

Care Home Winter Readiness Pack 26/27

Preparing for winter is an important part of support to residents and staff in care homes across the Greater Glasgow and Clyde area.

This pack contains a range of useful winter readiness information and planning resources. The information in the pack is aligned with good practice and national guidance, and is intended to complement local arrangements.

Contents

Planning
Winter Preparedness 03
Future Care Planning 04
Vaccinations 05
Technology and Interface Care 06

Supporting residents health and wellbeing
Nutrition and hydration 07
Skin 08
Keep moving 09
Reducing the risk of falls 10
Infection prevention and control 11

Public health advice
Managing an outbreak 13
Care Home symptomatic testing 14

Recognising deterioration
Responding to deterioration - RESTORE2/RESTORE2 Mini 16
Supporting residents with delirium 17
Rockwood Clinical Frailty Scale 18
Supportive Palliative Action Register (SPAR) 19

Supporting unwell residents (managing complexity)
Managing falls 20
Skin tears 21
Managing respiratory symptoms 22
Medicines 23
Red Bags 24
Additional support for complex care 25

Communication
Getting your message across (SBARD) 26
Care after death 27
Talking with relatives 28

Supporting last days of life
Resources for families and staff 29

Supporting staff
Self-care for staff 30
Support for leaders 31

Checklist and acknowledgements 32

Winter preparedness



As we move into the winter months, it is important that care homes take some simple steps to prepare for adverse weather and potential travel disruption. Planning ahead can help ensure essential care and support continue to be delivered safely, even during periods of severe weather.

Managers should review their business continuity plans and ensure they include arrangements for maintaining safe staffing levels and essential services during adverse weather. This should include identifying critical roles and responsibilities, considering how staffing shortages may be managed, and ensuring effective communication arrangements are in place.

It is also helpful to discuss these plans with staff in advance so everyone understands what to do if severe weather affects their ability to travel to work or impacts normal service delivery.

Managers are encouraged to:

- Review business continuity plans and ensure arrangements for adverse weather are up to date.
- Identify essential services and key roles that must be maintained during periods of disruption.
- Consider contingency staffing arrangements, including redeployment of duties where appropriate.
- Ensure staff know who to contact if they are unable to travel to work and that up-to-date contact details are available.
- Discuss winter preparedness plans with staff before adverse weather occurs.
- Check that emergency supplies, equipment and communication systems can support continued safe care if access to the care home is affected.
- By preparing in advance, care homes can minimise disruption and help ensure residents continue to receive safe, high-quality care throughout the winter period.

🏠 WINTER READY CARE HOME

📋 REVIEW PLANS

Review Continuity Plans

👥 ESSENTIAL SERVICES

Identify Essential Services & Roles

📞 CONTACT ARRANGEMENTS

Confirm Staff Contact Arrangements

🚗 TRAVEL PLANNING

Plan for Travel Disruption

💬 COMMUNICATE

Discuss Arrangements with Staff

🛡️ SERVICE CONTINUITY

Maintain Essential Services

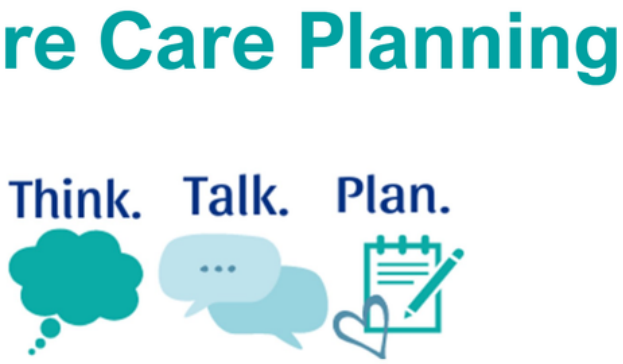
Future care planning

A Future Care Plan (FCP), previously known as Anticipatory Care Plan, is a record of someone's wishes. It should be created over time and reflect conversations between a resident, the people that matter to them and the health care professionals that work with them.

These conversations support resident choices about future care, including information about specific treatments or care that would be appropriate for them, when they would consider or accept this care, and where they would like to be cared for. Speak to your local HSCP team to upload this to clinical portal and eKIS.

Everyone has a role to play in Future Care Planning, whether its having the conversations and recording them or accessing the information when necessary.

This interactive Microsoft Sway provides an overview of what Future Care Planning is, who it is for, what to discuss and why it is important to plan for future health and care.



What to do with the Future Care Plan

- Make sure a copy is easily accessible in the resident's file
- Commencements or any updates must be shared with other health and social care professionals in your locality who can update Clinical Portal and the Key Information Summary (KIS). The KIS is an electronic record which NHS24 and the Scottish Ambulance Service can access.

RDS Resources

Vaccinations

Seasonal vaccination programme

Respiratory infections, such as Covid and Flu, can spread easily and cause serious illness for vulnerable people. Vaccination helps to build up immunity to viruses, so that the body can more easily fight them if infected. Like all medicines, no vaccine is completely effective, and some people may still get respiratory infections despite having a vaccine, but any illness should be less severe.

Vaccinations support care home residents in the same way, and help to limit the onward spread of infection within the care home.



Respiratory Syncytial Virus (RSV)

RSV is a common respiratory virus which circulates **all** year, although cases tend to peak in winter. RSV can be serious in older adults and in some cases it can lead to severe infection of the lungs and other life threatening conditions. Vaccination offers the best form of protection. Visit the NHS Inform website for further details on eligibility

Staff vaccine programme

Working in a care home can mean greater exposure to winter viruses. As part of supporting your health and wellbeing, all care home staff - cleaner, cook, anyone who has contact with residents - are eligible for a free vaccination.



For more information and to book your appointment:

NHS Inform Winter Vaccines

Vaccination Helpline
0800 030 8013

Protect yourself and those you care for this winter by taking up the vaccination offer.

Please see the NHSGGC vaccination webpage for further information, including how to access the vaccination via a participating community pharmacy.

Vaccination protects both staff and residents through reducing serious illness and transmission.

