The Purple Book
A reference source for Care Home staff in Suffolk

Section 1
## Quick reference Contact List

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<th>Team</th>
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<th>Description</th>
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<tr>
<td><strong>111</strong></td>
<td>111</td>
<td>Provides out-of-hours medical advice in urgent situations which cannot wait until GP practices are open, or are unsuitable for management via self-care.</td>
</tr>
<tr>
<td>Crisis Action Team (East Suffolk)</td>
<td>Via CCC: 0300 123 2425</td>
<td>Multi-agency (health, social and voluntary care) service working to reduce unnecessary emergency admissions.</td>
</tr>
<tr>
<td>Early Intervention Team (West Suffolk)</td>
<td>01284 713712</td>
<td>Multi-agency (health, social and voluntary care) service working to reduce unnecessary emergency admissions.</td>
</tr>
<tr>
<td>Age UK Suffolk</td>
<td>01473 351234</td>
<td>Information and advice for services provided by Age UK, including befriending.</td>
</tr>
<tr>
<td>Care Co-ordination Centre (CCC)</td>
<td>0300 123 2425</td>
<td>Coordinates services provided by Suffolk Community Healthcare</td>
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<tr>
<td>Dietetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Suffolk Community Team</td>
<td>01284 713760</td>
<td>Teams provide support in a variety of settings including own home, sheltered accommodation, supported living, care homes, hospice and community hospitals.</td>
</tr>
<tr>
<td>Ipswich Hospital Dietetic Service</td>
<td>01473 704000</td>
<td></td>
</tr>
<tr>
<td>CCG Medicines Management Team (East Suffolk)</td>
<td>01473 770249</td>
<td>Team consisting of pharmacists, pharmacy technicians, a dietitian and appliance nurse who are able to answer queries relating to the use of medicines within the care home setting.</td>
</tr>
<tr>
<td>CCG Medicines Management Team (West Suffolk)</td>
<td>01284 758010</td>
<td></td>
</tr>
<tr>
<td>Customer First</td>
<td>0808 800 4005</td>
<td>Provision of social services</td>
</tr>
<tr>
<td>Discharge Planning Team Ipswich Hospital</td>
<td>01473 703540</td>
<td>Discharge planning for adults (over 18) who need Adult and Community Services as part of their discharge plan.</td>
</tr>
<tr>
<td>Discharge Planning Team West Suffolk Hospital</td>
<td>01284 713369</td>
<td></td>
</tr>
<tr>
<td>Dementia Intensive Support Team (DIST)</td>
<td>07852 769172</td>
<td>Intensive support for dementia patients.</td>
</tr>
<tr>
<td>Dementia Friends</td>
<td>0300 222 5855</td>
<td>Charity aiming to increase understanding of living with and understanding dementia for the wider population.</td>
</tr>
<tr>
<td>Dementia Together</td>
<td></td>
<td>Provides practical information and support for people living with dementia and their carers in Suffolk, excluding Waveney.</td>
</tr>
<tr>
<td>Service</td>
<td>Contact Information</td>
<td>Description</td>
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<tr>
<td>Falls Service</td>
<td>Via CCC: 0300 123 2425</td>
<td>Falls prevention and assessment</td>
</tr>
<tr>
<td>Local Heath Protection Team</td>
<td>0344 225 3546</td>
<td>Provides general advice and guidance on specific infectious diseases.</td>
</tr>
<tr>
<td>Local Pharmacy</td>
<td>Local to you</td>
<td>Source of support for short term and minor medical conditions. Provides general health and medication advice. Should be the first contact for non-urgent queries.</td>
</tr>
<tr>
<td>Medicines Information Team</td>
<td>01473 704431</td>
<td>Provides evidence-based information and advice to ensure the safe, effective and optimal use of medicines.</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>Via CCC: 0300 123 2425</td>
<td>Practical support to help overcome barriers preventing everyday tasks</td>
</tr>
<tr>
<td>Palliative Care team</td>
<td>01473 704932</td>
<td>Offers guidance on pain and symptom control, assessment and management of end-of-life care.</td>
</tr>
<tr>
<td>Ipswich Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative Care Team</td>
<td>01284 713776</td>
<td></td>
</tr>
<tr>
<td>West Suffolk Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parkinson’s Disease specialist nurse</td>
<td>01284 748840</td>
<td>Provides services for those living with Parkinson’s</td>
</tr>
<tr>
<td>West Suffolk only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Via CCC: 0300 123 2425</td>
<td>Physiotherapy to aid with respiratory conditions</td>
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<tr>
<td>• Pulmonary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poisons Service</td>
<td>Accessed via 111</td>
<td>Advice on ingestion of poisons</td>
</tr>
<tr>
<td>Rapid Assessment Clinic</td>
<td>01473 704163 or 702533</td>
<td>The Rapid Assessment Clinic assesses patients referred by their GP following a stroke or fall(s).</td>
</tr>
<tr>
<td>Ipswich Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke Unit West Suffolk Hospital</td>
<td>01284 712983</td>
<td></td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
<td>01473 275285</td>
<td>A service for patients with communication and/or swallowing difficulties.</td>
</tr>
<tr>
<td>Ipswich Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
<td>01284 713303</td>
<td></td>
</tr>
<tr>
<td>West Suffolk Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Nicholas Hospice</td>
<td>01284 766133</td>
<td>Provides guidance on palliative care, and advice and support for patients, families and clinicians.</td>
</tr>
<tr>
<td>St Elizabeth Hospice</td>
<td>0800 5670111</td>
<td></td>
</tr>
<tr>
<td>Suffolk Family Carers</td>
<td>01473 835400</td>
<td>A registered charity providing information, advice and support to those looking after a family member.</td>
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Introduction to the guide

From consulting with care homes, we understand that the inability to get proper medical support in the community often means that the only way to ensure that residents’ needs are properly assessed is to send them to hospital.

The aim of this booklet is to support care homes in their decision-making and, using local resources, reduce unnecessary and unplanned admissions to acute hospitals.

When we analysed the hospital admission information 2017/18, we discovered that the top reasons for admission were:

- Falls
- Urinary Tract Infections
- Respiratory Tract Infections

This booklet contains guidance on best practice and a care pathway for each of the above where available. It also contains a wealth of information on the better management of medication, as many hospital admissions are known to be medicines-related.

The Purple Book should give you the contact details and tools you need to prevent inappropriate attendances at A&E and unnecessary hospital admissions. It also provides information on how to manage conditions better within the care home setting.

The information in this guide is supported by: The Ipswich Hospital NHS Trust (IHT), West Suffolk Hospital NHS Trust (WSFT), East and West Community Services, Ipswich and East Suffolk CCG (IESCCG), West Suffolk CCG (WSCCG), Suffolk County Council and St. Nicholas Hospice.

If you have questions about medication, you should first contact your community pharmacist. Pharmacists are trained to provide advice on both prescribed and over the counter (OTC) medicines and can help you to manage minor conditions without the need to contact a GP. If the pharmacist is unable to deal with your query you can contact the Pharmacy Teams at:

**Ipswich Hospital:** 01473 70364
**West Suffolk Hospital:** 01284 713232

Alternatively, you can contact one of the CCG Medicines Management Teams:

**Ipswich and East CCG:** 01473 770249
**West Suffolk CCG:** 01284 758010

The Medicines Management Teams, in conjunction with IHT, WSFT and a variety of specialists, produce a number of formularies and guidance on the use of drugs and appliances. These can be found in the Medicines Management sections of the Ipswich and East Suffolk CCG and West Suffolk CCG websites:

[http://www.ipswichandeastsuffolkccg.nhs.uk/GPpracticememberarea/Clinicalarea/Medicinesmanagement.aspx](http://www.ipswichandeastsuffolkccg.nhs.uk/GPpracticememberarea/Clinicalarea/Medicinesmanagement.aspx)
Care homes staff can also access NHS-approved training modules **free-of-charge** from the PresQIPP website. Registration is free and the registration webpage can be accessed by clicking on the following link:

https://www.prescqipp.info/register registers

In addition to the range of training materials available to all registered users, IESCCG and WSCCG have purchased access to the ‘Medicines use in care homes course 1 e-learning’ for all care homes staff. This is a NICE-accredited course, which results in the issue of a certificate on completion. The course covers the following topics:

**MODULE 1**  
Welcome and introduction  
**MODULE 2**  
The role of CQC and the NICE guideline and quality standards  
**MODULE 3**  
The management of medicines in care homes  
**MODULE 4**  
Management of self-medicating residents  
**MODULE 5**  
Administration of inhalers  
**MODULE 6**  
Administration of eye drops  
**MODULE 7**  
Administration of transdermal patches  
**MODULE 8**  
Administration of topical products  
**MODULE 9**  
Administration of PRN medicines

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**Medicines use in care homes course 1 e-learning**

The NICE Quality Standards for medicines management in care homes quote a study that found more than 90% of the residents in long-term residential care were exposed to at least one potential medicine administration error in a three month period. To improve the safe and effective use of medicines by people who live in care homes, clear systems and processes are needed across the medicines optimisation pathway.

