Recognising And Responding to Deterioration in Care Home Residents

Testing the use of a tool to support care home staff in recognising the softer signs of deterioration. Improving response and communication to colleagues/health professionals (incorporating SBAR)

#yhRAPiD

Project Report - December 2019

NHS Vale of York CCG

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Abstract

Background

The number of elderly residents admitted to hospital from care homes as an emergency has increased by 63% since 2011[i]. Admissions to hospital come with a cost, financially and to patients wellbeing and risk of harm[ii]. Residents care needs are increasingly complex and on average they will have six or more diagnosed conditions and seven or more prescribed medicines, which places them at greater risk of deterioration.

The NHS Vale of York CCG is committed to supporting Care Homes and Domiciliary Care organisations in providing best care to residents. The aim of this work was to reduce avoidable harm, enhance clinical outcomes and improve the experience of deteriorating residents in care homes. To achieve this focus was placed on improving recognition (softer signs and NEWS2 where used), response and communication.

Working in care homes provides a great opportunity to understand the barriers and enablers to recognition, response and clear communication; focusing on the needs of residents and the staff caring for them. Working across pathways of care this programme has the potential to improve care quality, resident and staff experience, reduce harm and avoidable hospital admissions.

Methods

This project focused on supporting care home staff, informal carers and residents to use a softer signs tool to help identify early signs of deterioration. To improve communication both within the team and externally with responders and to promote a safety culture within the home itself. This was achieved with the assistance of tools such as the Teamwork and Safety Climate surveys (Improvement Academy, Version 4, 2017), Safety Huddles, SBAR format (Situation, Background, Assessment, Recommendation) and NEWS2 (where used).

Training to homes was delivered by the project team, supporting staff to recognise and respond to deterioration, use appropriate escalation and onwards communication to colleagues such as those in Primary Care Teams and the Ambulance Service. Training included how to use the softer signs recognition prompt tool and the SBAR communication tool. The homes also received on-going support from the project nurse and data was collected to measure for improvement.

Results

Tools easy and quick to use

Improves monitoring and communication between shifts

Staff more confident and empowered to report changes in residents condition

Professional colleagues reporting improved communication and rationale for appropriate referral

Tools useful for physical and mental health deterioration

Fills the gap where NEWS2 is not appropriate, or triggers a set of observations to be taken

Informing developments around referral pathways and reviews, proactive care and Advance Care Planning

Not dependent on technology, the tool recognises functional ability changes before physiological changes

Conclusions

Positive impacts on resident safety and quality of experience

Data collected in a pilot care home has demonstrated a step change in reduction of unplanned attendances/ admissions.

Role of project nurse pivotal to the provision of on-going training and support.

Improves monitoring and communication between teams

Can be integrated with Technology or as a stand alone document

Leadership within the Care Homes is pivotal to role modelling, supporting implementation, embedding and sustaining the interventions. Champions can also be useful.

Peripatetic training approach is better received than other methods such as e-learning or course attendance outside of the care environment

Supports internal process change and that of other Health and Social care colleagues i.e. GP triage

Closing the loop and learning is encouraged after the tools are used to share with staff positive outcomes from their actions and potential areas for lessons learned. This ensure staff feel recognised for their contribution and are involved in the residents journey. Feedback is often overlooked in many care settings and this allows opportunity

Role of family, can it be used in discharge advice and other settings? Early results indicate yes for domiciliary care and day care centres/ assisted living

Lack of data is a challenge in Care Home/ Domiciliary Care Sector but qualitative data is impactful

Transferable to other care settings

Introduction

With an increasing aging population there continues to be a growing demand for long term care provision including residential care[iii]. Residents in care homes have complex health and care needs including Dementia and Frailty, there are 405,000 older people living in care homes across England[iv]. Across the Vale of York there are a total of 83 care homes with a bed base of approximately 2600. Both Health and Social care face similar challenges including financial constraints, reduced staffing and lack of training and development opportunities, all of which can affect morale, motivation and potentially care standards[v]

The NHS Five Year Forward View and the 'Framework for Enhanced Health in Care Homes'[vi] along with the Kings Fund[vii] recognises the need for improved integration of services and collaboration with strong leadership and shared learning to care and support frail, older people. Aiming to reduce harm, decrease unnecessary hospital admissions and improve quality of care provided in care homes, it is anticipated more care will be delivered within the individuals usual place of residence.

The Health Foundation (2019) identified how permanent care home residents aged 65 and over had increased unplanned attendances or admissions to hospital compared to those in their own home. Interestingly, it was identified that there were higher number of emergency admissions from residential care homes compared with nursing which supported the hypothesis for this project where residential homes were initially targeted. The Health Foundation identified a high number of avoidable admissions, estimating that as many as 41% due to conditions that could potentially be managed outside of hospital. This of course relies on the infrastructure in place supporting the system, however there appears to be many opportunities to maximise coproduction across Health and Social Care to support vulnerable individuals within our community.