Technology

The contribution of technology to health and social care is growing. Digital apps such as the Right Decision Service give health and social care staff access to a wealth of information at the touch of a button.

The Right Decision Service is a 'Once for Scotland' source of digital tools that enable people to make safe decisions quickly ‘on the go’, based on validated evidence. It provides health and social care organisations with tools to build decision-ready guidance, pathways, risk scoring tools, shared decision aids and other decision support resources.

Technology enabled care and video consultation services support quicker access to advice, support and treatment, in the comfort of the care home environment.

Near Me

Video consultations

Near Me is a video consulting service that enables people to attend appointments from home.

To access this you need a device for making video calls like a smartphone and an internet connection.

Interface Care

Interface Care is all about making sure people get the care they need, where and when they need it, from the right team. That might be at home, in a care home, out in the community, or in hospital. It helps join up services across hospital and community settings so people can move between them more easily—and avoid hospital stays when they’re not needed.

The NHSGGC Interface Division is leading the way with new approaches like the Flow Navigation Centre Plus (FNC+Plus), remote monitoring, and the virtual hospital.

FNC+Plus

At present there are Care Home Pathways which enable care home staff / community health care staff access to professional triage, clinical advice, and support. This includes pathways for residents who have fallen, who are deteriorating or require care when they are dying. The Interface Division will build on these pathways by working collaboratively with acute, HSCP, primary care and social care colleagues.

Nutrition and Hydration

Our bodies can react differently to the cold, making it harder to manage some health conditions and more difficult to fight infections. Within NHSGGC, the Malnutrition Universal Screening Tool (MUST) is used to screen all residents to identify malnutrition risk. For more information about nutrition in care homes, please click here.

Eating and drinking tips to stay well this winter:

- Increasing protein sources will support maintenance of muscle mass, keeping the body stronger to fight infection. Protein sources include meat, poultry, fish, eggs, milk and dairy, tofu, nuts and seeds.

- Encourage healthy snacking. Sometimes appetite can decrease in the winter months so it is important to follow a small and often approach, offering nourishing snacks between meals.

- Make mealtimes count. Healthy meals consist of protein, carbohydrates, healthy fats and fruit/ vegetables. A balanced diet will help residents obtain all vital nutrients throughout the day. For more information have a look at the mealtime experience poster here

- Get a vitamin boost:
  - **Vitamin C** boosts immunity. Find it in citrus foods, strawberries, red peppers, and cruciferous vegetables (e.g. broccoli, cauliflower and sprouts)
  - **Vitamin B12** helps support cognitive health and memory. Find it in eggs, milk and dairy, meat and some seafood
  - **Vitamin A and K** support many things, including bone health and immunity. Good sources include leafy greens, dairy products and tofu.



Making the most of familiar foods

If a resident is unwell, or their appetite is poor, it can be useful to offer nourishing versions of foods you know they like.

For further ideas check out the food fortification poster.



Offer regular fluids:

It can be hard to stay hydrated when the weather is colder. Encourage residents to drink regularly throughout the day.

For more information have a look at the hydration poster.



How to offer fortified milkshakes

If a resident scores a MUST of 1 or above and is started on a MUST Step 5 pathway, fortified milkshakes can be an important source of additional nutrition. For more information please have a look at our resources.

Skin

Colder weather and indoor heating can cause increased moisture loss, so during the winter months your residents' skin might be drier. This can make skin feel rougher, itchy, or flaky, increasing the risk of skin breakdown from skin tears, moisture associated skin damage and pressure ulcers. Thankfully there are lots of ways to protect your residents' skin

Skincare

Moisturisers (emollients) can help smooth and hydrate the skin. Creams and ointments are more effective and less irritating than lotions. Recent studies within care homes have shown that keeping residents' skin moisturised and supple with application of emollients can significantly reduce skin tears and pressure ulcers.





Shorter baths or showers

Contact with water, and non pH balanced soaps, can strip away the skin's protective oily layer, leaving skin irritated. So, try to keep baths and showers as short as possible, and use pH balanced cleansing products. Gently pat dry the skin and apply emollients straight after to lock in the hydration

Stay hydrated and eat well

Drinking water boosts our skin moisture levels. We know that if we're dehydrated our skin will feel dry. We often don't feel particularly thirsty during winter, but central heating can make us more dehydrated.
Eating foods that contain water can keep your skin hydrated. So try to eat foods like cucumber, tomato, spinach, broccoli, watermelon, apples, citrus fruits and berries.



Scan the QR code for more skin and wound care from the Right Decision Service

Scan the QR code to access the NHSGGC Prevention and Management of Skin Tears

Keep moving

Physical activity helps manage stress and anxiety, improve sleep quality, and maintain mobility. Keeping care home residents active during the winter months, can be challenging, but is essential for their physical and mental well-being.

Here are some practical ideas and resources to encourage activity among residents during winter:



Indoor Walking: facilitate walks within the care home or local venues such as shopping centres, cafes, or garden centres. Museums and stately homes can also provide a change of scenery and an opportunity for gentle exercise.

Indoor Gardening: Cultivating indoor plants can be a rewarding winter activity. Staff can assist residents in setting up a small indoor garden in a conservatory, greenhouse, or even on a window sill. Engaging in tasks such as pruning, re-potting, or planting seeds provides physical activity while allowing residents to maintain a connection with nature.





Festive Preparations: The holiday season offers numerous opportunities for residents to stay active through festive activities. Staff can involve residents in wrapping presents, decorating the care home, or light baking. These tasks not only promote physical activity but also foster a sense of community and shared experience among residents.