The Care homes 1 e-learning package is aimed at all care home staff involved with managing medicines. It is the first of several-planned e-learning packages for Care homes and will include the following modules in addition to three case studies to help apply learning to practice. Quizzes at the end of each module will test understanding and recap key learning points, and a pass mark of 70% is required to complete the course and receive a certificate.

This e-learning course supports the implementation of recommendations in the NICE guideline on managing medicines in care homes. It also supports statement 3 in the NICE quality standard on medicines management in care homes.
**Course access**

The course is **free** for all healthcare professionals in your commissioning area.

You will need to be logged in to the PrescQIPP site so that it can record your progress and issue your e-learning certificate.

If you do not already have a log in for the PrescQIPP site, you can [register here](#). Please ensure that you specify the commissioning area on registration as this will ensure that you are provided with the correct access and do not have to pay for the course.

1. Log in to the [PrescQIPP site](#)
2. Locate the course link under the top 'Learn' menu or from the [E-learning Hub](#)
3. Select 'Take this course'

Don't forget that you can complete the course over a period of time. To return to the course and pick up where you left off at any time, simply log back into the site and go to the 'My e-learning courses' page which you will find under the top 'Learn' menu after logging in, or on the right hand side of the [E-learning Hub](#).

Please note that you will need an up to date browser and sufficient bandwidth to view the course. If you have any questions about the course, please contact [help@prescqipp.info](mailto:help@prescqipp.info).
The My Care Wishes approach supports choice around care wishes, so that all individuals living with long-term, complex healthcare conditions, frailty, mental health conditions and/or dementia and their families have the opportunity to be fully involved in their care. My Care Wishes should be initiated when an individual is identified as any of the following:

- Individuals with long-term conditions and/or complex health and social care needs.
- Individuals with a frailty score greater than 5, using the Rockwood assessment tool.
- Individuals identified as being in the last 12 months of their life.

The approach considers the individual’s wishes and preferences regarding the care they receive at the end of their life. My Care Wishes provides clear guidance on how an individual would like to be cared for in an emergency situation through the Shared Care and Support Plan document. My Care Wishes also captures patient/resident wishes around further ‘active’ treatment and hospitalisation, versus remaining in their usual place of residence and receiving palliative care/symptom control at the end of life.

Recording these wishes and preferences will enable the individual to receive the care they desire, by ensuring that all health and social care professionals involved in their care understand the agreed arrangements.

We recommend that the My Care Wishes folder should remain in the resident’s room, or another easily accessible place. This is particularly important in out-of-hours emergency situations, especially if bank and/or agency staff are on duty. It ensures that staff have all key information in one place.

The folder holds a suite of documents which should be completed appropriately according to individual wishes and preferences. The individual’s name should be written clearly and the boxes on the front of the folder ticked according to its completed contents.

The My Care Wishes (MCWs) folder currently holds:

1. Personalised Shared Care & Support Plan
2. Thinking Ahead – Advance Care Planning Discussion Sheet
3. Directory of key Contacts
4. NHS East of England DNACPR form and associated Guidance (included as appendix) if appropriate
5. Clinical frailty scale (Rockwood) Please see Rockwood Frailty Scale (Purple Book section 3, page 26)
6. SCRai – Information and Consent sheet
7. My Care Wishes guidance
8. Tissue Donation leaflet
End of Life Care

Current Medication – please ensure that the medication list in the Personalised Shared Care and Support Plan is updated, or enclose a copy of the current MAR sheet.
For further information please see My Care Wishes Guidance:
http://www.ipswichandeastsuffolkccg.nhs.uk/GPpracticememberarea/Clinicalarea/Clinical(QIPP)workstreams/Palliativecare/EndofLifedocuments.aspx


Background

End of Life care is the provision of supportive and palliative care in response to the assessed needs of patient and family during the last phase of life (National Council for Palliative Care 2006).

The aims of care should be

- Relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process
- Intends neither to hasten nor postpone death
- Integrates the psychological and spiritual aspects of patient care
- Offers a support system to help patients live as actively as possible until death
- Offers a support system to help the family cope during the patient’s illness and in their own bereavement
- Uses a team approach to address the needs of patients and their families. Will enhance quality of life and may also positively influence the course of an illness
- Is applicable early in the course of illness

General principles

- Focus on quality of life, which includes good symptom control
- Whole person approach, taking into account the person’s past life experience and current situation
- Care which encompasses both the person with the life-threatening illness and those that matter to the person
- Respect for patient autonomy and choice
- Emphasis on open and sensitive communication which extends to patients, informal carers and professionals colleagues

National Guidance

Gold Standards Framework

http://www.goldstandardsframework.org.uk/

The Gold Standards Framework in palliative care helps GPs, care staff and allied healthcare professionals to identify those people who may be nearing the end of life and may need additional support. If there is uncertainty about whether an individual is likely to be nearing the end of life, consider:
“The Surprise Question”

“Would you be surprised if this patient (individual) were to die in the next few months, weeks or days?”

If you answer no to the above question, it would be appropriate to consider future care planning for possible deterioration.

Priorities of Care for the Dying Person – One Chance to get it Right:

http://wales.pallcare.info/files/One_chance_to_get_it_right.pdf

Guidance issued in 2014 has influenced the latest NICE guidance, see below:

NICE Guideline NG31 “Care of Dying Adults in the Last Days of Life (December 2015):

https://www.nice.org.uk/guidance/ng31

- Aimed at non-specialists working in primary care or in care homes.
- Provides recommendations to help healthcare professionals to recognise when a person is entering the last days of life; to communicate and share decisions respectfully with the dying person and those people who are important to them, and to manage commonly experienced symptoms.

Local Guidance

Suffolk End of Life Care Guidelines May 2017 and Support tool for end of life care:

http://www.ipswichandeastsuffolkccg.nhs.uk/GPpracticememberarea/Clinicalarea/Clinical(QIPP)workstreams/Palliativecare/EndofLifedocuments.aspx


End of Life – Key Features

1. Recognising when a person may be in the last days of life

If it is thought that an individual may be entering the last days of life, there should be an holistic medical assessment of their clinical signs and symptoms, within the clinical context of their medical history and in accordance with their goals, wishes and the views of those important to them.

Undertaking investigations that are unlikely to affect care in the last few days of life should be avoided.

Monitoring for further changes in the person should take place at least every 24 hours.

When there is a high level of uncertainty about whether a person is entering the last days of life, they appear to be stabilising, or there is potential for even temporary recovery, advice should be sought from colleagues with more experience of providing end-of-life care.

2. Communication

Healthcare professionals caring for adults at the end-of-life need to take into consideration the person’s current mental capacity to communicate.

Healthcare professionals should establish the communication needs and expectations of people who may be entering the last days of life and provide opportunities for the dying person and those who are important to them to talk about their fears and anxieties and to ask questions about their care in the last days of life.
3. Shared Decision Making

Healthcare professionals should establish the level of involvement that the dying person wishes to have in relation to decision making. Healthcare professionals should facilitate opportunities for the person to discuss options for their future care so that their preferred choices for care and treatment can be recognised and recorded. Care planning should be individualised. **It is important to refer to the individual’s preferred wishes as recorded in their My Care Wishes documentation.**

4. Symptom management

Symptoms should be monitored and measures taken to alleviate them. Commonly experienced symptoms are:

- Pain
- Breathlessness
- Nausea and vomiting
- Anxiety, delirium and agitation
- Respiratory Secretions

Maintaining hydration – The health care professional should support the dying person to drink if they wish to and are able to. There should be a discussion about the risks and benefits of continuing to drink, with the dying person and those involved in the dying person’s care. Consideration for clinically-assisted hydration should be individualised.

Individuals should have an individualised care plan for end-of-life care.

5. Anticipatory Prescribing

Patients near the end of their lives are at risk of developing new or worsening symptoms. A set of just in case medications aimed at relieving these symptoms can help to avoid distress caused by limited, or delayed access to medication when needed. As the name ‘just in case’ implies, the medications may not be needed but having them available can help healthcare professionals to control any symptoms that do occur.

**There are two phases as a person is approaching end of life:**

**Anticipatory Phase:**

- Might reasonably be expected to die within next few weeks or days.
- At risk of deteriorating rapidly but does not currently need regular PRNs or a syringe pump
- Established management adequately controls the person’s symptoms

**Active Phase:**

- Death is likely in a matter of days
- Currently needing PRNs for symptom control and high chance of needing a syringe pump in the next few days
- No acute intervention is planned or required

Just in case medications would be appropriate in the anticipatory phase if a rapid deterioration could be expected and is often within the last 2 – 3 months of life.
Many people enter the dying phase and have no significant symptoms, but some may have new or worsening symptoms that may be distressing. It is important to carry out a holistic assessment to identify potential care needs.

