The Purple Book

A reference source for Care Home staff in Suffolk

Section 3 - Protocols
<table>
<thead>
<tr>
<th>Contents Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home MUST Local Policy</td>
</tr>
<tr>
<td>ONS in Care Homes Policy</td>
</tr>
<tr>
<td>Dietary advice</td>
</tr>
<tr>
<td>Recipes</td>
</tr>
<tr>
<td>Managing Swallowing Difficulties</td>
</tr>
<tr>
<td>COPD Symptoms &amp; Action to take</td>
</tr>
<tr>
<td>Good Sleep Guide</td>
</tr>
<tr>
<td>Diagnosis &amp; Management of UTIs</td>
</tr>
<tr>
<td>UTI Information Leaflet</td>
</tr>
<tr>
<td>Cases of Diarrhoea and/or Vomiting</td>
</tr>
<tr>
<td>Hand Hygiene</td>
</tr>
<tr>
<td>Recognising Cellulitis</td>
</tr>
<tr>
<td>Guidance Following a fall</td>
</tr>
<tr>
<td>iStumble Falls Protocol</td>
</tr>
<tr>
<td>MAR Chart Reconciliation Form</td>
</tr>
<tr>
<td>Clinical Frailty Scale</td>
</tr>
<tr>
<td>Support Tool EOL care</td>
</tr>
<tr>
<td>Contracture Early Warning Trigger Tool</td>
</tr>
</tbody>
</table>
Care Home “MUST” Local Policy and Action Plan

All risk categories:
- Treat underlying condition
- Check patient can potentially meet nutritional needs safely via oral route
- Record any other food preferences
- Record need for specific diets and follow local policy

MUST 0 - Low Risk
Routine Clinical Care
Screen at initial contact (within 48hrs) and then rescreen using MUST monthly.

MUST 1 Medium Risk
Observe
- Commence food record chart for 3 days
- Commence Food First Principles:
  o Encourage eating and drinking
  o In-between meal nourishing snacks
  o One nourishing drink per day (See Food First Pathway poster)
  o Food Fortification
Consider providing daily over the counter multivitamin and mineral supplementation if intake has reduced to ensure all nutrient requirements are met.

MUST 2 or more without high risk factors
Treat
- Commence food record chart
- Increase Food First Principles:
  o Encourage eating and drinking
  o In-between meal nourishing snacks
  o Fortify Food and drinks
- Commence two nourishing drinks per day. See Food First Pathway poster
- Trial over the counter sip feed up to twice per day i.e. Complan, AYRYES, Melline Energis
- Rescreen using MUST
Consider providing daily over the counter multivitamin and mineral supplementation if intake has reduced.

MUST 2 or more with high risk factors
Treat
- Commence food record chart
- Increase Food First Principles:
  o Encourage eating and drinking
  o In-between meal nourishing snacks
  o Fortify Food and drink
- Commence two nourishing drinks per day. See Food First Pathway poster
- Rescreen weekly using MUST
- Consider daily over the counter multivitamin and mineral supplementation if intake has reduced.

*Use Food First advice in the Nutrition Action Pack provided by your local Nutrition & Dietetics Department. Additional copies are available on our website (link)

Refferrals to the Dietitian
All staff who have received training on “MUST” can refer directly to the dietitian using the ‘MUST’ referral form.
Refferrals will be reviewed on receipt and if the action plan has not been followed or if the referral is inappropriate, they will be returned

High Risk Factors
- Rapid weight loss (More than 10% in 3-6 months)
- Therapeutic Diet i.e. Renal, diabetics
- Breathing difficulties i.e. COPD
- Current increased nutritional requirements e.g. infection, pressure sores
- Trialled 2 different types of over the counter sip feed and no improvement in nutritional status
- Dysphagia/swallowing difficulties

The Purple Book version 1 – Section 3
Produced by IESCCG and WSCCG May 2018
Oral Nutritional Supplements* (ONS) in Care Homes Policy
This policy applies across Ipswich & East Suffolk and West Suffolk

From 01 September 2016, both the Ipswich & East and West Suffolk Clinical Commissioning Groups do not support the prescribing of ONS for residents in care homes, unless one of the exclusion criteria listed below applies. Residents with a poor intake should be commenced on homemade milkshakes and food first instead of ONS.

This policy has been introduced because Regulation 14 of the Care Quality Commission Guidance for Providers is clear that care homes are responsible for assessing and making the necessary arrangements for the provision of suitable nutrition and hydration for all residents. Residents in care homes should have their nutritional status documented on admission and thereafter screened using the Malnutrition Universal Screening Tool (MUST) and the local policy guidelines followed. Food and fluid charts should be completed where there is risk of malnutrition or where malnutrition has been diagnosed. First line nutrition support is by food fortification for residents at medium (MUST score 1) or high (MUST score 2 or higher) risk of malnutrition. All care homes have the facilities to prepare fortified meals and high energy snacks where disease-related malnutrition is either a risk or is present. For residents with swallowing difficulties, liquidised or soft diets can also be provided.

Supportive resources are available on the CGC and Ipswich Hospital and West Suffolk Hospital dietetics websites. All care homes are offered training in identifying malnutrition, using MUST and in the principles of food fortification by the community dietetic services.

In addition to fortifying foods and drinks, there is the option of purchasing “over the counter” supplements such as:
- Complan* (Nutricia) milkshake or soup powders from supermarkets/pharmacies
- Nutriment* and Nutriment Extra* (Dunn’s River) from supermarkets and cash & carry wholesalers
- AYMES* retail range (AYMES) milkshake powder from pharmacies
- Meritene Energies* (Nestle) milkshake or soup powders from pharmacies

Exclusion criteria
ONS can continue to be prescribed for residents who:
- Require ONS to be administered via an enteral tube
- Require a specialist formula, e.g. Elemental 028 Extra
- Have been assessed as requiring ONS by a dietitian, after food fortification and homemade supplements have failed to result in weight gain or due to underlying clinical condition.