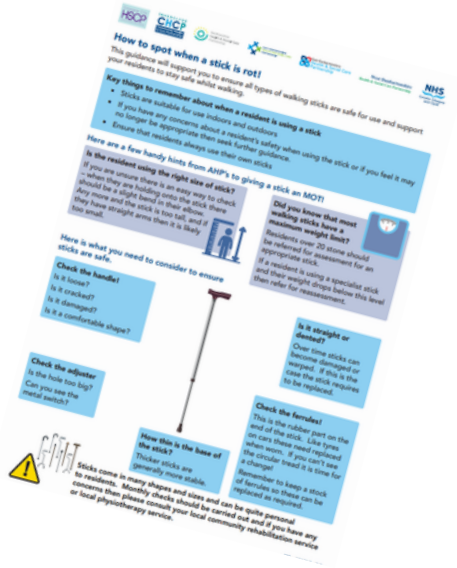
For further information and resources on keeping residents active and engaged in meaningful activity in winter and throughout the year visit the resource section under Meaningful Activity - Keep Moving

Reducing the risk of falls

Falls can have a serious impact on a resident's health and wellbeing. Falls cannot always be prevented but there are many simple things that you can do to promote the health of your residents and to try and reduce the risk of falls and injury.

Completing a regular Falls Risk Assessment and developing a falls care plan will help to reduce the risk of your resident falling. Click the posters for a more in-depth look.









Video resources include:

- Falls facts and risk factors
- Reducing falls risk
- Vision and Hearing
- Footwear and foot health
- Mobility and Physical activity
- Dizziness, blackouts and palpitations
- Medication
- Consequences of falls

WATCH VIDEO

Access all falls prevention resources

Infection prevention and control

Standard Infection Control Precautions (SICPs)

SICPs are the basic infection prevention and control measures, whether infection is known to be present or not. SICPs should be applied by all staff, in all care settings, at all times for all residents. By following SICPs you are helping ensure the safety of residents, staff and visitors in your care home.





Transmission Based Precautions (TBPs)

Sometimes additional precautions are required. These are called Transmission based precautions or TBPs. An example of when TBPs may be required is when caring for a resident with unexplained respiratory illness, in this situation it may be necessary to care for the resident separate to others to help minimise the spread of infection to another.

Did you know updated TBPs guidance was published 3 August 2026 and the way in which we describe transmission routes has changed? You can find out more about this in a 'What's changed?' guide available within the Care Home Infection Prevention and Control manual (CH IPCM). Also available within the manual is a Frequently Asked Questions guide providing answers to some of the common queries associated with the changes.



Infection prevention and control

Personal Protective Equipment (PPE)

PPE is required during the application of both SICPs and TBPs. The items of PPE required should be based on risk assessment of any likely exposure to blood and/or body fluids and the risks associated with task being undertaken.

When undertaking care tasks, or entering a resident's room who has a suspected or known infection, additional items of PPE, for example FFP3 masks, may be required.

Prior to you donning an FFP3 mask, face fit testing must be carried out by a trained face fit tester. For more information on face fit testing please speak with your line manager

Please visit the National Infection Prevention & Control Manual (NIPCM) and the CH IPCM to find out more about PPE. Here you will find resources showing the correct order for putting on and for removing PPE as well algorithms to help guide glove and face mask selection.

Hand Hygiene

Hand hygiene is one of the simplest things we can do to help prevent the spread of infection. Scan the CHC QR code to view our two short videos demonstrating hand hygiene technique.



Remember alcohol based hand rub should not be used to carry out hand hygiene when caring for a resident with vomiting or diarrhoeal illness.

NIPCM

You can find more on SICPs and TBPs by visiting the National Infection Prevention & Control Manual (NIPCM) and the sector specific Care Home Infection Prevention & Control Manual (CH IPCM).

The manual includes materials such as posters you may want to display in your home to remind staff, residents and visitors of simple measures such as respiratory and hand hygiene. Also within the manual are helpful resources for staff including posters showing the correct order for putting on and removing PPE as well as guidance on glove selection.

Care Home Collaborative

Find further IPC resources at the Care Home Collaborative website

Managing an outbreak

If you notice 2 or more residents or staff members (whilst working) meeting the criteria below, occurring within 5 days of symptom onset, in the same area of the care home you might have an outbreak

- a new continuous cough this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours
- sneezing or a stuffy or runny nose when the resident does not usually suffer from hay fever or has respiratory issues
- a sore throat
- headache and sore muscles
- breathlessness, tight chest or wheezing
- fever (temperature of 37.8°C or above) or chills
- Malaise
- New onset of confusion
- Nausea and Vomiting (feeling sick or being sick, two or more episodes within 24 hours)
- Diarrhoea – this means three or more loose (liquid) stools in 24 hours or more frequently than normal for the person

Handy Tip

Consider influenza, Covid-19, and RSV as alternatives in residents with suspected chest infection or cough.

For further information on what to do in the event of an outbreak of acute respiratory infections in a community, social and residential care setting, please visit NHSGGC Public Health for advice.

If you suspect an outbreak please contact the NHSGGC health protection team for further advice on (during office hours via email to ggc.phpu@nhs.scot, or out of hours via Switchboard 0141 211 3600 asking for Public Health for Glasgow). If appropriate, you will be guided to take appropriate samples of up to 5 symptomatic people to help to confirm the cause of the outbreak.

You can also visit the National Infection Prevention & Control Manual (NIPCM) and the sector specific Care Home Infection Prevention & Control Manual (CH IPCM) where you will find helpful resources for gastrointestinal and respiratory illness, including checklists and charts for recording resident symptoms.