The following book provides helpful advice and guidance about symptom management. It is the recommended resource book for Suffolk, used by GPs and other healthcare professionals:

**The Palliative Adult Network Guidelines, fourth edition 2016**

**Bereavement**

The care of an individual and those who support them extends beyond the death and into bereavement. Bereavement is a natural process. Bereaved individuals should be assessed in terms of their coping strategies, and the possibility of needing further bereavement support beyond their own social network. Support can be provided in many ways, including one-to-one counselling, telephone contact, companionship, or joining activity based groups. **St Nicholas Hospice Care and St Elizabeth Hospice both offer bereavement support services for adults and children.** See below for contact numbers. Individuals do not need to have been receiving hospice care or support in order to access hospice bereavement support.

Other bereavement resources are:

**The Bereavement Advice Centre**

[www.bereavementadvice.org](http://www.bereavementadvice.org)

Contact: 0800 634 9494

**Cruse Bereavement Care**

[www.crusebereavementcare.org.uk](http://www.crusebereavementcare.org.uk)

Contact:

**01284 767674 (West Suffolk)**

**01473 230888 (East Suffolk)**

**End of Life Resources Suffolk**

**St Elizabeth Hospice One Call: 0800 567 0111 (East Suffolk)**

**St Nicholas Hospice Care 24 hour advice line: 01284 766133 (West Suffolk)**

If you have any concerns relating to a palliative or end of life situation, please call either of the above numbers. There are clinicians on duty who will be able to support you.

**Crisis Action Team 0300 123 2425 (via CCC) (East Suffolk)**

**Early Intervention Team 0300 123 2425 (via CCC) (West Suffolk)**

*Please see ‘Support tool for end of life care in Suffolk’ (Purple Book section 3, page 27)*
Symptoms of Dementia

Each individual is unique and will experience dementia in their own way. The different types of dementia also tend to affect people differently, especially in the early stages. Other factors that will affect how well someone can live with dementia include how other people respond to them and the environment around them.

A person with dementia will have cognitive symptoms (to do with thinking or memory). They will often have problems with some of the following:

- **Day-to-day memory**: for example, difficulty recalling events that happened recently.
- **Concentrating, planning or organising**: for example, difficulties making decisions, solving problems or carrying out a sequence of tasks (such as cooking a meal).
- **Language**: for example, difficulties following a conversation or finding the right word for something.
- **Visuospatial skills**: for example, problems judging distances (such as on stairs) and seeing objects in three dimensions.
- **Orientation**: for example, losing track of the day or date, or becoming confused about where they are.
- **Changes in mood**: for example, they may become frustrated or irritable, apathetic or withdrawn, anxious, easily upset or unusually sad.

With some types of dementia, the person may see things that are not really there (visual hallucinations) or strongly believe things that are not true (delusions).

Dementia is progressive, which means the symptoms gradually get worse over time. How quickly this happens varies greatly from person to person. As dementia progresses, the person may develop behaviours that seem unusual or out of character. These behaviours may include asking the same question over and over again, pacing, restlessness or agitation. They can be distressing or challenging for the person and those close to them.

A person with dementia, especially in the later stages, may have physical symptoms such as muscle weakness or weight loss. Changes in sleep pattern and appetite are also common.

Diagnosing Dementia

It is very important for anyone who has problems with their memory or thinking to undergo a proper assessment. Memory problems may be caused by a treatable condition such as depression or infection, rather than dementia. Finding out the cause may allow the individual to get the right treatment.

If the problems are caused by dementia, receiving a diagnosis has many benefits. It provides the individual with an explanation for their symptoms, gives them access to treatment, advice and support, and allows them to prepare for the future and plan ahead. Knowing the type of Dementia (for example, Alzheimer’s disease or vascular dementia) is also important, partly because it enables the person to receive the most appropriate medical treatment.

Dementia will usually be diagnosed by a specialist doctor such as:
Occasionally a GP or specialist nurse will make the diagnosis, depending on their expertise and training. There is no single test for dementia. A diagnosis is based on a combination of factors:

- Taking a ‘history’: the doctor will talk to the individual (and someone who knows them well) about how their problems developed and how they are now affecting their daily life.
- Physical examination and tests (for example, blood tests) to exclude other possible causes of the symptoms.
- Tests of mental abilities (for example, memory, and thinking): simpler tests will be carried out by a nurse or doctor, and more specialist tests by a psychologist.
- Scan of the brain, if this is needed to make the diagnosis.

A common pattern is for the GP to make an initial assessment and then refer the individual to a memory clinic or other specialist service for a more detailed assessment. A specialist doctor will have more expertise in dementia and will be able to arrange more detailed tests and brain scans, if needed. The diagnosis should be communicated clearly to the person and usually those closest to them as well. There should also be a discussion about the next steps.

**Treating Dementia**

There is evidence that a healthy lifestyle, especially in mid-life, can help reduce the risk of dementia. Regular physical exercise (for example, cycling, swimming, brisk walking), maintaining a healthy weight, not smoking, and drinking alcohol only in moderation, if at all, are linked to a reduced risk of dementia.

A healthy, balanced diet also helps to reduce a person’s risk. A balanced diet is one which is low in saturated fat, does not have too much salt, sugar or red meat, and includes plenty of fish, starchy foods, and fruit and vegetables. These healthy lifestyle choices will also reduce the risk of other serious conditions such as stroke, heart disease and cancer. A person who is already living with conditions such as diabetes, heart conditions, high blood pressure or high cholesterol should follow professional advice to keep their condition under control.

It also appears that keeping mentally and socially active into later life may help lower a person’s risk of dementia. Being mentally active could include doing puzzles, reading, or learning a new skill. Being socially active could include visiting friends or going to a place of worship. Volunteering could offer both mental and social activity and many organisations offer opportunities for people looking to donate their time or skills.

It can be difficult to know how to react when a person with Dementia is behaving aggressively. Try to take a moment to think about their needs and why they might be behaving aggressively. They are not likely to be doing it on purpose, and trying to reason with them is not likely to lead them to change their behaviour.

The following tips may help you – they are things you can do, and avoid doing, while the person is behaving aggressively and afterwards:

**At the time**

- Before you react, take a deep breath, step back to give the person space and take some time. It may help to leave the room until they’re feeling calmer.
- Although it can be difficult, try to stay calm. An angry response may make the situation worse.
• Make sure you are safe. You should never tolerate violence against you.
• If the person’s behaviour is physically violent, try not to show any fear, alarm or anxiety, as this may increase the person’s agitation. This may be hard if you feel threatened. If you do feel threatened, walk away from the situation and call for help.
• Give them plenty of space and time. Unless it’s absolutely necessary, avoid moving too close or trying to restrain someone, as this can make things worse.
• Try not to shout or initiate physical contact – the person may see this as threatening behaviour.
• Reassure the person and acknowledge their feelings. For example, if the person is angry because they are being stopped from collecting their children, acknowledge that they want to look after their children and reassure them that they are safe.
• Try not to take the behaviour personally – the person is probably trying to communicate a need or that something is wrong, rather than attacking you personally. Listen to what they are saying. Try to keep your body language open (for example, by not crossing your arms) and calm. It can also help if your body language is similar to the person’s – for example if they are sitting down with their arms by their side, you may want to mirror this. This shows that you are not against them and that you want to help.
• Keep eye contact and try to explain calmly why you are there. Encourage the person to communicate with you.
• Try to distract the person’s attention if they continue to be angry.
• If you are trying to support the person with an activity or task, does it need to be done at that moment? If you are able to give them space, come back later and try again – it may help you both to feel calmer.

When the behaviour has passed

• Try not to blame or punish the person for their behaviour. They are unlikely to have done it on purpose and they may not understand why you are treating them differently. Try to carry on as normal and be as reassuring as possible.
• Focus on the person, not the behaviour. They may still be upset and distressed after the behaviour has passed.
• Take some time and talk through your feelings with others – for example, the GP or home manager. If you don’t talk about your feelings, it may be harder to care for the person and also mean that you find yourself focusing on the behaviour instead of the person

GP visits

A scheduled visit by the GP (or other healthcare professional) to the care home is an opportunity for care homes to be involved in the shared responsibility and multi-disciplinary process for managing medicines and completing My Care Wishes documentation, following discussion and agreement with individual residents. It is also an ideal opportunity to clarify any unclear directions on a resident’s prescribed medication and to ask the GP to provide more specific instructions.

A list of residents requiring review should be communicated to the GP practice prior to the agreed visit. This advance notice is important, to ensure that the full medical record of the resident(s) can be reviewed at the surgery, before the doctor/nurse visits the care home.

All care home staff should be consulted/involved in compiling the list of necessary reviews, to co-ordinate GP visits and prevent multiple phone calls to the practice.
Dehydration is one of the most common indicators of transfers from a nursing home to hospital. Maintaining adequate fluid intake in older adults is associated with fewer falls, lower rates of constipation and laxative use and lower rates of urinary tract infections.