The Slip Feed Prescribing Guidelines for GPs and community staff provides advice on which first and second line slip feeds are recommended for residents who satisfy the exclusion criteria, based on cost and clinical effectiveness. A regular review of the ONS should always be documented in the care plan.

Residents on food first plans should continue to be screened regularly using MUST and referred to community dietitians as per local policy guidelines.

Concerns or complaints should be directed to the Patient Advice and Liaison Service (PALS) tel. 0800 389 6819 or email pals@suffolk.nhs.uk

*ONS includes fortified food, additional snacks, slip feeds, semi-solid desserts, high energy/protein powders and liquids.

1. https://www.cqc.org.uk/content/regulation-14-meeting-nutritional-and-hydration-needs
2. https://www.nice.org.uk/guidance/cg32/chapter/1-Guidance

Produced by the NHS IESCCG and WSCCG Medicines Management Teams in collaboration with Ipswich and West Suffolk Community Dietitians

Version 1.1 August 2016 Review date August 2018
Oral Nutritional Supplements in Care Homes: Information for Care Home Staff

Care home staff should refer to the Oral Nutritional Supplements (ONS) in Care Homes Policy¹, which applies across Ipswich & East Suffolk and West Suffolk from 01 September 2016. The information below explains how the Policy will be implemented.

Care home residents who are not currently prescribed ONS
- Do not request ONS on prescription unless authorised to do so by a dietician.
- Follow the general dietetic advice below.

Care home residents who are currently prescribed ONS
- Continue the ONS for now.
- A dietician will review these residents between September and December 2016, with a view to stopping prescribed ONS where appropriate and switching to homemade supplements with extra snacks and food fortification*. The dietician will communicate this to the GP and care home, to ensure the prescribing change is implemented and documented.

General dietetic advice
- Document nutritional status on admission and thereafter using the Malnutrition Universal Screening Tool (MUST)² and follow the local policy guidelines.
  - MUST score 1 (medium risk of malnutrition): Offer homemade supplements and extra snacks. If no improvement after 2 weeks, add in food fortification*.
  - MUST score 2 or higher (high risk of malnutrition): Offer homemade supplements and extra snacks in addition to food fortification*.
- Monitor all intake on food and fluid charts.
- Refer to a community dietitian if weight loss continues after four weeks of offering homemade supplements, snacks and food fortification*. All residents including those on a food first plan should be screened regularly using MUST and the local policy followed. This plan includes how and when to refer to a dietitian.
- Residents with diabetes. Do not offer homemade fruit juice. Offer savoury and dairy snacks/fortified foods rather than sweet options.

*Food fortification – This means adding ingredients to normal food to increase energy content without increasing the volume of food eaten.

Recipes
Recipes for homemade supplements, snacks and food fortification are available on the Ipswich Hospital, West Suffolk Hospital and CCG websites:
- http://www.wsh.nhs.uk/ServicesAtoZ/ClinicalServices/N-P/NutritionandDietetics/NutritionandDietetics.aspx

Training and further information
Training is available free of charge for care home staff from: Ipswich Hospital Dietitians, tel. 01473 704000 or West Suffolk Community Dietitians, tel 01284 748850.
Further information: The National Association of Care Catering, and The Caroline Walker Trust

Concerns or complaints
Contact the Patient Advice and Liaison Service (PALS): 0800 389 6819 or pals@suffolk.nhs.uk

¹ Oral Nutritional Supplements (ONS) in Care Homes Policy. See www.ipswichandeastsuffolkccg.nhs.uk or http://www.westsuffolkccg.nhs.uk/ ² http://www.bapen.org.uk/screening-and-must/must/introducing-must

Author: Medicines Management Teams, Ipswich & East Suffolk CCG and West Suffolk CCG
Version 1.1 August 2016 Review August 2018
Dietary advice for people with poor appetite / unplanned weight loss

Food is a useful medicine. It contains protein, vitamins and minerals to help the body repair itself and gives valuable energy for recovery. However, when you feel ill you may not have much of an appetite, just when you need the food most!

Try to include the following in the daily diet:

- 3 small meals daily as well as 2 – 3 snacks or milky drinks.
- At least 1 pint of fortified full cream milk.
- 2 servings of protein-rich food: meat, chicken, fish, well-cooked eggs, cheese, yoghurt, nuts, beans or lentils.
- 1 serving of bread, potatoes, rice, pasta, cereal or chapatti with each meal. Choose wholemeal varieties where possible.
- Fruit and vegetables daily. Drink a glass of orange juice, grapefruit juice, or squash fortified with Vitamin C if little fruit is eaten. (Fruit juice is not advised for people with Diabetes if blood glucose levels are high).
- At least 6 – 8 cups of fluid e.g. tea, coffee, fruit juice, fruit squash, soups and milky drinks. Taking drinks after meals rather than before or during them may help if people feel full quickly.

Try high calorie snacks and drinks:

- Breakfast cereals with fortified full-cream milk
- Cheese and biscuits
- Full-fat / Thick and Creamy yoghurt
- Cold, ready-made desserts, e.g. truffles, crème caramels, fromage frais, individual custard pots.
- Small sandwich – filled with cold meat, bacon, tinned fish, cheese, hard-boiled egg, peanut butter, meat or fish paste, hummus.
- Teacake, scone, crumpet, bagel or current bun with butter/margarine and jam
- Horlicks, Ovaltine, Bournville, Cocoa, drinking Chocolate made with fortified full-cream milk. (Diet, Light or low-sugar versions of these drinks should be used by people with Diabetes if blood glucose levels are high).
- Cold or warm full cream milk – flavoured as desired

Fortify food and drink wherever possible by:

People with diabetes should take care when adding sugar, honey, syrup, dried fruit and evaporated milk and should not do so if blood glucose levels are too high.