Resources

Management of acute respiratory infection in community settings

Care Home IPC Resource for Respiratory Illness

GI Outbreaks in Care Homes



Care Home Symptomatic Testing

HSCP	SCI request via GP Yes/No	Test generated by HSCP Yes/No	Who delivers test e.g. HSCP tester, NHS Driver	Who undertakes test e.g. HSCP tester, Care Home	How is test returned to lab e.g NHS driver from home or clinic
East Dunbartonshire	Yes	Yes	Vaccinators drop off tests to the care homes	Nursing staff if Nursing home, HSCP tester if residential care home	Vaccinator will pick up test from care home, return them to HSCP base where transport will pick them up with routine specimens
East Renfrewshire	No – No longer requested via SCI gateway. GP Practice have access to Respiratory PCR kits	No – HSCP no longer involved with testing unless requested by PHPU	GP Practice – GP's have access to Respiratory PCR kits that can be used to test for any respiratory virus including COVID	Care Home/GP Practice Staff	Royal Mail – Kit supplied by GP practice has a pre-paid box that allows it to be put into the post and posted to the lab
Glasgow	Please confirm arrangements with your local Care Home Team	Please confirm arrangements with your local Care Home Team	Please confirm arrangements with your local Care Home Team	Please confirm arrangements with your local Care Home Team	Please confirm arrangements with your local Care Home Team

Care Home Symptomatic Testing

HSCP	SCI request via GP Yes/No	Test generated by HSCP Yes/No	Who delivers test e.g. HSCP tester, NHS Driver	Who undertakes test e.g. HSCP tester, Care Home	How is test returned to lab e.g NHS driver from home or clinic
Inverclyde	Yes	Yes	NHS Driver/ Transport	Care Home Staff or visiting clinician	Picked up from Care Homes by NHS Driver and taken direct to lab
Renfrewshire	Yes - GP or ANP	Yes - admin support provide testing kits	HCSW wtihin Phlebotomy tam deliver, carry out and return test to Health Centre for all homes	HCSW wtihin phlebotomy team	Arranged by the testing team
West Dunbartonshire	Yes	Yes	NHS Driver	Nursing staff if Nursing home, HSCP DN staff if residential care home	NHS Driver collects from care home

Responding to deterioration

RESTORE2 is a physical deterioration and escalation tool for care/nursing homes, and is based on nationally recognised methodologies including early recognition (Soft Signs), the national early warning score (NEWS2) and structured communications (SBARD).

RESTORE2 is designed to support homes and health professionals to:

- Recognise when a resident may be deteriorating or at risk of physical deterioration
- Act appropriately according to the resident's care plan
- Obtain a complete set of physical observations to inform escalation and conversations with health professionals
- Speak with the most appropriate health professional in a timely way to get the right support
- Provide a concise escalation history to health professionals to support their professional decision making

RESTORE2™
Recognise Early Soft Signs, Take Observations, Respond, Escalate

Care Home Collaborative

The Care Home Collaborative can support implementation in care homes across GGC.

Contact us for more information

RESTORE2™ mini
Recognise Early Soft Signs, Take Observations, Respond, Escalate

RESTORE2 Mini is a shortened version of the full RESTORE2 tool and is ideal for introducing to residential homes (that are currently unable to take physical observations) to the concepts of soft signs and SBARD structured communication.

RESTORE2 Mini can help your team to:

- Identify if a resident is deteriorating and to get help earlier, supporting the resident to remain at home.

Resources

Wessex Patient Safety Collaborative: RESTORE2 and RESTORE2 Mini resources can be found on the Care Home Collaborative Website.

Care Home Collaborative

Supporting residents with delirium

Delirium is a mental state that causes confusion, disorientation, and problems thinking or remembering clearly. It usually starts suddenly, over days or hours but, if detected quickly and treated, it can be completely reversible.



HIS (Health Improvement Scotland) resource outlining strategies and tools for the identification, management and prevention of delirium.

What is Delirium?

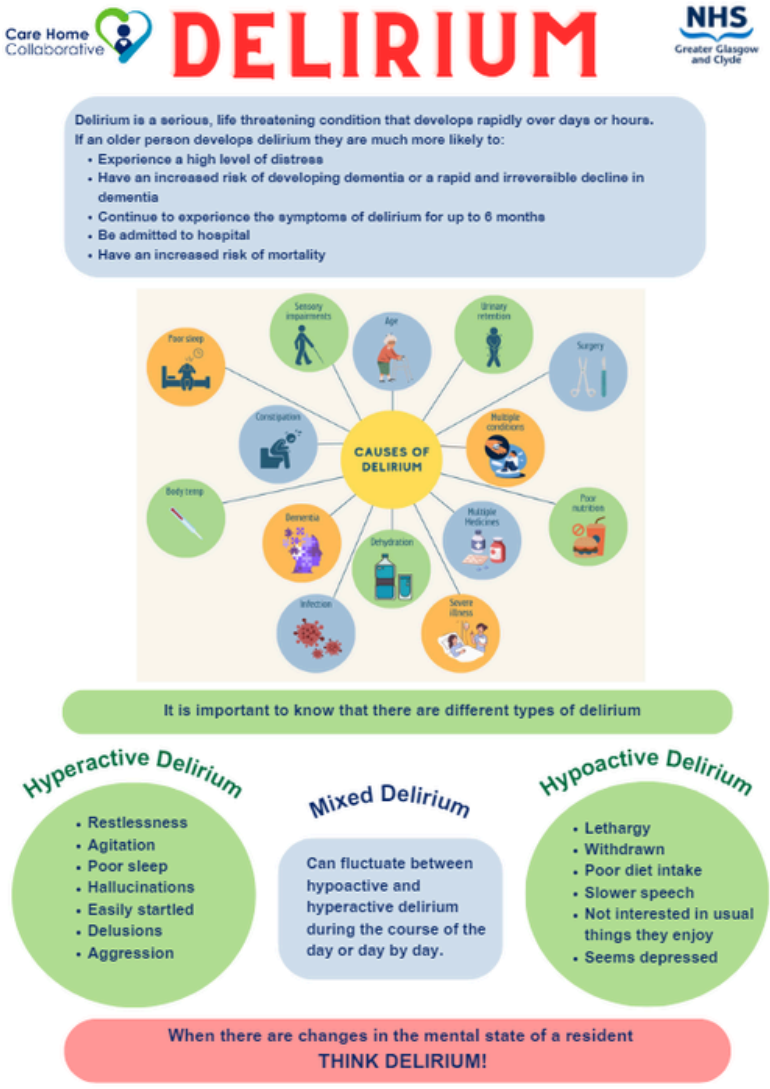
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Delirium Guidance

MyPsych

Prevent it, suspect it, stop it

Delirium can be prevented and treated. Remember the causes of delirium.