- **What are the causes of dehydration?** Not drinking enough fluid to replace what is lost. Older people may lose their thirst sensation, mouth discomfort may limit fluid intake, and reduced fluid provision or lack of encouragement to drink can all result in dehydration. Increased fluid loss may also result from vomiting, diarrhoea or sweating from fever.

- **What are the signs of dehydration?** Thirst, dark strong smelling urine, dry mouth and dry skin.

- **Other signs of dehydration:** Increased irritability, confusion, sluggishness, light headedness / feeling faint when standing, headaches, constipation, nausea, impaired cognition, tiredness, blurred vision and increased risk of slips, trips and falls.

- **How much should we drink?** People over 60 years of age should drink 30ml/kg - an average 50kg person will need to drink 1,500mls of fluid per day to retain good hydration (residents with cardiac or renal failure may be advised to restrict fluids).

- **Sources of fluid:** Cold drinks, including water, diluted squash and fruit juices. Hot drinks, including tea and coffee. Thickened fluids for residents with dysphagia (swallowing difficulties). Some foods have good fluid content, such as jelly, ice cream, custard, yoghurt, soup, tomatoes and cucumber. Alcohol does not count as it has a diuretic effect.

Care Quality Commission standards apply to hydration, with a focus on identification and assessment, monitoring fluid intake and care. These include requirements for:-

- Staff to identify when a person is at risk of dehydration.
- Individuals identified as being at risk to have their fluid intake monitored.
- Hydration requirements to be identified, reviewed and communicated.
- The care plan to identify how the risks will be managed.
- Patients and families to be confident that staff will support them to safely meet their drinking needs.

Hydration is also important in residents with diabetes as they are more prone to becoming dehydrated. They should be provided with adequate hydration, but particular care should be taken to monitor their fluid intake.

**If you would like information on food and fluid requirements for your residents please contact the CCG’s Dietetic Advisor on 01473 770113.**
Nutritional Screening

Nutritional screening is the first step to identify risk of malnutrition and should be undertaken by healthcare professionals with appropriate skills and training. All residents in care homes should be screened on admission and where there is clinical concern. The Malnutrition Universal Screening Tool (MUST) is the tool that is recommended for use both in the hospital and the community. This screening tool has been included in this booklet together with the local policy and action plan.

Referral to a Dietician

Dieticians assess, diagnose and treat nutrition-related problems. A referral can be made to a dietician for advice and support for the following reasons:

- A therapeutic diet is required e.g. newly diagnosed diabetes, Coeliac Disease or renal failure.
- An individual is found to be at high risk of malnutrition following nutritional screening and initial nutrition support and over the counter sip feeds provided at home have not been effective.

The Nutrition and Dietetics Department also offer training on nutritional screening and ways to provide nutrition support. Information can be found on the Ipswich Hospital NHS Trust and West Suffolk Hospital NHS Trust websites using the following links:

http://www.ipswichhospital.nhs.uk/dietetics

You can also contact Ipswich Hospital on 01473 704000 or West Suffolk Hospital on 01284 713760.

The CCG have a range of documents to support care homes with dietetic queries, including dietetic advice, leaflets and recipe sheets written by our CCG dietician. This information can be found at:


Since 1st September 2016, the ONS policy, developed by the CCG dietician, Ipswich Hospital and West Suffolk Hospital dieticians has been in place. Please ensure you are familiar with the policy for your Residents who are currently under care of a dietician and who are using supplements.
Thickeners for swallowing difficulties

Swallowing problems can lead to malnutrition, dehydration, reduced quality of life and risk of choking. Thickeners are approved for the treatment of this; they are used to thicken liquids and foods to various consistencies. The thickener helps to slow down transit to allow the patient more time to co-ordinate the swallowing process safely.

GPs should review other medications to ensure they are suitable for a resident with dysphagia. Liquid formulations are not always appropriate, as they may also require thickening to enable the resident to swallow them.

Review the quantities prescribed each month, as ordering too much can lead to stockpiling and waste; too little could mean residents are put at risk. If you find you are getting a backlog of these products, please inform your GP or pharmacist.

Review the resident’s record or management plan to ensure it contains clearly documented details of the consistency they are able to manage, according to trained healthcare professional advice, e.g. Speech and Language Therapist (SALT) and duration of treatment. This should also be noted on the resident’s Medicines Administration Record (MAR) chart.

Key points:

- Thickeners should be recommended by an appropriately trained healthcare professional, e.g. a Speech and Language Therapist (SALT)
- When thickening foods and fluids it is important that only the scoop provided with the thickener is used as these can vary between different products. Using the correct scoop will enable the correct amount of thickener to be mixed with the correct amount of foods and fluids.
- Always follow the manufacturer’s instructions to enable the correct texture to be achieved
- Always follow SALT advice regarding the thickened fluid consistency offered to individual residents
- Ensure thickeners are stored securely when not in use

Types of thickeners:

- Starch-based products (e.g. Thick and Easy) thicken foods and liquids by swelling up. Fluids thickened with a starch-based thickener tend to be unstable and continue to thicken over time.
- Gum-based thickeners (e.g. Resource Thicken up Clear) form a mesh in which water molecules become entangled. Gum thickeners are more stable over time, but may need to be shaken vigorously when mixing. They maintain their thickness.

- Please see Care Home MUST Local Policy (Purple Book Section 3, page 3)
- Please see ONS in Care Homes Policy (Purple Book Section 3, page 4)
- Please see Dietary advice (Purple Book Section 3, page 6)
- Please see Recipes (Purple Book Section 3, page 7)
- Please see Managing Swallowing Difficulties (Purple Book Section 3, page 8)
### SWALLOWING DIFFICULTIES

**‘DYSPHAGIA’**

<table>
<thead>
<tr>
<th>Obvious signs of a swallowing difficulty include:</th>
<th>Subtle signs of a swallowing difficulty include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Difficult / painful chewing or swallowing</td>
<td>- Change in breathing pattern</td>
</tr>
<tr>
<td>- Food comes back up/ regurgitation</td>
<td>- Unexplained temperature spikes or chest infections</td>
</tr>
<tr>
<td>- Difficulty moving/holding food or liquid in the mouth</td>
<td>- Wet /gurgly voice</td>
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<tr>
<td>- Drooling</td>
<td>- Dry mouth</td>
</tr>
<tr>
<td>- Coughing / choking before, during or after swallowing</td>
<td>- Heartburn</td>
</tr>
<tr>
<td>- Rough voice quality</td>
<td>- Change in eating habits for example, eating slowly or avoiding social occasions</td>
</tr>
<tr>
<td>- Sensation of something being stuck</td>
<td>- Frequent throat clearing</td>
</tr>
<tr>
<td>- Food comes back out of nose</td>
<td>- Ongoing chest infections</td>
</tr>
<tr>
<td>- Unintentional weight loss i.e. people with dementia</td>
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</tbody>
</table>

**Aspiration**- when food or fluid goes down “the wrong way” into the airway as a result of a swallowing difficulty. Aspiration can be overt (e.g. coughing) or covert (no obvious signs). Aspiration may cause chest infections or a specific pneumonia.

**Signs of Aspiration**- any of the following signs observed when the patient is eating and drinking may indicate a swallowing problem:

- Coughing/choking
- Wet, gurgly voice quality
- Shortness of breath
- Red face
- Eyes watering
- Deteriorating chest status

**IF ANY SIGNS OF ASPIRATION OR SWALLOWING DIFFICULTIES ARE NOTED, THEN PLEASE REFER TO THE SPEECH AND LANGUAGE THERAPY TEAM.**
Please see the below advice sheet on keeping COPD symptoms at bay, and useful information on helping with flare-ups:


https://www.blf.org.uk/support-for-you/copd/treatment/flare-ups

**Looking after patients with COPD and asthma**

- Try to encourage the resident to stop smoking. Ask the GP or nurse practitioner for smoking cessation support, as stopping smoking is the most important change which can be made to improve quality of life in respiratory disease.
- Take care in winter: Keep the resident warm and ensure that they have good footwear and sensible clothing.

*Please see COPD Symptoms & Action to take (Purple Book Section 3, page 9)*

**Correct use of inhalers**

The patient information leaflet (PIL) is the leaflet that's included in the box with a medicine and explains the best way to use, clean, store and look after the inhaler. If you are unsure about anything or have any questions about the PIL, speak to your GP, pharmacist or asthma nurse.

If a resident has lost or misplaced their PIL, you can download an electronic copy here:

http://www.medicines.org.uk/emc/

A list of ‘how to use’ leaflets and videos are also available on the WSCCG website:


**Tips to reduce common errors in inhaler use**

- Encourage the resident to breathe out fully (or as much as they comfortably can) just before using their inhaler. This creates more space in their airways for their next breath in.
- The resident should only inhale one dose at a time.
- The resident should try to hold their breath after each dose of their inhaler, to give more time for the medicine to get into their lungs. If they can hold their breath for 10 seconds, this is ideal, but they will still benefit by holding it for as long as they feel comfortable.
- The resident should sit as upright as possible before using their inhaler.