- Add 4 tablespoons dried milk powder to 1 pint of full cream milk to make fortified milk. Use in place of ordinary milk in drinks, desserts and cooking etc.
- Add cream, evaporated milk, dried milk powder or grated cheese to milk based sauces
- To soup add grated cheese, cream, dried milk powder, evaporated milk, dumplings, baked beans or pasta
- To potatoes and vegetables: add grated cheese, cream, margarine/butter, salad cream, milk based sauces or fried onions
- To puddings add cream, custard, margarine/butter, evaporated/condensed milk, ice cream, jam, honey, syrup or dried fruit
- To breakfast cereals add fortified milk (see above), evaporated milk, yoghurt, sugar, honey, syrup, frosh or dried fruit.

Keep a record of food and drink consumed. For further information, contact your GP
Try These Recipes

Rather than filling up on drinks such as tea, coffee, fizzy drinks or water which are low in nutritional value, try making some of the following which are higher in energy and protein.

People with diabetes should take care when adding sugar, honey, syrup and evaporated milk and should not do so if blood glucose levels are too high.

Homemade 'Build Up' Style Milkshake
4 level teaspoons chocolate or strawberry Nesquik powder or 2 teaspoons of Crusha syrup
2 level teaspoons skimmed milk powder
200ml (1/3 pint) full cream milk

Blend together the Crusha and skimmed milk powder with a little milk then add the remaining milk and mix thoroughly with a fork or whisk until completely blended.

Rich Soup
300ml (1/2 pint) soup
3 tablespoons skimmed milk powder

Mix the skimmed milk powder with a little milk to form a smooth paste. Heat the soup but do not boil, and slowly stir in the paste. Serve hot.

Evaporated milk, cream, or grated cheese, can be added to make the soup even more nutritious.

Fruit Fool
300ml (1/2 pint) thick fruit puree
150ml (1/4 pint) thick custard
(Add two tablespoons of skimmed milk powder to milk)
150ml (1/4 pint) chilled evaporated milk
1 tablespoon of honey

Whip the evaporated milk to a thick consistency. Mix the custard with the fruit puree and fold in the milk. Chill before serving.

Commercially available Food Supplements
There are many nourishing drinks which can be bought over-the-counter at most chemists or supermarkets, e.g. Complan or Build-up / Meritene Energis.

What about Healthy Eating?
Low-fat and low-sugar foods are promoted as part of a healthy diet. It is not appropriate to use such foods while you are ill and not eating well. Higher-calorie foods will help you get your energy back and keep your strength up.
MANAGING SWALLOWING DIFFICULTIES

Advice which may make swallowing easier and lower but not eliminate the risk of aspiration

<table>
<thead>
<tr>
<th>Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Decrease distractions e.g. turn TV off</td>
</tr>
<tr>
<td>☐ Present food that is appealing to the eye</td>
</tr>
<tr>
<td>☐ Make the mealtime as natural as possible e.g. eat with others</td>
</tr>
<tr>
<td>☐ Avoid talking whilst eating and drinking</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Positioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Ensure the resident is sat upright ideally at a chair or in a 90° angle in bed. If it is possible, the resident needs to remain in this position for approximately 30 minutes after eating and drinking</td>
</tr>
<tr>
<td>☐ Ensure the resident’s head is well supported in a neutral, midline position</td>
</tr>
<tr>
<td>☐ Use extra pillows to ensure the resident is well supported and comfortable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oral care / Hygiene</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Ensure the Resident’s mouth is clean e.g. use a toothbrush or sponge. Mouth care products may be recommended e.g. non-foaming toothpaste. Please see the Speech and Language Therapist or Dentist for further advice.</td>
</tr>
<tr>
<td>☐ If the resident wears dentures, ensure they are used for meals and are well fitted. Clean dentures after meals.</td>
</tr>
<tr>
<td>☐ Mouth care is also required after meals for all residents to ensure all food/fluid residue is removed. Bacteria may form if food/fluid residue is left in the mouth.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family and Friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Ensure that family and friends are aware of the swallowing recommendations and the potential risks associated if these are not followed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Some residents with dysphagia may have difficulty swallowing medications. Signs may include: chewing medications, holding medication in their mouth or expelling them from their mouth.</td>
</tr>
<tr>
<td>☐ See the Pharmacist or GP for advice if they have any difficulties swallowing medications.</td>
</tr>
</tbody>
</table>
# COPD Symptoms & Action to take

<table>
<thead>
<tr>
<th>Good days</th>
<th>Bad days</th>
<th>Need to call for help</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SYMPTOMS</strong></td>
<td><strong>SYMPTOMS</strong></td>
<td><strong>SYMPTOMS</strong></td>
</tr>
<tr>
<td>• Client is able to do what they usually do</td>
<td>• Needing to use reliever inhaler more frequently</td>
<td>• Severe breathlessness with no relief from inhalers</td>
</tr>
<tr>
<td>• Energy levels good</td>
<td>• More breathless and /or wheezy than normal</td>
<td>• Feverish / temperature</td>
</tr>
<tr>
<td>• Sleeping at night time</td>
<td>• Difficulty with usual activities (washing/dressing/eating) due to shortness of breath</td>
<td>• More fatigued / sleeping more/drowsy</td>
</tr>
<tr>
<td>• Coughing and clearing normal amounts of sputum</td>
<td>• More chest tightness</td>
<td>• Coughing</td>
</tr>
<tr>
<td>• Normal levels of breathlessness</td>
<td>• More coughing</td>
<td>• More sputum / secretions than usual</td>
</tr>
<tr>
<td>• Rarely needing reliever inhaler</td>
<td>• More sputum than normal</td>
<td>• Sputum/ secretions changed in colour compared with normal</td>
</tr>
<tr>
<td>• No more tired than usual</td>
<td>• Feeling unwell and less energy</td>
<td>• Sounding wheezy or noisy breathing despite use of inhalers</td>
</tr>
<tr>
<td><strong>ACTION</strong></td>
<td><strong>ACTION</strong></td>
<td><strong>ACTION</strong></td>
</tr>
<tr>
<td>• Encourage to keep doing normal daily activities where possible</td>
<td>• Check inhalers have not run out.</td>
<td>• Consider starting steroid/antibiotic pack IF worsening breathlessness/discoloured sputum persists over 2 days. (See flare ups leaflet)</td>
</tr>
<tr>
<td>• Exercise daily e.g. walking for about 30 minutes a day or seated exercises</td>
<td>• Encourage breathing/relaxation exercises (as per advice sheet)</td>
<td>• Call GP for advice. They may start steroids/antibiotics (if no emergency packs held)</td>
</tr>
<tr>
<td>• Keep drinking plenty to stay hydrated</td>
<td>• Use a handheld fan to control breathlessness (as per advice sheet)</td>
<td>• GP may refer to COPD team for Admission Avoidance support if required.</td>
</tr>
<tr>
<td>• Maintain healthy weight by eating a balanced diet</td>
<td>• Increase use of ‘reliever’ inhalers as instructed by GP or nurse.</td>
<td>• If GP unavailable, call out of hours service/111</td>
</tr>
<tr>
<td>• Take medication as prescribed</td>
<td>• If signs of aspiration or choking due to breathlessness when eating or drinking provide with soft diet, and plenty of rest between small mouthfuls to enable client to ‘catch’ breath</td>
<td><strong>Call ambulance 999 if very short of breath/unable to wake patient</strong></td>
</tr>
<tr>
<td>• Make sure client uses a spacer where indicated to take inhalers and uses correct technique.</td>
<td>• Encourage regular fluids to stay hydrated</td>
<td></td>
</tr>
<tr>
<td>• Make sure client has flu vaccine and pneumovax injections</td>
<td>• Encourage combination of gentle rest and activity</td>
<td></td>
</tr>
<tr>
<td>• Smoking cessation advice if smoker</td>
<td>• Encourage regular small amounts of high fat/calorie foods</td>
<td></td>
</tr>
</tbody>
</table>