When caring for someone with delirium, it's helpful to:

- ensure hearing aids, glasses and dentures are available at all times
- have a gentle and friendly approach, smiling and providing reassurance
- talk and keep the person informed in short, simple sentences
- check that the person has understood you and be prepared to repeat what you have said if necessary
- try to make sure someone the person knows well is with them, because familiarity helps
- try not to agree with any incorrect ideas caused by delirium but disagree tactfully and change the subject
- keep a calendar or clock (or both) within view
- bring in some familiar objects from the person's home to keep at their bedside
- remind the person to eat and drink, and help if needed

Rockwood Clinical Frailty Scale

Frailty Screening and Assessment

The Rockwood Clinical Frailty Scale is a measure of frailty based on clinical judgement, designed to grade the degree of frailty following a comprehensive assessment.

The scale has nine points from 1: Very Fit to 9: Terminally ill

Screening can result in early detection of frailty, which can help make changes to plans or put support in place that can:

- Improve outcomes for residents
- Support residents to live well at home
- Potentially reverse the severity of frailty

The information can be recorded in the resident's Future Care Plan

Information on using the screening tool and access to a free 15 minute eLearning resource is available here

Healthcare Improvement Scotland | Right Decision Service

CLINICAL FRAILTY SCALE



1 VERY FIT — People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.



2 FIT — 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**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.



4 LIVING WITH VERY MILD FRAILTY — Previously "vulnerable," this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up" and/or being tired during the day.



5 LIVING WITH MILD FRAILTY — People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.



6 LIVING WITH MODERATE FRAILTY — People who 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 LIVING WITH SEVERE FRAILTY — **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 LIVING WITH VERY SEVERE FRAILTY — Completely dependent for personal care and approaching 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 living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally 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.

In **very severe dementia** they are often bedfast. Many are virtually mute.

DALHOUSIE UNIVERSITY

Clinical Frailty Scale ©2005–2020 Rockwood, Version 2.0 (EN). All rights reserved. For permission: **www.geriatricmedicineresearch.ca**

Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

Supportive Palliative Action Register (SPAR)

SPAR is a palliative indicator tool which can be used by care staff to assess change or decline in any resident with a life limiting illness in a care home.



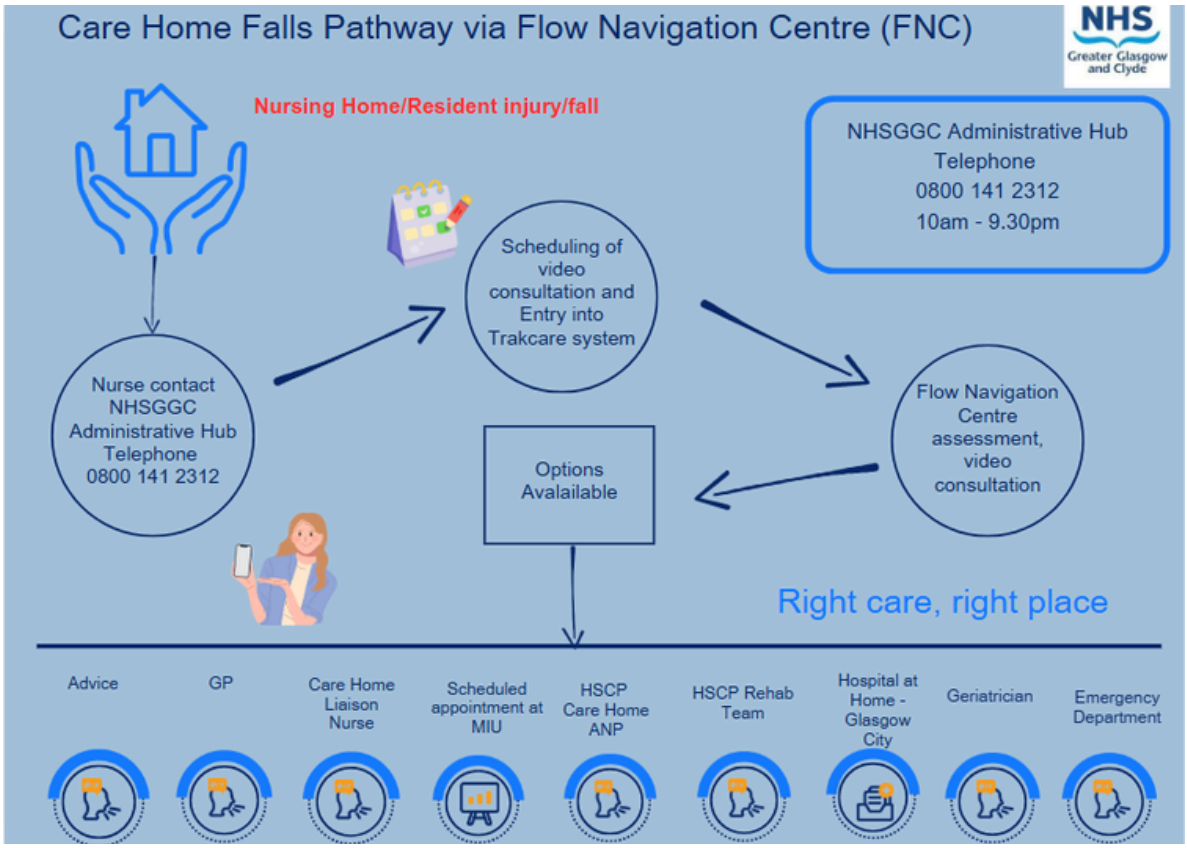
- SPAR is a combination of a palliative performance scale score (PPSv2) which describes the resident's functional ability; and a "traffic light" system, which indicates how quickly their condition has changed.
- Staff use the tool to assess residents, looking for any changes in condition, recognising both deterioration and improvement.
- Each change in the "traffic lights" prompts reflective care and conversations with the resident and their loved ones about choices for future care planning.
- SPAR also offers evidence of change and decline to visiting care professionals, facilitating a holistic approach.