**Avoiding oral thrush (white plaques) and/or a sore throat after using a preventer inhaler that contains steroids**

- Make sure that the resident is using the correct inhaler technique.
- Encourage the resident to brush their teeth, rinse out their mouth, or gargle and spit out, after using their preventer inhaler.
- Consider using a spacer with the preventer inhaler.
Spacer devices

- When using a spacer device, if the resident is not able to keep their lips sealed around the mouth-piece sufficiently, a device with a face mask should be requested from the GP or practice nurse to enable better use of the inhaler.

Washing spacer

- Spacers should be washed once a month using a mild detergent. Don’t scrub the inside of the spacer as this affects the way it works. Leave it to air-dry. Don’t worry if the spacer looks cloudy, it does not mean it is dirty. The spacer should be replaced at least every year, especially if used daily.

COPD/Asthma and Exercise:

Arm exercises, middle back stretches and leg exercises are useful in keeping people stronger and help to prevent complications such as chest infections. Improved fitness helps people to feel less breathless.

Chair exercises are a great way for keeping someone more active and people with heart and lung problems should be encouraged to join in.

Try to encourage nose breathing when walking and being more physical.

Useful contact numbers for guidance

**COPD outreach respiratory team (East and West Community Services) (Via CCC)** Tel: 0300 123 2425

*Respiratory physiotherapy department Ipswich Hospital* Tel: 01473 703240

*Respiratory physiotherapy department West Suffolk Hospital* Tel: 01284 713300
Diabetes

All residents, including those with diabetes, should be offered a balanced diet which includes a variety of foods including fruits and vegetables and limited sugary and processed foods.

‘Diabetic foods’ should be avoided as there is no evidence they are of benefit. They can have a laxative effect and consumption can affect blood glucose levels. ‘Sugar free’ items such as squashes and fizzy drinks can be helpful, particularly for residents who would otherwise have a low fluid intake. Residents should be encouraged to finish their meals and be given their medication at regular intervals, with meals where specified.

It is important to be aware of the signs of hypo- or hyper-glycaemia and to contact the GP for advice if you are concerned.

Signs and symptoms of hypoglycaemia include

- Heart palpitations
- Fatigue
- Pale skin
- Shakiness
- Anxiety
- Sweating
- Hunger
- Irritability
- Tingling sensation around the mouth
- Crying out during sleep

As hypoglycaemia worsens, signs and symptoms may include

- Confusion, abnormal behaviour or both, such as the inability to complete routine tasks
- Visual disturbances, such as blurred vision
- Seizures
- Loss of consciousness

People with severe hypoglycaemia may appear as if they’re intoxicated. They may slur their words and move clumsily.

Many conditions other than hypoglycaemia can cause these signs and symptoms. A blood sample to test blood sugar levels at the time of these signs and symptoms is how to know for sure that hypoglycaemia is the cause.

Early signs of hyperglycaemia include

- Increased thirst
- Headaches
- Trouble concentrating
- Blurred vision
- Frequent peeing
- Fatigue (weak, tired feeling)
- Weight loss
- Blood sugar more than 180 mg/dL
Ongoing high blood sugar may cause

- Vaginal and skin infections
- Slow-healing cuts and sores
- Worsening vision
- Nerve damage causing painful, cold, or insensitive feet.
- Loss of hair on the lower extremities.
- Erectile dysfunction
- Stomach and intestinal problems, such as chronic constipation or diarrhoea
- Damage to the eyes, blood vessels, or kidneys

It is important to remember that everyone with diabetes should be encouraged to have an annual review, including retinal (eye) screening and a diabetic foot check. This can be arranged via the resident’s GP or practice nurse.

People with Type 2 diabetes do not need to routinely test their blood glucose, unless they are prescribed insulin. For advice on when testing is recommended, and the frequency of testing, please follow the guidance in the links below:

http://www.ipswichandeastsuffolkccg.nhs.uk/GPpracticememberarea/Clinicalarea/Medicinesmanagement/Medicalconditions/Diabetes.aspx


Care home staff should use safety lancets and needles when caring for a resident, e.g. finger pricking or administering insulin. Under the ‘Health and Safety (Sharp Instruments in Healthcare) Regulations 2013’ it is the duty of the care home to provide ‘safer sharps’ for use by its employees:

‘All employers are required under existing health and safety law to ensure that risks from sharps injuries are adequately assessed and appropriate control measures are in place. The employer must substitute traditional, unprotected medical sharps with a ‘safer sharp’ where it is reasonably practicable to do so’

The GP should not be asked to prescribe any of the following safety needles and lancets:

- BD Autoshield Duo® Pen Needles
- Microdot Verifine Safety® Pen Needles
- Mylife Clickfine® AutoProtect
- Neon Verifine Safety® Pen needles
- NovoFine® Autocover® Pen Needles
- Apollo Pressure-Activated Safety Lancets®
- GlucoRx® Safety Lancets
- Mylife Safety® Lancets
- Mylife Safety Comfort® Lancets
- Sarstedt Safety® Lancets
- Sterilance Lite II® (Safety) Lancets
- Unistik 3 Comfort® Lancets
- Unistik 3 Extra® Lancets
• Unistik 3 Gentle® Lancets
• Unistik 3 Normal® Lancets

If a GP receives a request to prescribe any of the items listed above, they are advised to reject the request and prescribe a CCG-approved product as an alternative. Details of WSCCG policies on needles and lancets can be accessed via the following link:


Under:

‘WSCCG Policy on Needles for Insulin Devices – January 2018’

‘WSCCG Policy on Lancets – January 2018’
What is Parkinson’s disease?

- People with Parkinson’s do not have enough of a chemical in their brain called dopamine. This is because some of the nerve cells that are responsible for producing dopamine have died. Over time more will die, and the Parkinson’s disease will get worse.
- A lack of dopamine means that some information moves around the brain more slowly than normal.
- The main aim of treatment is to make more dopamine available in the brain, although this is not always straightforward to achieve.

Signs and Symptoms

- The most obvious symptoms are those related to movement: slowness, freezing, stiffness, shuffling and tremor.
- Less obvious, but equally important are the non-movement symptoms: anxiety, depression, confusion, hallucinations, sleep and dream disturbances, constipation, sweating, dribbling, swallowing difficulties, soft voice, small hand writing.
- It is important to remember that each person’s Parkinson’s disease is unique to them because of the combination of symptoms they have.

Mobility

Practical steps that might help you when caring for someone living with Parkinson’s disease:

- **Prompting:** People living with Parkinson’s can often benefit from verbal prompts, particularly if they are experiencing the sensation that their feet won’t move, like being ‘stuck in mud’ (freezing). In this situation, try using ‘ready, steady, step’ to get them going again. If regular freezing is an issue on a single journey or they are taking multiple fast short steps (festination) then try using either ‘1-2-1-2...’ or ‘right, left, right, left...’ to provide a rhythm for them.
- **Slow down:** It is important not to rush people with Parkinson’s. If they feel stressed, anxious or embarrassed this will make their mobility worse.
- **Talking to residents whilst walking may distract them:** With the exception of prompting, talking to someone with Parkinson’s (particularly those with advanced disease) whilst they are walking can cause difficulties. Try to avoid this whenever possible, as the resident may experience increasing episodes of freezing and festination.
- **Correct aids:** As for all residents, make sure that they are using the correct walking aid and look around your care environment for trip hazards such as rugs.
- **Variability:** People with Parkinson’s will often experience variations in their mobility across a 24 hour period. It is important to remember that these fluctuations mean that they may require varying levels of support throughout the day.

    **Mobility is likely to be at its best 30 to 60 minutes after Parkinson’s medication has been taken.**
Swallow

- The process of swallowing requires the use of multiple muscles in tandem.
- Parkinson’s disease (PD) can affect the strength and co-ordination of muscles and therefore can affect swallow.
- When the swallowing difficulties are experienced by a patient who also has dementia, they may be unable to make adjustments them self in order to swallow safely.