Call ambulance 999 if very short of breath/unable to wake patient
Good Sleep Guide

 ✓ Sleep duration varies from day to day. Try not to worry about sleeping.
 ✓ Establish fixed times for going to bed and waking up; avoid sleeping in after a poor night’s sleep and avoid daytime naps.
 ✓ Try to relax before going to bed and avoid anything mentally demanding within 30 minutes of bedtime.
 ✓ Do not watch television or use any back lit device e.g. tablets and phones for an hour before trying to go to sleep. The use of non-backlit e-readers and paper books is not thought to adversely affect sleep.
 ✓ Take regular exercise throughout the day but avoid strenuous exercise within four hours of bedtime.
 ✓ Avoid caffeine, nicotine, and alcohol within 6 hours of going to bed (consider complete elimination of caffeine from the diet). Caffeine and nicotine are stimulants which could keep you awake.
 ✓ Do not eat a heavy meal before bedtime.
 ✓ Create a bedtime routine to help set your body up for a restful night (take a warm bath, read a book, listen to soft music).
 ✓ If you have problems getting off to sleep have a mug of warm milk, Horlicks, Ovaltine or herbal tea.
 ✓ The bedroom should be dark, quiet and a relaxing place. The room should be not too hot or cold.
 ✓ Refrain from using the bedroom to eat or perform any work related activities, using it only for sleep.
 ✓ If after 30 minutes you cannot get to sleep, get up and go into another room and try to do something else (light reading or listening to relaxing music) until you feel sleepy, then go back to bed.
 ✓ Avoid taking over the counter sleep aids, as although they may help in short term use, they do not help the underlying problem causing disturbed sleep.
 ✓ A good sleep pattern may take weeks to establish, but it can be achieved.
Flowchart for the Diagnosis of UTI in Elderly Care Home Residents

Use this flowchart to assess residents presenting with any of the following:

- Fever: temperature of >37.9°C or 1.5°C increase above baseline (on at least two occasions in the last 12 hours).
- Hypothermia: temperature of <36°C
- Non-specific symptoms of infection: abdominal pain, behavioural change, loss of diabetes control.

FOR USE BY APPROPRIATELY TRAINED STAFF ONLY

DO NOT routinely use dipstick test in diagnosis of UTI

Does resident have a urinary catheter?

- NO

Does resident have ONE or more of the following symptoms?
- Shaking chills (rigors)
- Flank pain
- New onset confusion

- YES

UTI unlikely: but continue to monitor symptoms

- NO

Does resident have TWO or more of the following symptoms?
- Pain on urinating
- Need to pass urine urgently
- Urinating more often
- Urinary incontinence
- Shaking chills (rigors)
- Flank or suprapubic pain
- Blood in urine
- New or worsening confusion or agitation

- YES

UTI LIKELY

1) Contact GP
2) Complete ‘Record of Symptoms of UTI’.
3) Direct GP to ‘Management and Treatment of UTI’ guidance leaflet.
4) Review response to treatment daily.
5) Contact GP again if resident’s condition deteriorates or their symptoms do not improve.

Produced by the WSCCG Medicines Management Team. Version 1, November 2017.
Management and Treatment of UTI in Elderly Care Home Residents

Management
- If two or more symptoms of infection, obtain urine sample and send to microbiology for culture.
- Consider analgesia (paracetamol is recommended first line)
- Assess if retention or sub-acute retention of urine is likely (e.g. blocked catheter or distended bladder)
- If resident has a urinary catheter, remove and replace it. Consider the ongoing need for a long term catheter, in consultation with specialists.
- If flank or suprapubic pain, consider diagnosis of pyelonephritis and treat accordingly.

