Care Home Winter Readiness Pack 25/26

For General Practice

Preparing for winter is an important part of our support to care home residents and staff across Greater Glasgow and Clyde.

The Care Home Winter Readiness pack contains a range of useful information to support resident and staff wellbeing over winter. Details of the full pack are available here.

This abridged version highlights key information for GP colleagues. This information is aligned with good practice, national guidance, and is intended to complement local arrangements.

Contents

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.

Everyone has a role to play in Future Care Planning, helping to have record these conversations as well as access the information when necessary.

This is an interactive Microsoft Sway which will provide 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
- If possible, share it with other health and social care professionals in your locality who can update the Key Information Summary (KIS). This is an electronic record which NHS24, the Scottish Ambulance Service and hospitals 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 Public Health Scotland website for further details on eligibility

Staff vaccine programme

Health and social care staff who work directly with residents, or provide care and support services, are eligible for the flu vaccines this year.

For more information and to book your appointment:

NHS Inform Winter Vaccines

Vaccination Helpline
0800 030 8013

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 over the coming months.

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.

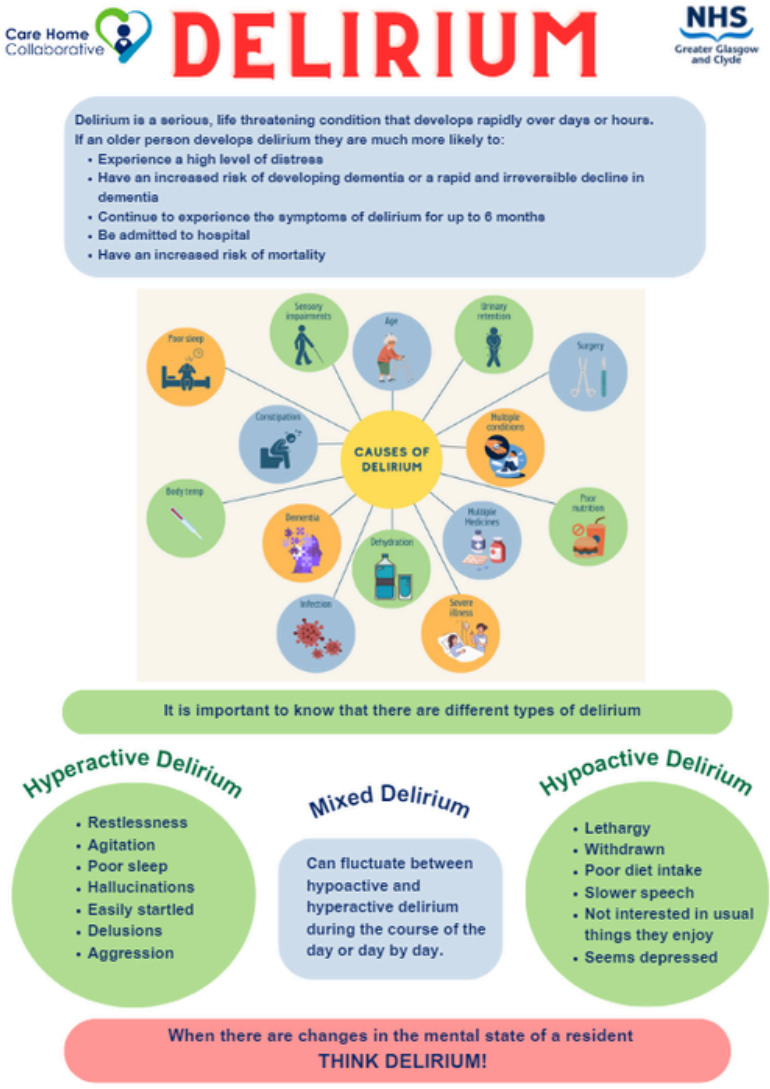
What is Delirium?

4AT

Delirium Guidance

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

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 is an ideal way to broach realistic conversations with relatives and loved ones.
- SPAR is a great way to evidence carer recognition of change and decline.

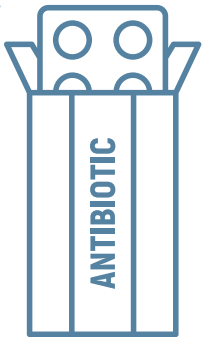
More information on SPAR

Medicines

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

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.



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

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.