Signs and Symptoms of difficulties with swallow

- Coughing or choking on food, drink or saliva
- Difficulties swallowing medication
- Inability to clear food from the mouth, or if food sticks in the throat
- Weight loss
- Pain or discomfort in the throat during eating, or shortly after
- Unclear (wet) voice
- Repeated chest infections

Practical Steps to assist safe swallow

- Ensure that the resident sits upright when eating
- Check that the resident is alert enough to eat at each meal time
- Encourage the individual to participate fully in the process of eating and drinking. Encourage them to hold the cup or cutlery with you.
- Pacing: Ensure that only a small amount of food is put into the mouth and that each mouthful is swallowed before more is added
- If dentures are worn, ensure that these fit appropriately and are secured as necessary
- Encourage sipping from the edge of a cup rather than using spouted beakers or straws
- Consider giving meals 30 to 60 minutes after Parkinson’s medication

If you suspect your resident is experiencing swallowing difficulties, please refer them to their GP who may go on to request a specialist review

Constipation

Patients with Parkinson’s disease are prone to constipation. Signs and Symptoms include:

- Bowel movements becoming less frequent than is normal for that person
- Difficulty or pain on passing faeces
- Very hard stools
- Development of watery stool accompanied by hard stool (suggests constipation with overflow)
- New or increased confusion or agitation (delirium)
- Drowsiness
- Decreased oral intake, which may be accompanied by nausea
- Faecal soiling of the fingers

If you suspect your resident is experiencing constipation, despite following the practical steps and flowchart below, please refer them to their GP, who may prescribe a laxative.
Practical Steps to help prevent constipation

- Start a stool chart, e.g. Bristol Stool Chart: https://www.bladderandbowel.org/bowel/bowel-resources/bristol-stool-form-scale/
- Bristol Stool chart is also included in Notes to Accompany Diarrhoea and Vomiting Flow chart (Purple Book section 3, page 17)
- Consider starting a food record chart
- If the resident is not independent encourage them regularly to sit on the toilet, even if they are normally incontinent
- Ensure that the resident is drinking plenty
- Increase the fibre in their diet slowly (fruit, vegetables, wholegrain and wholemeal)
- Ensure that any regular laxatives are being administered and consider giving those prescribed ‘as required’

Medication:

- Drugs treatment is the most common way to control Parkinson’s symptoms.
- Some drugs work by replacing or mimicking the actions of dopamine, the chemical that is lacking in the brains of people with Parkinson’s.
- It is very important that patients with Parkinson’s get their medication ‘on time, every time’, otherwise the chemical balance in the brain can be severely disturbed and lead to poorly controlled symptoms. This increases the likelihood of falls, pain, confusion, hallucinations, swallowing difficulties, anxiety and increased dependence on others.
- Some residents may need their Parkinson’s medication switching to a patch or dispersible formulation. The GP should be informed if a resident refuses to take their Parkinson’s medication, or has difficulty swallowing it.

For further information please visit www.parkinsons.org.uk or call 0845 121 2354 to order the ‘Caring for your Resident with Parkinson’s: Information for Care home staff’ for free.
Initial changes in bowel habit should be reported to the resident’s GP. Bowel charts should be kept in care plans for monitoring purposes. Constipation in the elderly is often due to insufficient fluid intake, but large glasses of fluid should be avoided - little and often is more effective.

Flowchart for the management of constipation

Does resident appear very unwell, or more confused than usual?

- YES → Contact GP for advice
- NO

Have there been any recent changes in the resident’s diet, medication, or mobility?

- YES → Continue to next step, but discuss with GP at next visit
- NO → Increase dietary fibre, try prune juice and increase mobility. If not possible, give macrogol sachets according to Homely Remedies policy
  - Effective within 48 hours → Continue lifestyle advice to prevent re-occurrence
  - Ineffective after 48 hours → In addition to above, give senna: two tablets at night
    - Effective within 48 hours → Continue lifestyle advice to prevent re-occurrence
    - Ineffective after 48 hours → Contact GP for advice
  - Re-occurrence
Infections

The full Infection Prevention Guide can be found at:

http://www.ipswichandeastsuffolkccg.nhs.uk/GPpracticememberarea/Clinicalarea/PatientSafetyandClinicalEffectiveness/InfectionPreventionandControl/TheCCGinfectionpreventionmanual.aspx


- Keep a record of allergies, the dose and duration of the antibiotic course, and the reason for treatment.
- The GP will provide initial advice on use. Further information can be requested from a pharmacist, or the local health protection unit.

Tips on infection prevention and control

- There should be a named ‘Infection Prevention and Control Lead’ within the care home, who is the first point of contact for advice about infections.
- Care home staff should know when to contact the Health Protection Unit
- Care home staff should be aware of which staff members know how and when to take samples.
- Care home staff should be able to identify the signs of infection (fever, swelling, temperature etc.)
- Residents should have their own room with en suite facilities to protect from the spread of infection. Where en suite facilities are not available, a risk assessment of the environment should be conducted to protect visitors, staff and other residents.

Please see the links below, which contain more information about c.difficile and MRSA infections:

http://www.ipswichandeastsuffolkccg.nhs.uk/GPpracticememberarea/Clinicalarea/Medicinesmanagement/Medicalconditions/Antibiotics.aspx


Signs which may indicate that a resident has an infection include

- High temperature or feeling hot to the touch
- Chills
- Sweating
- Aches and pains
- Headache

Other signs that an infection may need treating quickly include

- Lower back pain (could indicate kidney infection)
- Shortness of breath
- Confusion/agitation
- Presence of blood in mucus
- Rapid breathing or chest pains

Some of these signs may be easily overlooked or confused with different conditions. It is important to always consider that a resident may have an infection, and report any of these symptoms to their GP.
It is also important to be aware of Sepsis. Sepsis is a life threatening condition where the body responds to an infection, but also damages its own healthy tissue and organs.

**Signs of Sepsis include**

- Slurred Speech
- Extreme shivering or muscle pain
- Failure to pass urine for 24 hours
- Severe breathlessness
- Mottled or discoloured skin

If you suspect that a resident could have Sepsis call 999 immediately.

*For additional information on infection:*

- Please see Diagnosis & Management of UTIs (Purple Book Section 3, page 11)
- Please see UTI Information Leaflet (Purple Book Section 3, page 15)
- Please see Cases of Diarrhoea and/or Vomiting (Purple Book Section 3, page 16)
- Please see Hand Hygiene (Purple Book Section 3, page 19)
As people age, their skin becomes thinner and loses elasticity. There is often a reduced blood supply to the skin and the amount of fat under the skin tends to decrease. This makes the skin more fragile and easily damaged. Any injuries to the skin are generally slower to heal - vulnerable skin is more prone to damage from injury, moisture or pressure.

If skin becomes too wet, it can become soggy and more easily damaged. It is important to protect the skin from contact with urine and faeces, as these are irritant to the skin surface.

Pressure sores, sometimes known as bedsores or pressure ulcers, are painful sores which occur when the blood supply to parts of the body is interrupted. They can develop when a large amount of pressure is applied to an area of skin over a short period of time. They can also occur when less pressure is applied over a longer period of time.

As pressure sores can develop very quickly, sometimes over the course of just a few hours, it is important for care homes to have policies in place to prevent pressure sores developing in their residents. Early recognition of residents at risk of developing pressure ulcers is an essential part of prevention. Common tools for identifying residents at risk include:

- **Braden Scale**
- **Waterlow Risk Assessment Scale**, which can be accessed here:
  
Did you know that pressure ulcers affect around 20% of people in nursing and residential homes?

**Who is at risk?**

<table>
<thead>
<tr>
<th>RISK</th>
<th>GREEN</th>
<th>AMBER</th>
<th>RED</th>
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</thead>
<tbody>
<tr>
<td>SKIN</td>
<td>INACT/PINK</td>
<td>SWOLLEN</td>
<td>REDDENED/BROKEN</td>
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<tr>
<td>MOISTURE</td>
<td>CLEAN DRY</td>
<td>MOIST/SWEATY</td>
<td>WET INCONTINENT</td>
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<td>SENSATION</td>
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<td>BED-RIDDEN</td>
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<td>MEDIUM</td>
<td>HIGH</td>
</tr>
<tr>
<td>NUTRITION</td>
<td>HEALTHY</td>
<td>COMPROMISED</td>
<td>POOR</td>
</tr>
</tbody>
</table>
Identification of risk should trigger the use of the SSKIN Bundle and/or a care plan.

The five principles of pressure ulcer prevention are:

- **Surface**
- **Skin Inspection**
- **Keep moving**
- **Incontinence and moisture**
- **Nutrition and hydration**

**SURFACE**

When a resident is lying or sitting, pressure is exerted through the skin onto soft tissues. If the resident is not adequately supported, pressure to an area can lead to poor blood flow to the tissues, causing damage to cells and tissues. **This can happen in as little as two hours.**

Using an appropriate support surface is key to preventing and managing pressure ulcers, as well as increasing resident comfort. Any resident at risk of developing, or already suffering with a pressure ulcer, should be nursed on a support surface.

‘**HOW TO: Use support surfaces appropriately**’:

[http://nhs.stopthepressure.co.uk/How-To-Guides/howtogreatskinsupportfinal.pdf?v=L1WK2wh2Hpg](http://nhs.stopthepressure.co.uk/How-To-Guides/howtogreatskinsupportfinal.pdf?v=L1WK2wh2Hpg)

‘**Support me: Five things you should know about support surfaces**’:
Skin Inspection

The BEST SHOT acronym can be used as a reminder of the areas of skin to inspect:

- Buttocks
- Elbows/ears
- Sacral area
- Trochanter (hips)
- Spine/shoulders
- Heels
- Occipital area (back of head)
- Toes

This Great Skin ‘Skin inspection guide’ can be accessed here:

http://nhs.stopthepressure.co.uk/love-great-skin/LOVE%20GREAT%20SKIN%20A5%20INSPECTION%20SHEET%20WEB%202013.pdf
**Keep Moving**

Pressure ulcers tend to affect people with health conditions that make it difficult for them to move, especially those confined to bed and those who sit for prolonged periods of time. Pressure ulcers can develop very quickly in individuals who are unable to move, even for a very short time.