Treatment of infection

<table>
<thead>
<tr>
<th>Renal function: eGFR &gt; 45 mL/min</th>
<th>Renal function: eGFR &lt; 45 mL/min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nitrofurantoin 100mg m/r BD for 7 days</td>
<td>DO NOT USE</td>
</tr>
</tbody>
</table>

2nd Line Treatment: Trimethoprim

<table>
<thead>
<tr>
<th>Renal function: eGFR &gt; 30 mL/min</th>
<th>Renal function: eGFR 15-30 mL/min</th>
<th>Renal function: eGFR &lt; 15 mL/min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trimethoprim 200mg BD for 7 days</td>
<td>Trimethoprim 200mg BD for 3 days then 100mg BD for 4 days</td>
<td>Trimethoprim 100mg BD for 7 days</td>
</tr>
</tbody>
</table>

Women

1st Line Treatment: Nitrofurantoin

<table>
<thead>
<tr>
<th>Renal function: eGFR &gt; 45 mL/min</th>
<th>Renal function: eGFR &lt; 45 mL/min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nitrofurantoin 100mg m/r BD for 3 days</td>
<td>DO NOT USE</td>
</tr>
</tbody>
</table>

2nd Line Treatment: Trimethoprim

<table>
<thead>
<tr>
<th>Renal function: eGFR &gt; 15 mL/min</th>
<th>Renal function: eGFR &lt; 15 mL/min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trimethoprim 200mg BD for 3 days</td>
<td>Trimethoprim 100mg BD for 3 days</td>
</tr>
</tbody>
</table>

If Care Home reports deterioration or no improvement of symptoms, consider increased level of care or admission to hospital.

FOR CARE HOME USE ONLY

RECORD OF SYMPTOMS OF UTI: complete when flowchart indicates UTI is likely and add to resident notes.

<table>
<thead>
<tr>
<th>Resident name:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS number:</th>
<th>Usual GP:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name and job title of person conducting assessment:</th>
<th>Date symptoms were assessed:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1) Does the resident have a urinary catheter?

- YES and removed / replaced
- NO

2) Which symptoms does the resident have?
(Please tick all that apply)

- ☐ Pain on urinating
- ☐ Need to pass urine urgently
- ☐ Urinating more often
- ☐ Urinary incontinence
- ☐ Shaking chills (rigors)
- ☐ Flank or suprapubic pain
- ☐ Blood in urine
- ☐ New or worsening confusion or agitation
FOR CARE HOME USE ONLY

RECORD OF MANAGEMENT OF UTI: complete only after consultation with GP where flowchart indicates UTI is likely and add to resident notes.

<table>
<thead>
<tr>
<th>Resident name:</th>
<th>D/OB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of consultation with GP:</td>
<td>Type of consultation (please delete as appropriate): TELEPHONE CALL HOME VISIT</td>
</tr>
<tr>
<td>Name of GP consulted:</td>
<td>Name of person describing symptoms to GP:</td>
</tr>
</tbody>
</table>

1) Urine sample taken for culture?  
   - YES  
   - NO

2) Did the GP prescribe antibiotics for this resident?  
   - YES  
   - NO

1) Date antibiotic course was started (if applicable): 

2) Other management (please tick all that apply):
   - Paracetamol prescribed or given under homely remedies policy.
   - Ibuprofen prescribed or given under homely remedies policy.
   - Specialist contacted regarding ongoing need for catheterisation (if known).
   - Resident admitted to hospital (please state reason for admission if known).

Signature of staff member completing form:  
Date of completion:

Produced by the WSCCG Medicines Management Team. Version 1, November 2017.
# Urinary tract infection (UTI) information leaflet

**For women outside care homes with suspected uncomplicated urinary tract infections (UTIs) or uncomplicated recurrent UTIs**

<table>
<thead>
<tr>
<th>Possible urinary symptoms</th>
<th>The outcome</th>
<th>Recommended care</th>
<th>Types of urinary tract infection (UTI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency: Passing urine (wee) more often than usual</td>
<td>Mild, or 1 to 2, symptoms or vaginal discharge (or both)</td>
<td>Self-care and pain relief</td>
<td>UTIs are caused by bacteria getting into your urethra or bladder, usually from your gut. Infections may occur in different parts of the urinary tract.</td>
</tr>
<tr>
<td>Dysuria: Burning pain when passing urine</td>
<td></td>
<td>• Antibiotics less likely to help.</td>
<td></td>
</tr>
<tr>
<td>Hematuria: Blood in your urine</td>
<td>Severe, or 3 or more, symptoms and no vaginal discharge</td>
<td></td>
<td>• Pyelonephritis (pain-to-not-right-side)</td>
</tr>
<tr>
<td>Nocturia: Needing to pass urine in the night</td>
<td>With antibiotics:</td>
<td>Antibiotic prescription</td>
<td><strong>Bladder (stores urine)</strong></td>
</tr>
<tr>
<td>Suprapubic pain: Pain in your lower tummy</td>
<td>• Symptoms should start to improve within 48 hours.</td>
<td>Immediate treatment with antibiotics, plus self-care.</td>
<td>• Cystitis (air-right-side)</td>
</tr>
<tr>
<td><strong>Other things to consider</strong></td>
<td>• Symptoms usually last 3 days.</td>
<td>Start delayed or backup treatment with antibiotics:</td>
<td><strong>Urethra (takes urine out of the body)</strong></td>
</tr>
<tr>
<td><strong>Recent sexual history</strong></td>
<td></td>
<td>• if symptoms get worse.</td>
<td>• Urethritis (your-th-right-side)</td>
</tr>
<tr>
<td>Some sexually transmitted infections (STIs) can have symptoms similar to those of a UTI.</td>
<td></td>
<td>• if symptoms do not get a little better with self-care after 24 to 48 hours.</td>
<td></td>
</tr>
<tr>
<td>Inflammation due to sexual activity can feel similar to the symptoms of a UTI.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When should you get help?</th>
<th>Options to help prevent a UTI</th>
<th>Antibiotic resistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact your GP practice or contact NHS 111 (England), NHS 24 (Scottish) dial 111, or NHS direct (Wales) dial 0845 604 22 22</td>
<td><strong>The following symptoms are possible signs of serious infection and should be assessed urgently.</strong> Phone for advice if you are not sure how urgent the symptoms are:</td>
<td><strong>Antibiotics may not always be needed.</strong> Only take them after advice from a health professional. This way they are more likely to work if you have a UTI in the future.</td>
</tr>
<tr>
<td><strong>Drink enough fluids to stop you feeling thirsty.</strong> Aim to drink 6 to 8 glasses including water, decaffeinated and sugar-free drinks.</td>
<td><strong>Stop the spread of bacteria from your gut into your bladder.</strong> Wipe from front (vagina) to back (bottom) when you go to the toilet.</td>
<td><strong>Antibiotic resistance means that the antibiotics cannot kill that bacteria.</strong></td>
</tr>
<tr>
<td><strong>Take paracetamol or ibuprofen at regular intervals for pain relief, if you’ve had no previous side effects.</strong></td>
<td><strong>Avoid waiting to pass urine.</strong> Pass urine as soon as you need a Wc.</td>
<td><strong>Common side effects to taking antibiotics include thrush, rashes, vomiting and diarrhoea.</strong></td>
</tr>
<tr>
<td>You could try taking cranberry capsules or cystitis sachets. These are effective for some women.</td>
<td>Go for a wee after having sex to flush out any bacteria that may be near the opening to the urethra.</td>
<td></td>
</tr>
<tr>
<td>There is currently little evidence to support their use.</td>
<td>Wash the external vagina area with water before and after sex to wash away any bacteria that may be near the opening to the urethra.</td>
<td></td>
</tr>
<tr>
<td>Consider the risk factors in the ‘Options to help prevent UTI’ column to reduce future UTIs.</td>
<td>Drink enough fluids to make sure you are regularly throughout the day, especially during hot weather.</td>
<td></td>
</tr>
</tbody>
</table>