It is pertinent to ensure care home staff are equipped with the confidence, skills and tools to recognise and respond to deterioration in their residents. It is also important that staff within the care sector are respected and acknowledged for the diverse skill set they possess and feel empowered to play an active role as a member of the multidisciplinary teams that exists across Health and Social Care.

The term “deterioration” can be defined as when a resident moves from their normal clinical state to a worse clinical state. This increases their risk of morbidity, organ failure, hospital admission, further disability and even sometimes death”[viii]. It is therefore in the best interest of the resident, care staff and the wider Health and Social Care systems that deterioration is recognised and responded to promptly. Research has shown that Nursing Assistants in Care Homes were able to identify changes in residents up to 5 days before clinical observations were taken by spotting “behavioural and functional status changes”[ix] . It is logical to assume that by intervening early and keeping residents within their home appropriately this will cause less disruption, distress and exposure to other potential harms. The hypothesis for this project was that the introduction of a structured and easy to use tool to support early identification and onwards escalation in care homes could prove effective.

Early warning scores such as NEWS2[x] rely on physiological parameters scoring systems and are not always appropriate in a residential setting where clinical observations such as temperature, pulse and respiration are not routinely taken. Even in Care Homes with the capability of taking physiological observations, they may not be routinely measured (as mandated in acute care settings) but rather triggered only if carers have concerns. This makes baseline, some argue, difficult to identify and subsequent changes from that for escalation more challenging.

In the NHS Vale of York CCG (VOY CCG) work is progressing to support the use of NEWS2 across primary care as part of the escalation process and this is supported by the ambulance service. However, if someone has deteriorated and observations are deemed necessary to articulate physiological status there still remains that initial step in the process when a carer gets that ‘gut feeling’ there is something wrong. It is at this point, that initial feeling that something is different, where the softer signs tool is invaluable for some. Softer signs are indicators that a person is becoming unwell; these signs are evidence based and are linked to the physiological changes that result from deterioration.

The VOY CCG has worked with the Improvement Academy (IA) within Care Homes on a number of Quality Improvement initiatives including work with hydration, sepsis, falls and pressure ulcer prevention. The programmes use Quality Improvement (QI) methodology focusing on safety culture, team work and communication through the

introduction of key tools such as safety huddles. There is a focus upon celebrating achievement and ensuring improvement is visible and engaging to all stakeholders. The collaboration also builds capacity across Health and Social Care in developing those with QI skills.

This strand of work was developed following a chance conversation with a care home nurse who identified recognition and response to deterioration as a priority. A literature search for improvement ideas to support this was conducted including the use of NEWS2 and softer signs. Softer signs tools were clearly identified as helpful for early recognition allowing care home staff to respond quicker and get the help needed. This search allowed learning that informed on the project design. One home had trialled use of a tool which had too many prompts, making it Impractical to use and another had no evidence of impact. A successful project in 2012, using the STOP & WATCH tool developed by INTERACT, seemed to be the most appropriate to trial in the VOY CCG Care Homes. The Stop and Watch tool appeared to

