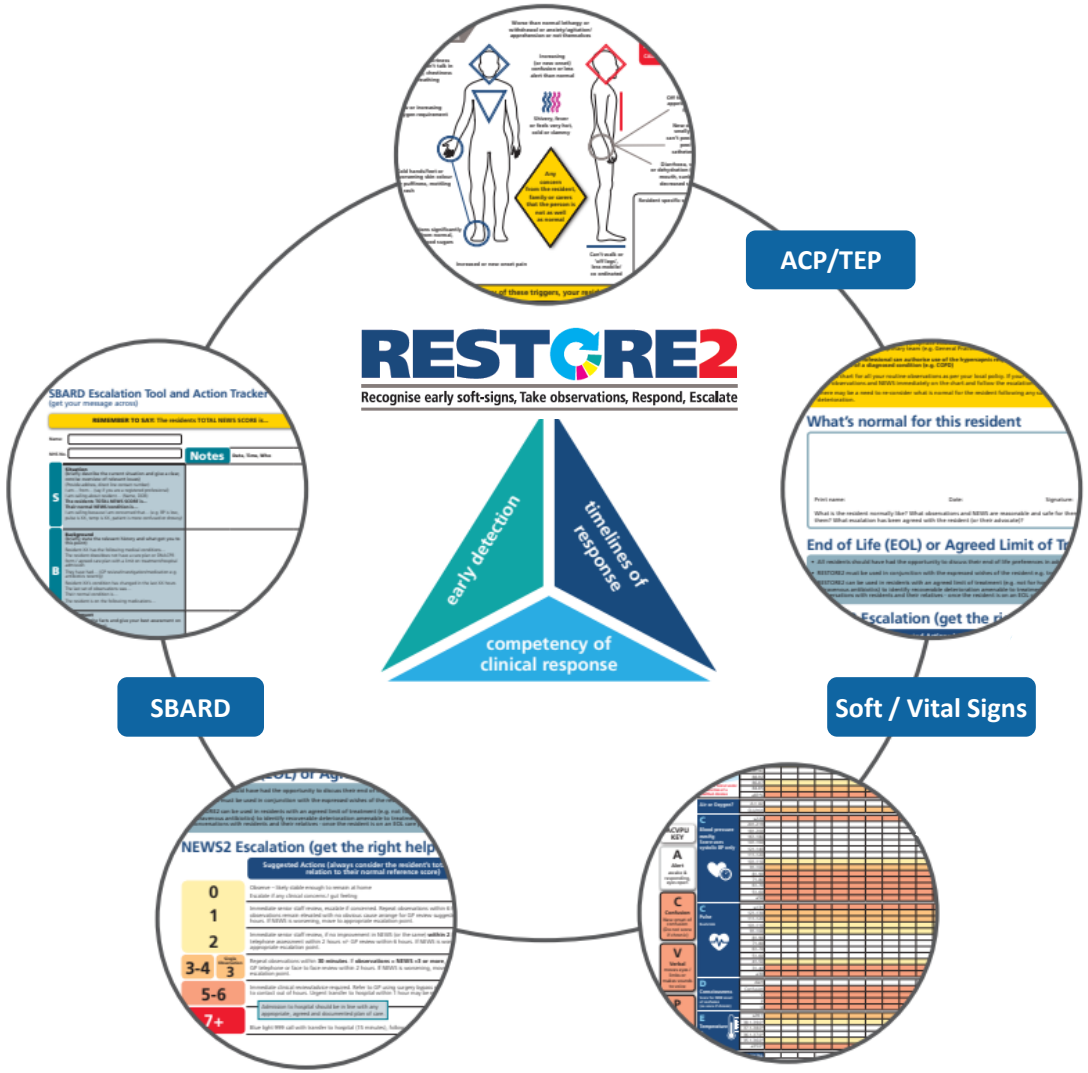

You may be familiar with different tools

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The aim of holistic care is to provide care in the context of the whole person.

Delivering that aim requires an effective response to deterioration whilst adhering to the underlying principles of Advance Care Planning.

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Universal Principles for Advance Care Planning

1. The person is central to developing and agreeing their advance care plan including deciding who else should be involved in the process.
2. The person has personalised conversations about their future care focused on what matters to them and their needs.
3. The person agrees the outcomes of their advance care planning conversation through a shared decision making process in partnership with relevant professionals.
4. The person has a shareable advance care plan which records what matters to them, and their preferences and decisions about future care and treatment.
5. The person has the opportunity, and is encouraged, to review and revise their advance care plan.
6. Anyone involved in advance care planning is able to speak up if they feel that these universal principles are not being followed.

The Universal Principles for Advance Care Planning has been jointly published by a coalition of partners in response to the Care Quality Commission report 'Protect, Connect, Respect – decisions about living and dying well' (2021)

www.england.nhs.uk/eolc/resources/.

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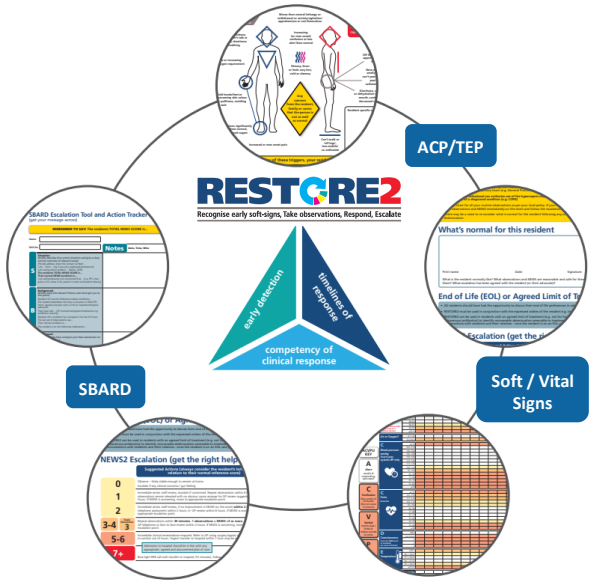

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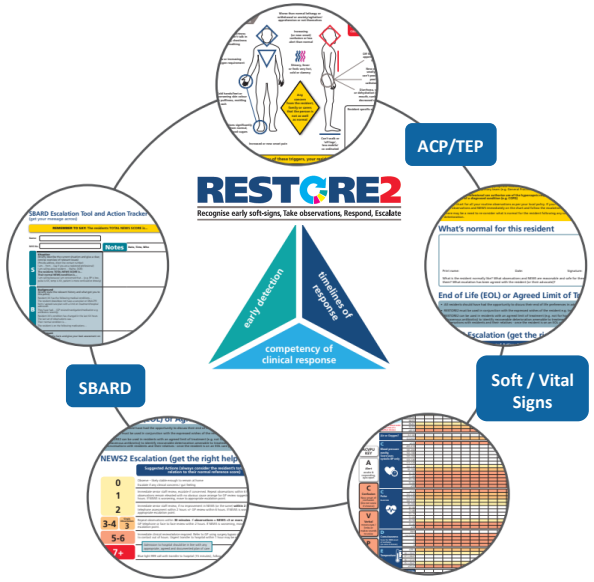

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