www.antibioticguardian.com

**RCGP**

Royal College of General Practitioners

**BIA**

British Infection Association

**SSU**

Scottish Society for Urogenital Medicine

**BPS**

Scottish Pharmaceutical Society

**GIG**

Glasgow Infectious Diseases Group

**NHS**

Public Health England

V17, 30th November 2016

The Purple Book version 1 – Section 3
Produced by IESCCG and WSCCG May 2018
Local Health Protection Team: Regional Health Protection Unit at Croxton Way, Thetford on 0344 225 3546 for Care Home related outbreaks.
Notes to accompany Diarrhoea and Vomiting Flow Chart

1. Diarrhoea in older people is not always caused by an infection but all cases should be taken seriously and presumed to be infectious until advised otherwise.

Many healthcare settings use the Bristol Stool Chart to assess whether a person has diarrhoea and to monitor these symptoms. Stool type 5, 6 or 7 is typically classified as diarrhoea.

The Bristol Stool Form Scale

<table>
<thead>
<tr>
<th>Type 1</th>
<th>Separate hard lumps, like nuts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2</td>
<td>Sausage-like but lumpy</td>
</tr>
<tr>
<td>Type 3</td>
<td>Like a sausage but with cracks in the surface</td>
</tr>
<tr>
<td>Type 4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>Type 5</td>
<td>Soft blobs with clear-cut edges</td>
</tr>
<tr>
<td>Type 6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>Type 7</td>
<td>Watery, no solid pieces</td>
</tr>
</tbody>
</table>

2. An outbreak of infection: is defined as two or more cases of infection occurring around the same time, in residents and/or care workers or an increase in the number of cases more than normally observed. The most common agent that causes diarrhoea and vomiting is norovirus.

3. Hand hygiene: alcohol hand rub is not effective against norovirus or Clostridium difficile diarrhoea, so always use soap and water when having contact with residents with diarrhoea or vomiting.

4. Gloves and aprons: are single use items and must be changed in between patients. Hands must be decontaminated immediately following removal.

5. Enhanced cleaning: must be undertaken by staff trained appropriately to undertake cleaning.
   - Use a detergent followed by disinfection with a bleach-based product at a concentration of 1000 parts per million (ppm) available chlorine, or a combined chlorine and detergent solution.
   - Use disposable cloths and washable mops to clean hard surfaces twice-daily.
   - Pay particular attention to frequently touched surfaces, including toilet seats, toilet flush, taps, light switches, soap dispenser, door handles and telephones.
   - Keep cleaning equipment for the toilet and bathroom areas separate from those used in other areas, especially catering.
   - Undertake a “Terminal Clean” of the home following resolution of symptoms for 48 hours.
     - In any room where a recovered resident has had contact:
       - Remove window and privacy curtains and launder
       - Discard unused disposable patient-care items
       - Remove bed linen and unused linen and launder
     - Thoroughly clean all hard surfaces in the home with a detergent followed by disinfection or a combined chlorine and detergent solution.
• Decontaminate all equipment in accordance with manufacturer’s instructions
• It is recommended that soft furnishings and carpets are steam cleaned.

6. Laundry:
   - Wear gloves and aprons for handling contaminated clothing or linen.
   - Segregate laundry in resident’s room to avoid additional handling by laundry staff.
   - Ideally bag linen in a water soluble bag which can be placed directly into the washing machine.
   - Never empty bags of linen on the floor to sort. Wash hands after handling linen.
   - Careworker clothing/uniforms – wear clean uniform daily & change out of uniform before leaving work if caring for symptomatic residents. Place in a plastic bag & wash in washing machine at home.

7. Visiting during an outbreak of diarrhoea and/or vomiting:
   - Discourage children of school age and non-essential visitors to visit.
   - Terminally ill residents, vulnerable adults and those for whom visiting is an essential part of recovery should be allowed visitors at the discretion of the home manager.
   - Visits to multiple residents (e.g. by ministers of religion) should be planned so that those under isolation are visited last.

8. Communication:
   - Provide written advice for resident’s family and visitors and care staff.
   - During an outbreak, if notices in the home are felt to be too intrusive, then consider using alternative methods, such as speaking with visitors on arrival and providing information sheets or leaflets.

9. Outbreak report: summarize the outbreak including type of outbreak, cause, dates of outbreak, number of residents affected, number of staff affected, actions implemented, areas of good practice, lessons learnt.

Useful documents:


Hand Hygiene

1. Palms together
2. Backs Backs
3. Through i.e. fingers interlaced
4. Knuckles Knuckles i.e. finger tips into the base of fingers both sides
5. Thumbs Thumbs
6. Palms Palms
7. Wrists Wrists

More information is available at http://sepsistrust.org/

Don’t forget your wrists!