One of the best ways to reduce pressure over vulnerable areas, is by moving and changing positions as much as possible. When residents are able to, they should be encouraged to move frequently – these movements can be quite small, such as crossing the legs or leaning forwards in a chair. Residents who are able to get out of their bed or chair should be encouraged to do so frequently.

Less mobile residents should be positioned to minimise pressure, friction and shear. It is important that care home staff work with their residents to find ways to help them move around and change position. Sitting time should be restricted to less than two hours in any one period. If a resident is to remain in bed, his or her position should be changed at least every two hours.

Turning clocks can be used alongside repositioning charts to provide a visual reminder of when a change of position is due.

‘How to: Keep patients moving’:
http://nhs.stopthepressure.co.uk/How-To-Guides/howtogreatskinmovingfinal.pdf

‘Keep me moving: Five things you should know about keeping patients moving’:
http://nhs.stopthepressure.co.uk/love-great-skin/LOVE%20GREAT%20SKIN%20keep%20moving%20factguide.pdf

**INCONTINENCE AND MOISTURE**

Approximately 30–85% of nursing home residents are incontinent. Urinary incontinence affects over 50% and a majority of these residents also have faecal incontinence.

N.B. It is important to establish the cause of incontinence through a full assessment.

When the skin comes into contact with fluid, e.g. sweat, urine or faeces, for a prolonged of time, it becomes soft, wrinkled, and eventually saturated. This makes it more vulnerable to damage and increases the risk of a pressure ulcer developing. This skin irritation is known as maceration, incontinence associated dermatitis (IAD) or excoriation and can be very painful for residents.

‘How to: Keep patients’ skin healthy’:
http://nhs.stopthepressure.co.uk/How-To-Guides/howtogreatskinHEALTHYfinal.pdf?v=L1WKZwh2Hpg

‘Improve my skin five things you should know about keeping skin healthy’:
http://nhs.stopthepressure.co.uk/love-great-skin/LOVE%20GREAT%20SKIN%20improve%20skin%20factguide.pdf?v=L1WKZwh2Hpg

‘How to: Manage incontinence/moisture’:
http://nhs.stopthepressure.co.uk/How-To-Guides/howtogreatskinincontinencefinal.pdf
Keeping the skin healthy is vital for the prevention of moisture lesions. The aim is to keep the skin clean and dry and involves the use of:

- Protective skin barrier products
- Gentle cleansers
- Simple moisturisers
- Incontinence products — e.g. incontinence pads.
- Faecal management systems.

### How to manage wet skin

1. Too moist
   - a. Use a barrier film or cream to keep fluid away from the skin.
   - b. Use a faecal management system if the cause is profuse or prolonged diarrhoea.
   - c. Use incontinence products when required.
   - d. Use an appropriate surface to manage the skin temperature and humidity.

### Which barrier product to select?

**Barrier films**
- Available as a spray, wipes and foam applicator.
- Can be applied to broken or irritated skin and dry to create an absorbable and transparent film on the skin.

**Barrier creams**
- Available as a spray, sachet or tube.
- Can be used on intact or irritated skin, but not on broken skin.
- Ideally the cream should be absorbed into the skin and not leave a sticky residue.

Nutrition And Hydration

Eating well and drinking enough is very important for good skin health. It is particularly important for people at risk of developing a pressure ulcer or those with an existing pressure ulcer, as their condition may worsen without it.

All residents should eat a healthy, balanced diet – see sections on ‘Hydration’ and ‘Nutrition’ for further information. Additional guidance is available here:

‘How to: Maintain high quality nutritional care’:

[http://nhs.stopthepressure.co.uk/How-To-Guides/howtogreatskinnutritionfinal.pdf](http://nhs.stopthepressure.co.uk/How-To-Guides/howtogreatskinnutritionfinal.pdf)
‘Feed me well: Five things you should know about nutrition’:

http://nhs.stopthepressure.co.uk/love-great-skin/LOVE%20GREAT%20SKIN%20nutrition%20factguide.pdf?v=L1WKZwh2Hpg

Managing and treating pressure ulcers and moisture lesions

If a resident is identified as having a pressure ulcer or moisture lesion, a grading tool should be used to guide the treatment process. An example grading tool is included below.

- Pressure ulcers can be described as a category or grade, ranging from 1 to 4.
- Distinguishing between moisture lesions and pressure ulcers - the difference between pressure damage and moisture damage may be distinguished by location, shape and depth. The ‘Scottish Excoriation & Moisture Related Skin Damage Tool’ can be accessed here:

http://www.tissueviabilityscotland.org/downloads/Moisture%20Damage%20Tool.pdf

- Where a resident experiences incontinence, it is important not to damage the skin further – emollients should be used as soap substitutes when washing and the skin should be dried fully.
- The resident should be assessed, taking into consideration (this list is not exhaustive):
  - Full medical history
- Skin assessment
- Factors which may impair healing
- Nutritional status – inadequate food or fluid intake should be managed accordingly.
- Level of pain experienced - using a validated pain assessment scale.
- Physical capacity for movement
- Level of staff training and competence in managing pressure ulcers

- The ulcer should be observed at each dressing change, for signs of development or infection.
- The ulcer should be assessed for physical characteristics (size, depth, location, odour etc.) and these details documented.
- The ulcer should be measured using a consistent method.
- The wound should be monitored during healing, using clinical judgement, photographs and/or a validated assessment tool, e.g. TIME framework:

  [Link to TIME framework]

<table>
<thead>
<tr>
<th>TIME – Principles of wound bed preparation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical observations</strong></td>
</tr>
<tr>
<td>tissue non-viable or deficient</td>
</tr>
<tr>
<td>Infection or Inflammation</td>
</tr>
<tr>
<td>Moisture imbalance</td>
</tr>
<tr>
<td>Excessive fluid causes maceration of wound margin</td>
</tr>
<tr>
<td>Loss of wound – non-advancing or undermining</td>
</tr>
<tr>
<td>Non-responding wound cells and alterations in extracellular matrix or abnormal protease activity</td>
</tr>
</tbody>
</table>

- Pain should be managed using a combination of the following:
  - Lifting and handling techniques – including use of appropriate support surfaces.
  - Repositioning
  - Appropriate wound cleaning products and techniques
  - Use of appropriate dressings
  - Analgesic medication (‘pain killers’)

- Further guidance is available here:

  [Link to further guidance]

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Pressure Ulcer Grading Chart

EPUAP - Category/Grade 1
- Non-blanchable erythema of intact skin: persistent redness in lightly pigmented skin.
- Discoloration of the skin: observe for a change of colour as compared to surrounding skin.
- In darker skin, the ulcer may be blue or purple.
- Warmth, oedema, induration or hardness as compared to adjacent tissue may also be used as indication, particularly on individuals with darker skin.
- May include sensation (pain, itching).

EPUAP System - Category/Grade 2
- Partial thickness skin loss involving epidermis, dermis or both.
- Presents clinically as an abrasion or clear blister.
- Ulcer is superficial without bruising.
- Check for moisture lesion.
*Bruising appearance and blood filled blister would indicate deep tissue injury.

EPUAP - Category/Grade 3
- Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed.
- May include undermining and tunneling.
- The depth varies by anatomical location (Bridge of the nose, ear, occiput and malleolus do not have adipose subcutaneous tissue and grade 3 ulcers can be shallow).
- In contrast area of significant adiposity can develop extensive deep grade 3 pressure ulcers.
- Bone/Adipose Ulcers are not visible or directly palpable.
- Fissures: UnClassified PU – now Grade 3
- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green, brown, black, eschar) in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth cannot be determined. But it will be either grade 3 or 4.
- Stable eschar (dry, adherent, intact without erythema or fluctuance on the wound surface or the body natural [biological] layer) should not be removed.
- Should be documented as grade 3 until proven otherwise.

EPUAP - Category/Grade 4
- Full thickness tissue loss with exposed bone (or directly palpable), tendon.
- Often include undermining and tunneling.
- The depth varies by anatomical location (Bridge of the nose, ear, occiput and malleolus do not have adipose subcutaneous tissue and grade 4 ulcers can be shallow).
- Grade 4 ulcers can extend into the muscle and/or supporting structures (e.g. fascia, tendon or joint capsule).

Moisture Lesions
- Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces or sweat.
- These lesions are not usually associated with a bony prominence.
- They can however be seen alongside a pressure ulcer of any grade.
Cellulitis

Cellulitis is a skin infection that is treated with antibiotics. It can be serious if not treated quickly. Cellulitis can occur on any part of the body, but is most common on legs, hands and feet.