Key points

- SPAR can be used in conjunction with other indicator tools such as RESTORE2.
- SPAR creates opportunities for timely, realistic conversations about future care, helping residents and families plan ahead together.
- SPAR is a great way to evidence carer recognition of change and decline.

More information on SPAR

Managing falls



Care Home Falls Pathway Guidance Document

Take a look at Michael's Story using the Care Home Falls Pathway

Care Home Falls Pathway via Flow Navigation Centre (FNC)

The Falls Pathway allows care home staff to quickly access support and advice when a resident has fallen.

- Using the Care Home Falls Pathway can help to avoid unnecessary visits to hospital.
- It can also help to keep residents comfortable at home in their own environment.

The support offered might include advice, and/or a next day appointment at a Minor Injury Unit (MIU) or a range of other community supports.

FNC - contact details
NHSGGC Administration Hub
0800 141 2312
10.00 - 21.30

Think
Is an emergency ambulance required for the resident who has fallen?

Ask
Contact your GP, community team, flow navigation centre or NHS24 for clinical advice and support.

Do
Use assessment and observation to monitor for deterioration or injury in the hours following a fall. If available and safe, use appropriate lifting equipment. If it is unsafe to move someone who has fallen, keep them warm and reassure them until the ambulance arrives. Ensure you have up to date moving and handling training. Continue to implement existing falls prevention measures.

Skin tears

Skin tears are traumatic wounds often involving friction or the removal of adhesives. They are particularly common in elderly people due to age-related changes in the skin.

Without appropriate care, skin tears can become chronic wounds, causing pain and distress, and resulting in prolonged healing times.



Risk Factors in the Elderly

Elderly residents are at increased risk of skin tears due to:

- Fragile, dry, or thin skin
- Reduced mobility and increased falls
- Polypharmacy and comorbidities
- Nutritional deficiencies
- Cognitive or sensory impairment

Prevention Strategies

- Skin care (see page 7)
- Protective clothing: encourage long sleeves and trousers
- Environmental safety, such as adequate lighting, removal of sharp edged furniture and safe moving and handling practices
- Maintaining a good nutrition and hydration intake (see page 6)

Initial management of a skin tear

- The tear should be classified using the ISTAP system (Click here for details)
- Cleanse the wound with drinkable tap-water or saline
- Realign skin flap gently, using saline soaks for (5-10 mins) if needed
- Dress with silicone-based products such as Kliniderm Foam Silicone Border Avoid adhesives, hydrocolloids, and iodine-based dressings.
- Monitor the wound for infection and reassess after 5 days. Refer to Tissue Viability if no improvement

Resources

Access full guidance here

Care Home Collaborative

Managing respiratory symptoms

Feeling breathless can be frightening and stressful. There are simple actions you can take to help the resident.

- Positioning - support with pillows, whether sitting up or side lying in bed
- Loosen tight clothing
- Open a window and allow air to circulate
- Encourage fluids and start fluid chart if appropriate
- Breathing techniques/relaxation techniques if the resident has a chronic respiratory condition.

Does the resident have an existing respiratory condition?

- What's normal for the resident?
- Have they had their prescribed medications?
- Do they have a rescue pack? Use this as instructed or seek advice from a healthcare professional.

If a resident develops any of the following new or worsening respiratory symptoms further action is needed:

- sounds more chesty or wheezy than usual
- breathlessness
- cough or cold symptoms
- yellow or green sputum

Where possible monitor the resident's vital signs.

Concerns should be escalated to a senior within the care home or advice sought from the appropriate health care professional.

Please consider these red flags:

- coughing up blood
- lips or hands changing colour
- chest tightness
- non-resolving chest pain
- severe or persistent hoarseness
- increase in rate of breathing which would affect their ability to speak in sentences

Consider, an urgent referral to the appropriate service, if this is applicable for your resident (please refer to their FCP and agreed plan of care).

Further respiratory resources



Medicines

Polypharmacy

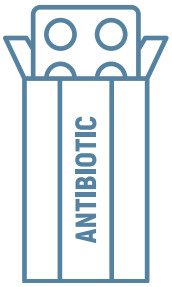
People living in care homes may have several conditions for which they are taking medication. This can result in polypharmacy, which is described as the use of multiple medicines.

Consider referring residents to their GP or Care Home pharmacy team for polypharmacy medication review if a resident is prescribed:

- 10 or more regular medicines
- High Risk Medicines e.g. medicines for stress and distress, pain-relief or sleeping tablets.

Falls can sometimes be linked to medicines such as those which cause sedation, lower blood pressure or those used to treat incontinence. If a resident has had a recent fall, increased unsteadiness or dizziness, consider a referral for a medication review.

Refer to Pharmacy Team linked to residents GP practice



Diagnosis of UTI should be based on any symptoms and guided by the Care Home UTI assessment tool.

National guidance recommends that we should not dipstick test urine of people over 65 years.

Taking antibiotics for UTI (or any condition) when they are not needed puts residents at risk of developing resistance

If an antibiotic is required, treatment should be started as soon as possible, ideally on the same day that diagnosis is made.

Anticipatory medication

Residents who are approaching the end of life should have access to anticipatory medicines (just-in-case), ordered proactively, to ensure supply is at the care home when needed. A palliative Kardex should accompany the supply of medicines and any unnecessary medications should be reduced or stopped if clinically appropriate.

Scottish Palliative Care Guidelines - Right Decision Service

Medicines for Common Conditions

Pharmacy First is available via all community pharmacies, and care home residents can access a defined list of medicines for common conditions. This includes treatment of conditions such as simple pain relief, cough, indigestion, hay-fever, skin conditions, dry eyes.

Pharmacy First can support timely access to medicines and treatment for a range of common acute conditions.

For times when some community pharmacies may be closed (at night and weekends) you may want to consider having a homely remedy policy in place. This allows care homes to keep a small stock of non-prescription medicines which can be used to treat minor conditions for up to 48 hours. These may include medicines like paracetamol, simple linctus and antacids.