Alcohol gel does not kill Clostridium Difficile spores or Norovirus
Recognising Cellulitis

Does the Resident have a swollen limb?
(Usually the leg, but upper arm may be affected)

YES

- The leg and ankle have become more swollen QUICKLY.
- There is no distinct area of inflammation.
- The leg is generally tender.

POSSIBLE DVT

A SCAN IS NEEDED
NOTIFY THE GP

NO

CELLULITIS UNLIKELY

- The swelling seems localised.
- There is a distinct red, tender area.
- The whole limb is not NEWLY swollen.
- There may be signs of fever.

PROBABLE CELLULITIS

ANTIBIOTICS ARE REQUIRED
NOTIFY THE GP

YES

Using a pen or permanent marker, draw on the limb around the outside of the inflamed area.
Record temperature, pulse and respiration.

- Give pain relief.
- Provide adequate fluids to drink.
- Elevate the limb where appropriate.
“I STUMBLE” Algorithm for Help

CALL 999

- Keep resident CALM STILL COMFORTABLE
- Answer all questions and follow instructions from 999 call taker
- Wait with resident until ambulance arrives
- Prepare medications:
  - MAR sheets
  - Relevant documentation
- Inform Next of Kin

**INTENSE PAIN**

**Suspected collapse**

**Trauma to neck/back/head**

**Unusual behaviour**

**Marked difficulty in breathing/cheat pain**

**Bleeding freely**

**Loss of consciousness/knocked out**

**Evidence of fracture**

**FAST Test normal**
- Face – equal on both sides
- Arms – able to hold both arms up without assistance
- Speech – no slurring, able to speak as normal
- Time – Get an accurate time of onset

**Yes**

Use correct lifting aids and manual handling to lift resident from the floor

**No**

REASSESS

**Yes**

**No**

**Treat minor injuries within scope of practice**

**Consider GP/Nurse for minor injury treatment**

**Observe regularly for changes in condition**

**For further advice, call NHS 111**

**Document Falls record and any injuries on body map**

**Commence Falls investigation**

**Complete a Falls Referral**

**EEAST/NWILLiams** Adapted from West Midlands Ambulance Service

The Purple Book version 1 – Section 3
Produced by IESCCG and WSCCG May 2018
21
“I STUMBLE” a falls assessment tool

Intense Pain
- New Pain since Fall
- Includes Headache, Chest Pain and Abdominal Pain
- Consider both pain from injury caused by fall or medical causes

Suspected Collapse
- Ask resident if this was a trip or collapse (do they remember falling)
- Any dizziness, sudden nausea or pain before the fall
- Includes “near fainting” episodes

Trauma – to Head/Neck/Back
- New pain in Head/Neck or Back following the fall
- New visible or physical injury, lump or dents to head – with or without bleeding
- Any new numbness or paralysis in any limbs or face

Unusual Behaviour
- New Confusion
- Acting Different to Normal Self e.g. agitated, combative, aggressive, sleepy, quiet
- Difficulty Speaking e.g. Slurred Speech, words mixed up, unable to verbalise objects, stuttering

Marked Difficulty in Breathing/Chest Pain
- Severe shortness of breath, not improved when any anxiety is reduced
- Unable to complete full sentences
- Blue/Pale lips or fingers, becoming lethargic or confused
- New Onset of inability to mobilise/lay still without difficulty in breathing

Bleeding Freely
- Free flowing, pumping or squirting blood from a wound
- Widespread swelling and bruising to face/head or injured limb
- Apply constant direct pressure to injury with clean dressing, elevate if possible
- Try to “estimate” blood loss, in mugfuls (often difficult)

Loss of Consciousness
- Knocked Out
- Drifting in and out of consciousness
- Limited memory of events leading up to, during or after fall. (unusual for resident)
- Unable to retain or recall information, repetitive speaking (unusual for resident)

Evidence of Fracture
- Obvious Deformity – e.g. shortened and rotated limb, bone visible, severe swelling
- Reduced range of movement in affected area
- Unusual movement in affected area

In all 999 cases remember to keep resident: CALM, STILL & COMFORTABLE
If any bleeding is present, apply constant pressure with a clean dressing
**MAR chart reconciliation form**

It is important that every Care Home Resident has an accurate and up-to-date medication administration record (MAR) chart.

This form should be used to inform your community pharmacy if any items currently listed on a Resident’s MAR chart are no longer in use. The pharmacy should remove these medications from future MAR charts for that Resident.

Remembering to use this chart keeps the Resident's medication record as accurate as possible. It also alerts the pharmacy to any changes in the medication.

If you are unsure whether the Resident is, or should be, still using any of the items on their list, please contact the GP surgery to confirm.

The following blank MAR chart can be copied and used for Residents in your Care Home if needed.
**MAR chart reconciliation form**

Please use this form to inform the community pharmacy of items that are still listed on the patients MAR chart, but are not actively being used. This will apply to all items which are no longer listed on the patient’s repeat, and items which are not being given as a current acute course, including dressings, inhalers, creams and sprays, as well as drugs which may no longer be needed.

If you are unsure of whether the patient is still using one of the items listed, then please contact the GP surgery to confirm.

**Please use one form per patient**

Dear Pharmacist, Please remove the following items from the printed MAR charts for the listed patients, as they are no longer of clinical need.

Patient name: __________________________

NHS number: __________________________

DOB: ______________

<table>
<thead>
<tr>
<th>Name of drug</th>
<th>Strength</th>
<th>Directions</th>
<th>Additional comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MAR charts should only contain items in current use by the patient in order to reduce errors in reconciliation and administration of medicines.
Clinical Frailty Scale*

1. Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3. Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowly up,” and/or being tired during the day.

5. Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7. Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging; Revised 2008.