Symptoms of Cellulitis

- Redness or inflammation of the skin
- Pain in the affected area
- Swollen, painful glands

Individuals at risk of contracting Cellulitis

- Have poor circulation in arms, legs, hands or feet
- Find it difficult to move around
- Have a weakened immune system, because of chemotherapy treatment or diabetes
- Have pressure ulcers (bedsores)
- Have lymphedema, which causes fluid build-up under the skin
- Inject drugs
- Have a wound from surgery
- Have had cellulitis before

Please see Recognising cellulitis flow chart (Purple Book Section 3, page 20)

If you suspect that a resident may have cellulitis, call the GP or out-of-hours service (111) for advice.
Venous Thromboembolism (VTE)

Venous thromboembolism refers to both DVT (Deep Vein Thrombosis) and PE (Pulmonary Embolism) which are both forms of life-threatening blood clots. Risk factors for developing these clots include:

- Aged 60+
- Cancer/chemotherapy
- Use of contraceptives or HRT
- Being in hospital for an extended period of time
- Undergoing surgery
- Not moving for long periods of time (bed-ridden, poor mobility)

It is important to be aware of the warning signs

DVT (commonly seen in legs)

- Pain or tenderness, often in calf
- Swelling (of ankle or foot)
- Redness or discoloration
- Warmth

PE

- Unexplained shortness of breath
- Rapid Breathing
- Chest Pain (which may worsen on deep breath)
- Rapid heart rate
- Light headedness or fainting

If you suspect a resident may be suffering with VTE, contact their GP immediately or if you are concerned about their immediate situation, call 999.
Falls Prevention

There are many factors that affect an individual’s risk of falling.

Intrinsic factors include

- Balance, gait or mobility problems, including those due to degenerative joint disease or motor disorders such as stroke and Parkinson’s disease.
- Strength level
- Visual impairment
- Impaired cognition or depression
- Postural hypotension
- Taking 4 or more medicines, in particular those that lower blood pressure, or cause sedation

Extrinsic factors include

- Uneven or slippery surfaces
- Loose mats
- Inadequate light
- Lack of safety rails
- Poorly maintained equipment (e.g. ferrules on sticks and frames)
- Unfamiliar environment
- Clutter
- Pets

Physical and mental conditions that may increase the risk of falling

- Parkinson’s disease
- Osteoporosis
- Dementia
- Arthritis
- Learning disabilities

*Please also see Guidance Following a fall (Purple Book Section 3, page 21)*
*Please also see I-Stumble Falls Protocol (Purple Book Section 3, page 22)*

Visual Impairments should be taken into consideration when assessing an individual’s risk of falling. Vision is very important in maintaining upright posture and balance while sitting, standing and moving through the environment.
For further information please see links below:

www.ipswichandeastsuffolkccg.nhs.uk/FallsDirectory

http://www.ageuk.org.uk/professional-resources-home/services-and-practice/health-and-wellbeing/falls-prevention-resources/

Medication can play a part in the likelihood of a person falling. Falls may be due to recent medication changes, but are usually caused by medicines that have been given for a long time without appropriate review. The most common drugs which can increase the likelihood of a fall are:

- Drugs that act on the brain e.g. sedatives, antipsychotics and sedating antidepressants. These can cause drowsiness and slow reaction times. Some antidepressants and antipsychotics can also cause low blood pressure on standing.
- Drugs that act on the heart and circulation. Any drug that reduces the blood pressure or slows the heart can cause falls, feeling faint, loss of consciousness or sensation of ‘legs giving way’.

**If you suspect that any resident may be at risk, or is falling due to their medication, please highlight your concerns to the resident’s GP**
Care home residents with severe breathing difficulties are sometimes prescribed oxygen to help them breathe more easily.

Safety is paramount whenever oxygen is present in the home, as it is highly flammable. Oxygen will only be supplied to the home if safety is guaranteed.

At-home training for residents and staff is delivered by BOC (oxygen provider) on installation, but key points to remember include:

**Storage**
- Oxygen cylinders should be stored in a well ventilated place.
- Cylinders should not be subjected to extremes of temperature.
- Oxygen cylinders must not be stored or used near an open flame or electrical heat source.
- Oxygen cylinders, extensions and pipes can present a trip hazard in the home.

**Smoking**
- The care home should ensure that there is an adequate number of smoke alarms in the home.
- There should be no use of cigarettes or e-cigarettes around oxygen.
- Clothing of residents who use oxygen should be ventilated in the open air for least 20 minutes before the resident is permitted to smoke. This is because clothing becomes enriched with oxygen, which causes it to burn vigorously.

**Skincare products**
- Staff using alcohol hand gel should ensure that it is massaged into the hands, then allowed to evaporate before handling oxygen equipment.
- Residents should not use oil-based creams or moisturisers when using oxygen (this includes the use of oil-based lip moisturisers and make up).
- Dressings and clothing in contact with products containing paraffin (e.g. white soft paraffin, white soft paraffin plus 50% liquid paraffin or emulsifying ointment) are especially easily ignited with a naked flame or a cigarette. Clothes and bedding should be changed regularly, as the paraffin soaks into the fabrics and can pose a fire hazard.
- Staff should make sure that paraffin-containing products do not soak into chairs, seating or other furniture in the care home.

BOC also produce information leaflets on the use of oxygen in the home. These can be accessed via the links below:

‘Dangers of smoking whilst using oxygen therapy’

‘Fire hazard with paraffin based skin products on dressings and clothing’


Further advice and information can be accessed via the following link:

http://www.ipswichandeastsuffolkccg.nhs.uk/GPpracticememberarea/Clinicalarea/Medicinesmanagement/Medicalconditions/RespiratoryAsthmaCOPD.aspx
Delirium

Delirium is a sudden change in a person’s mental state. It is a serious condition that develops quickly, but is usually temporary and treatment will depend on the underlying cause. Having delirium can result in:

- Longer hospital stays
- Increased risk of dementia
- Increased mortality

A high number of care home residents are at risk of delirium. Care staff have an important role to play in recognising possible signs of delirium and providing support to reduce the risk of it developing. In 30% of cases, delirium is preventable. Being well informed can help to reduce distress for the individual and their family. Risk factors include:

- Aged over 65 years
- Cognitive impairment and/or dementia
- Current hip fracture
- Severe illness

Hyperactive Delirium

This type of delirium makes the individual restless, agitated and aggressive. Signs/symptoms include:

- Increased confusion
- Hallucinations/delusions
- Sleep disturbance
- Less co-operative behaviour than usual

Hypoactive Delirium

This type of delirium makes the individual withdrawn, quiet and sleepy. Signs/symptoms include:

- Poor concentration
- Decreased awareness
- Reduced mobility
- Reduced appetite

N.B. Mixed delirium can occur, when the person moves between the two types. The severity of symptoms can vary during the course of a day.

If a resident displays any of the above changes in behaviour, an assessment from a healthcare professional (usually the GP) should be requested
Factors that increase the likelihood of delirium developing

- Cognitive impairment/disorientation
- Dehydration/constipation
- Infection
- Disturbed sleep
- Limited mobility
- Pain
- Inappropriate food intake

To minimise the likelihood of a resident developing delirium

- Check for any behavioural changes that may indicate delirium, on admission to the care home, then on a daily basis.
- Be alert to signs of infection
- Ensure that the resident is supported by carers familiar to them
- Keep surroundings familiar, and avoid moving the resident unnecessarily
- Ensure that they have access to a clock or calendar
- Talk to the individual to orientate them
- Ensure that any hearing aids or glasses are functional and are being worn
- If a resident has dentures ensure that they are clean, well-fitting and being worn
- Encourage walking/mobility
- If walking isn’t possible, encourage a range of different exercises
- As far as possible, avoid catheterising the individual
- Avoid disturbing the individual during sleep periods
- Encourage the individual to drink
- Support the individual to address/avoid constipation
- Be alert to signs of pain, particularly if the individual suffers from dementia or has a learning disability
- Ensure that any pain is well-controlled
- If a resident is prescribed multiple medications, request a review from their GP

Individuals with delirium may experience some of the following

- Worry that someone is trying to harm them
- Feelings of anxiety, fear, depression or irritability
- Difficulty in following what is being said to them
- Vivid dreams that continue on waking
- Difficulty speaking clearly
- Seeing and hearing things that are not real

*Please see Good sleep guide (Purple Book section 3, page 10)
A contracture is the abnormal shortening of muscle tissue, making the muscle highly resistant to stretch. Contracture can lead to permanent disability. A Contracture Early Warning Trigger Tool has been developed to assist care home staff in identifying contracture risk before a contracture develops. It will also assist in deciding whether to seek further assessment or in the set up of a management plan. The tool should be used on a monthly basis for residents, especially those who show any of the following factors:

- Less activity or movement than normal for that person
- Reduced food or fluid intake
- Reduced feeling/sensation on some or all of their body
- Incontinence or moisture to the skin
- Less able to communicate their needs to others

*Please see Contracture Early Warning Trigger Tool (Purple Book section 3, page 28)*