Scottish Palliative Care Guidelines - Right Decision Service

Polypharmacy

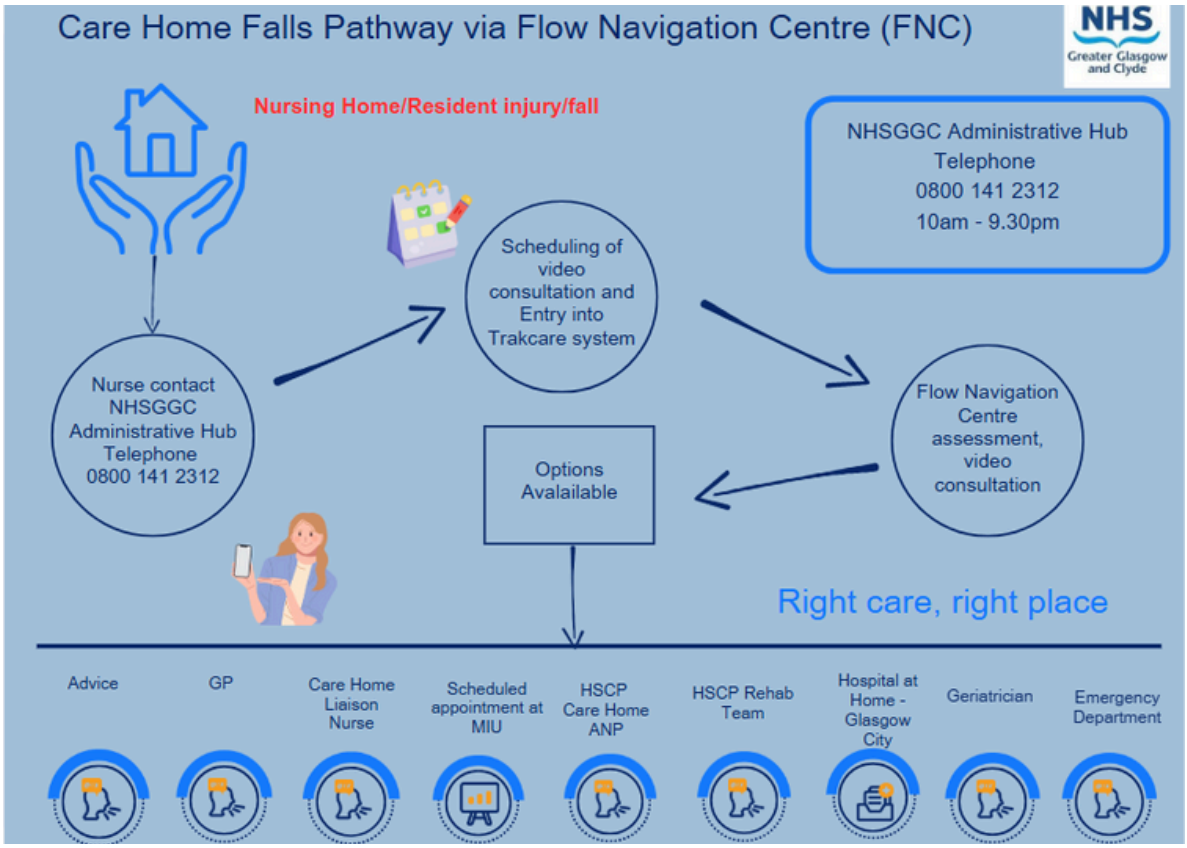
People living in care homes may have several conditions for which they are taking medication. This can result in polypharmacy, which is described as the use of multiple medicines.

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
- multiple medicines that can cause sedation (eg medicines for stress and distress, sleeping or pain)
- medicines which can lower blood pressure or blood sugars

Manage my meds - Right Decision Service

Managing falls



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

Care Home Falls Guidance Document

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.

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
- headaches
- muscle aches
- breathlessness, tight chest or wheezing
- fever (temperature of 37.8°C or above)
- chills
- malaise
- diarrhoea – this means three or more loose (liquid) stools in 24 hours or more frequently than normal for the person and/or feeling sick or being sick (two or more episodes within 24 hours)

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 Public Health for advice.

If you suspect an outbreak please contact the 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

Influenza testing and antivirals PC summary

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	NHS driver, occasionally HSCP Tester	Nursing staff if Nursing home, HSCP tester if residential care home	NHS driver, occasional tester will return to clinic for routine collection
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	Renfrewshire Care Home Testing Team	It is not delivered it is caried out by a member of the Cre Home Testing Team	Renfrewshire Care Home Testing 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

Acknowledgements

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 NHS GGC 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.