© 2007-09 Version 1.2. All rights reserved, Geriatric Medicine Research, Dalhousie University, Halifax, Canada. Permission granted to copy for research and educational purposes only.
Support tool for end of life care in Suffolk

1. Identification of risk of dying
   Incorporate proactive recognition into daily practice with the aim of assessing whether the patient is in the last few months or last days of life or could just benefit from advance care planning. Assess for any reversible factors.

2. Sensitive, proactive communication of prognosis and plans of care with the dying person and those important to them

3. Holistic needs assessment of patient and those important to them
   - Physical, psychological, social, financial, spiritual, religious and carer needs assessment

4. Offer an opportunity for Advance Care Planning (ACP) assessing for mental capacity as part of this process
   - Include any information on any ACP discussions in the My Care Wishes (yellow) folder
     - Consider completion of key documents within these e.g. DNACPR, Thinking Ahead, and tissue donation etc.
   - Consider if Just in case (JIC) medication is required

Specialist teams for some of these conditions can be contacted via the Care Coordination Centre (CCC)

5. Clinical review and action by appropriate Health Care Professional
   - Seek advice as needed as below
     - Take into consideration the patient’s fully informed preferences for place of care
     - Regular reassessment of effectiveness of the plan of care

For urgent and non-urgent advice/行动 (pain and distress are urgent; this does not just refer to acute life threatening problems)
- Care Coordination Centre 0300 123 2425
  - 24/7, multi-agency health, social care and voluntary sector admission avoidance services.
  - WEST: Early Intervention Team (EIT)
  - EAST: Crisis Action Team (CAT)
- The individual’s GP
- Direct call to your local Hospice (24/7) for specialist advice and support
  - WEST: St Nicholas Hospice Care 01284 766133
  - EAST: St Elizabeth Hospice 08005670111
- GP Out of Hours service via 111
- EEASt ambulance service (see notes to the right): 999

The majority of individuals would prefer to be cared for at home/usual place of residence.
- All possible options to prevent unwanted hospital admission should be considered if this is in their best interests. At times, hospital admission may be appropriate even in the last few weeks or months of life but it should not be the default option.
- Early recognition, high quality communication to patient and family, holistic assessment and advance care planning can help prevent the need for inappropriate hospital admission.
- Early referral to hospice services, agreement regarding DNACPR and ‘Just in Case’ medication are other important factors.

From diagnosis stable and may have prognosis over a year

Unstable or advanced disease likely prognosis of months

Deteriorating Likely prognosis of weeks

Dying: Likely prognosis of days

Care after death

The Purple Book version 1 – Section 3
Produced by IESCCG and WSCCG May 2018
26
Contracture Early Warning Trigger Tool

Guidance statement: This tool has been compiled by a working party of health care professionals working across acute and community services. It is designed to help identify muscle, skin or joint changes that are occurring whilst these are in a treatable phase, avoiding complications associated with contractures.

A contracture is an abnormal shortening of muscle tissue, making the muscle highly resistant to stretch, leading to permanent disability.

It is recommended to apply this tool on a monthly basis for each individual particularly if they show any of the factors below;

- Less moving or walking than normal for that person
- Less food or fluid intake
- Less feeling or sensation on some or all their body
- Incontinence or moisture to their skin
- Less able to communicate their needs to others

Part 1 - To be completed by the person delivering the direct care

The following questions will collectively look at range of movement, stiffness, ease of care, skin colour or condition. Please answer the following questions. If you answer yes to any of these move to Part 2.

Is it more difficult than previously to wash and dress? (either self managed or assisted)
- Yes
- No

Is it more difficult than previously to assist the person into a comfortable position?
- Yes
- No

Have you noticed any alteration in skin condition (colour, texture, moisture, skin damage)?
- Yes
- No

Part 2—Also to be completed by the person delivering the direct care

If you have answered yes to any of the questions in part 1, please tick all that apply:

Washing and Dressing Changes
- Top Half
- Bottom Half

Getting into a Comfortable Position Changes
- Sitting in a chair
- Lying in bed
- Supporting the residents arms

Change in Range of Movement Changes

Legs
- Hips can’t straighten out to lie flat
- Knees can’t straighten out to lie flat
- Ankles/feet can’t rest flat on the floor/footrests

Arms
- Shoulders difficult to lift arms
- Elbows difficult to bend or straighten fully
- Hand/wrist/fingers can’t lie flat on lap

Altered Skin Colour or Condition

Arm
- Upper Arm
- Elbow
- Lower Arm
- Hand

Leg
- Hip/Groin
- Knee
- Foot/heel

Torso
- Front
- Back/sacrum
- Side
Part 3—to be completed by the person delivering the direct care

What changes have you noticed?

If a skin colour change has been noted, what are these changes?

If there is a skin texture change noted, what are these changes?

Is a blister present?

Is there any broken skin? *

Is there pain related to this skin break down?

Is there any sign of infection? (redness, heat, fever, chills, continuous/increased pain, fluid from site)

Are there any further comments to add?

* If you have answered ‘yes’ to this question please make an urgent referral to the district nurse (if there is no on site nurse to refer to)

Form completed by (name, role and date):

Outcome reported to (Line manager name, role and date):

---

Part 4—to be completed by Line Manager

Now you have gathered all the relevant information, use this section to consider your impression of the risk and what you are planning to do about it.

** Impression (please circle all that apply):
- Contracture (non changeable)
- Muscle tightness (changeable)
- Skin condition alteration

** Referral required (please circle all that apply):
- Therapy (for positioning support)
- Nurse ** (for skin alteration)
- GP (for pain and infection)

** Is the referral urgent or routine (this may be different for each referral required)?
- Urgent
- Routine

When these referrals have been completed add the date completed here:

What actions have been immediately put in place?

Date the feedback was provided to carers/staff?

** Please remember this could be your nurse within your home (if your resident has nursing funding)

If after completing the form you identify a referral need in Part 4, please use the following referral routes:
- GP (Ring: GP direct) or Community nurse/Physio and OT (Ring: 0300 123 2425)

Feedback provided to the person’s carers (add to this and expand on a separate page as further advice is given):

Actions completed and signed off by (Manager name, signature, role and date):