Red Bags

The Red Bag Scheme plays an important role in improving communication, continuity of care, and resident safety during transfers between care homes and hospitals. To support safe and effective transfers, please ensure the Red Bag Checklist is completed every time, confirming that all essential documentation and the resident's belongings accompany them.

What should be included in the Red Bag?

- Information/paperwork that supports the communication of the resident's current care plan, including the original DNACPR.
- A limited supply of medication as per the checklist.
- The residents property e.g clothing, glasses / dentures / hearing aids and toiletries
- Complete the checklist and keep a copy in the Red Bag



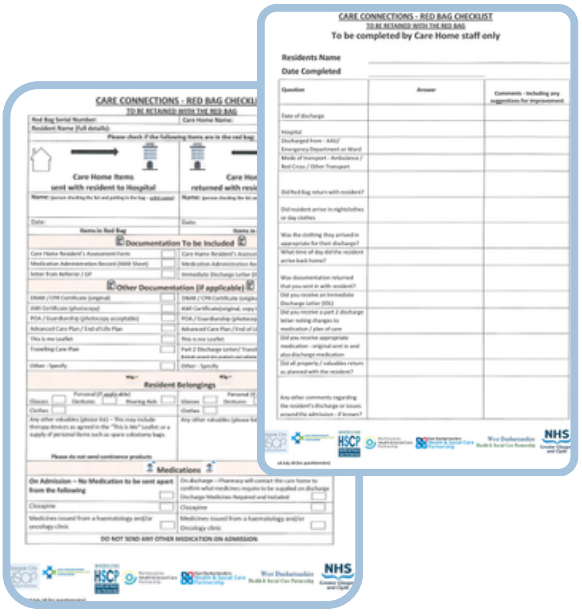
When the ambulance arrives:

- Ensure ambulance staff take the Red Bag
- Explain requirements to ambulance staff
- Confirm the Red Bag checklist and hand to ambulance staff

Resources, including the posters and video, are available via the NHSGGC Care Home Collaborative website.

When your resident returns home:

- Ensure the bag is with the resident and contains all the correct paperwork
- Clean the bag in accordance with infection control guidance – warm, soapy water or wipes
- Retain checklist for review
- Care home to complete the reverse of the checklist to support review
- Contact the redbag enquiries email as soon as possible if a bag is lost or not returned



think RED BAG

If a Red Bag is lost or not returned, Contact redbagenquiries@ggc.scot.nhs.uk as soon as possible, noting the bag number and location

Additional support for complex care

Your primary care team (Community Nursing Teams, ANPs, GPs, Pharmacist and others), along with local 'call before you convey' pathways, are the first point of contact for additional support if a resident deteriorates.

For additional support managing residents with complex needs, care homes should contact their local Multidisciplinary Team (MDT) and the Care Home Collaborative (CHC).

Additional support from the CHC includes

- Review of complex wounds
- Support and signposting for palliative care needs
- Support for environmental assessment for residents with dementia
- Support for IPC
- Links with specialist teams for the care of residents with complex needs
- Development of bespoke training tailored to reflect resident needs

For further details or support please enquire to the CHC on 0141 427 8254 or at ggc.chccontact@nhs.scot

Facilitating a complex admission to a Care Home

A 67-year-old visually impaired gentleman, living with Type 1 diabetes, and chronic kidney disease, needed admission to a care home. He also required renal dialysis in hospital three times a week. His family visited a local care home, as they wanted to keep their dad in familiar surroundings, maintaining his links to community and involvement in family life.

Their chosen care home was keen to support this gentleman, but also felt anxious about how they would be able to meet his needs. The care home manager reached out to the CHC for additional training to support the team prior to the gentleman's arrival.

The CHC team worked with acute colleagues, specialist dietitians and renal nurses, to develop a bespoke training package for the entire care home team. This created opportunities for the team to understand the particular needs of the gentleman and to feel confident in caring for him. The family were invited to the training sessions, giving them the opportunity to share their knowledge of their dad's condition and what mattered to them.

His daughter said that this approach gave the whole family confidence that their dad would be looked after safely within the home and that they could 'sleep well' at night.

This collaboration has built effective relationships between the gentleman, his family, the care home team and the renal dialysis unit. As a result the resident has been living well in the home for the last 6 months. This experience highlights how a coordinated and personalised approach to care can support residents with complex needs to live well within care homes.

Getting your message across

SBARD is widely used to support communication across different settings and different staff groups. It supports staff to plan and provide accurate resident information, making the reasons for escalation to health and care teams much clearer.

S

Situation

Who are you and where are you calling from?
Who is the resident?
What is the current situation?
Provide NEWS score if available

B

Background

What is the resident's normal condition?
How has their condition changed?
Provide any medical history if available

Getting your message across SBARD information

A

Assessment

What have you observed?
What have you done?
Do you have any idea what the problem might be?

- It's no problem if you do not know, just say that you are worried

R

Recommendation

What would you like to happen next

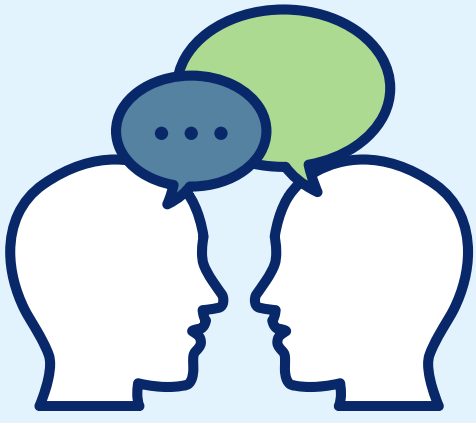
- e.g. I would like you to come and see the resident in the next...

What will you continue to do in the meantime (give medication/ repeat obs)

D

Decision

Summarise your agreed plans so that you are both clear on the ongoing support of the resident, and plans for further escalation



EASE
END OF LIFE AID SKILLS
FOR EVERYONE

End of Life Aid Skills for Everyone (EASE) is a course designed to enable people to be more comfortable and confident supporting family and community members with issues they face during dying, death and bereavement.

EASE is designed for members of the public, and welcomes adults of all ages, experiences and walks of life. The course can be accessed by scanning the QR code.

Care after death

Any registered healthcare professional can carry out Confirmation of Death once they have undertaken the appropriate training and completed the competency requirements set for the Greater Glasgow and Clyde area.

Verification of Expected Death (VoED) is no longer used. Practitioners previously trained in this can follow the resources and self certify their competency.



Most people at some point in their lives find themselves responsible for making the arrangements after the death of a relative or friend.

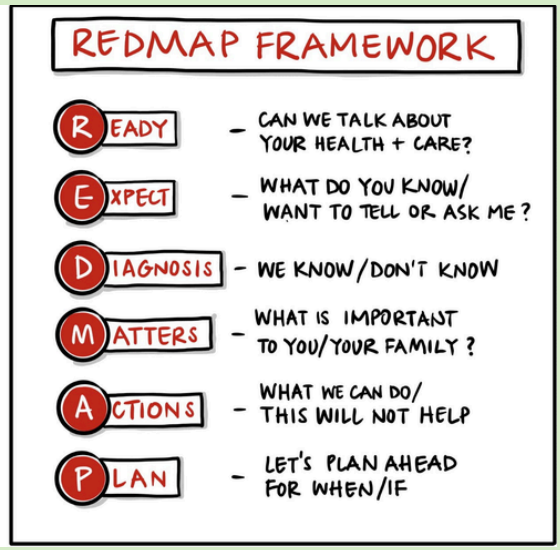
It can be a difficult and worrying time, and this helpful booklet helps advise relatives of some of the things they may have to do.

Talking to relatives

SAGE & THYME workshops support staff to use the evidence based skills required to provide person-centred support to people with emotional concerns or worries.

Using a memorable structure, each 2 hour 45 minutes online workshop reminds staff how to listen, and respond to distress in a way which empowers the resident. The workshops discourage staff from 'fixing', and demonstrate how to work with the resident's or relative's own ideas and solutions first. This training is provided free of charge for GGC care home staff.

REDMAP is a 6-step guide to conversations with people who are living with a serious illness, health condition or disability that may get worse at some stage, or older people who are becoming frailer, to help plan their care.



EC4H EFFECTIVE COMMUNICATION FOR HEALTHCARE

EC4H is an advanced interactive workshop which supports clinicians to talk about Future Care Planning, informed by an understanding of "what matters" to individuals and their families.

The focus is on initiating conversations about deteriorating health, people's priorities and plans for future care such as hospital treatments options, further admissions and CPR.

Although NHSGGC no longer subscribes to this licence, National webinars are available for staff to attend.

Resources for families

Good end of life care recognises the importance of grief and provides bereavement care and signposting to sources of further support

Cruse Scotland
Bereavement Support

The experience of bereavement often means that people's lives will never be the same. Sometimes they need help to manage their feelings. Cruse Scotland can provide them with time and support to work through these feelings and learn to live with their loss.

They have a free Helpline: 0808 802 6161

Monday to Friday 9am - 8pm
Weekends 10am - 2pm

good life good death good grief

This national organisation provides support and advice to enable people to have open and honest conversations around death, dying and bereavement.

Resources for staff



Support Around Death Scotland is an NHS Education for Scotland website which aims to support health and social care staff who are working with patients, carers and families before, at, and after death. It provides key information on the clinical, legislative, and practical issues involved.

Scan the QR code for a range of resources

Self-care for staff

People working in care spend their days caring for others, but it can sometimes be difficult to ask for help for themselves. A range of self-care and advice services for staff is shown below.

COPE scotland

COPE Scotland offer some gentle ideas to help calm your mind, reduce worry, and find ways to manage stress. Learn to embrace selfcare



ACTION FOR HAPPINESS



Action for Happiness brings people together and provides practical resources. We help each other learn evidence-based skills for happier living, feel a sense of belonging and commit to personal action to create more happiness, for ourselves and others.

National Wellbeing Hub

For staff to flourish and perform at their best, they need to feel supported. In fact, support from colleagues and managers is often reported as a key factor in good workplace wellbeing. Knowing the right thing to do to support staff through challenges they're facing isn't always easy though.

The National Wellbeing Hub is a partnership between national, local and professional bodies with a shared passion for looking after the wellbeing of health and social services staff, and contains a range of advice and resources.

Support for leaders

Leading to Change complements leadership development and support at local levels for the health, social work and social care workforces in the public, independent and third sectors.

Leading with kindness and inclusion, and working collaboratively with people will bring better leadership, and this is the key to a more thriving and resilient workforce within social work, social care and health. One that lets us focus on what really matters – the people we care for and who use our services.

Leading to Change



Checklist

Suggested checklist to support your care home winter readiness plan.

- ☐ The Care Home Leadership team have taken simple steps to prepare for adverse weather and potential travel disruption
- ☐ Future Care Plans have been reviewed and updated. Changes have been communicated to GP practice
- ☐ Covid/flu vaccinations have been offered to all those eligible who live or work in your care home.
- ☐ Staff have undertaken IPC training and are aware of how to manage an outbreak
- ☐ Staff are able to recognise deterioration and confident in escalating concerns
- ☐ Staff are aware of the Falls Pathway and how to access the Flow Navigation Service
- ☐ The contact details for the community teams are up to date
- ☐ Check what support the community pharmacy can offer e.g Pharmacy First service, palliative care pharmacy details, public holiday contact details
- ☐ Staff are aware of resources available to assist in talking to relatives, care after death and bereavement
- ☐ Registered nursing staff have completed confirmation of death training (CoD)
- ☐ Staff have access to wellbeing resources

This document was created using the South West Care Home Winter Readiness Pack by Cornwall and the Isles of Scilly Health and Care Partnership. The NHSGGC guide has been designed to complement and not replace local guidance and professional judgement. Full comprehensive guidance can be found in **NHS Inform** and **Public Health Scotland** and at the **NHSGGC Care Home Collaborative** websites.