• Be easy to use and understand

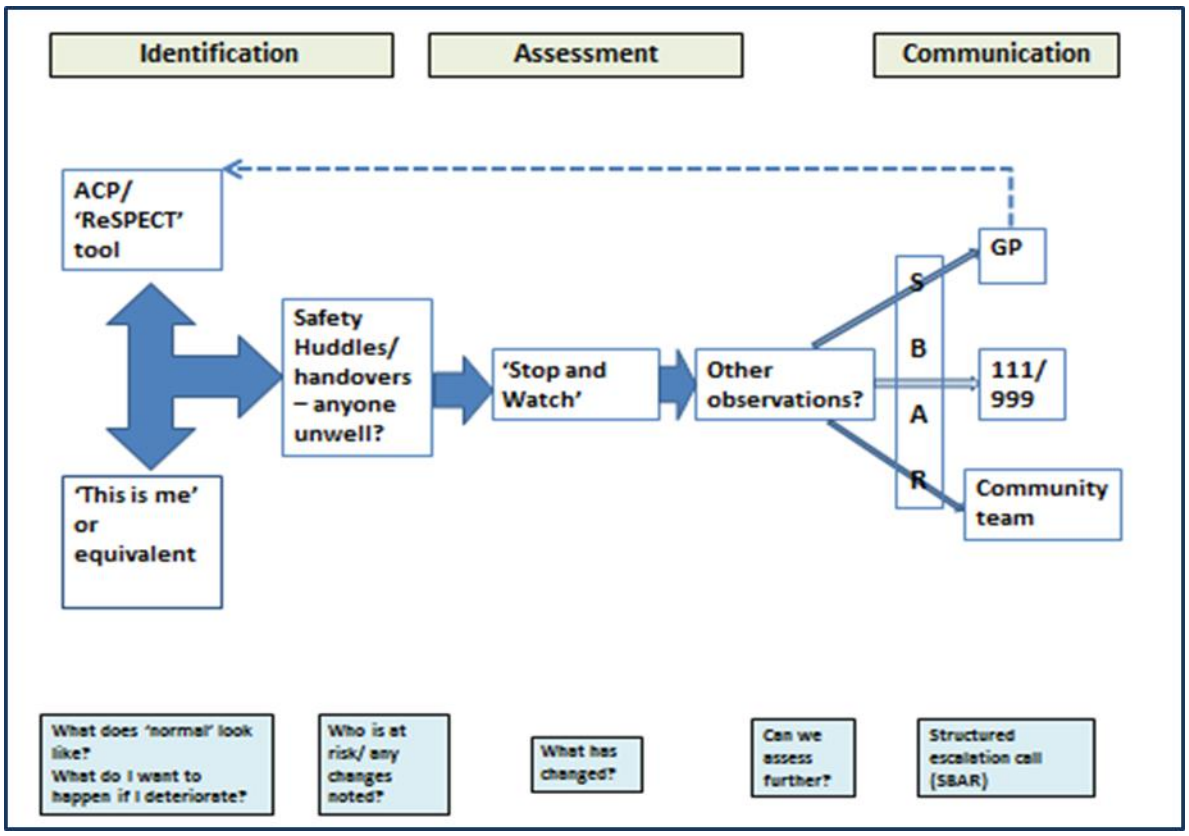
• Rely on recognition of subtle changes in the resident rather than a significant physiological change

• Recognises carers are often best placed to notice these change as they accompany residents on a daily basis and understand their 'normal' behaviours.

• Harnesses the carers 'gut instinct' of something being wrong

Methods

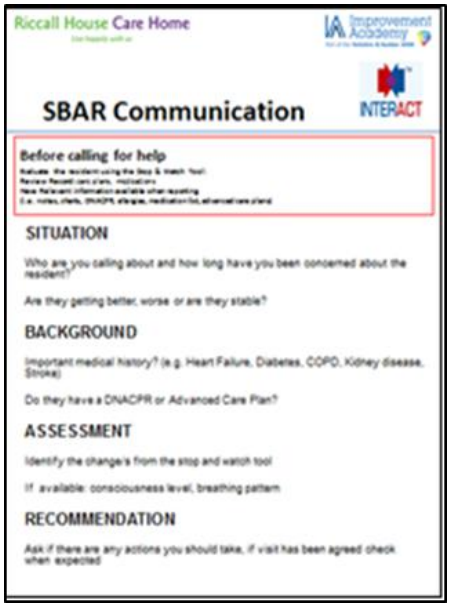
Working in collaboration with the IA our theory was that by introducing a softer signs tool to engaged homes whilst addressing safety culture, teamwork and communication it could be possible to measure an improvement to residents and staff experience. Below is a visual representation of the theory of change.



Theory of change

Tools Used

Stop & Watch



SBAR Communication

The Softer Signs Prompt Tool, "Stop and Watch" (INTERACT)

Following permission from INTERACT to use Stop & Watch (copyrighted by INTERACT following development in America within residential care), initial testing using 'PDSA' approach (Plan, Do, Study, Act) in one care home enabled development of materials with care staff in a format they found useful. These would then be used with other teams for further evolution, according to their needs.

The tool consists of 11 prompts to help spot early signs of deterioration in an individual. It uses a structured approach that helps explain the 'Gut Instinct' of care staff to articulate why they are worried about a resident to enable appropriate care decisions to be made. The acronym is easy to remember and each letter corresponds to a clinical issue, e.g. S – something different to usual (in the resident), T – Talks or communicate less or differently. The use of the Stop and Watch relies on the softer signs of observation, staff knowing the residents in the care homes and transferring those important 'gut instincts' to a structured objective assessment which can easily be relayed to care staff within the home during huddles and handovers or health and care colleagues outside the homes including GPs, District Nurses, YAS and first responders.

SBAR – Situation, Background, Assessment, Recommendation.

Introduction of the SBAR Communication tool aimed to help carers relay essential information to responders. This tool is widely adopted in health care internationally and is an effective 'common language' communication tool allowing for all relevant information to be gathered in one place prior to communicating with other health and care colleagues. Situation, Background, Assessment and Recommendation is used in conjunction with the Stop and Watch and incorporates the assessment for the Stop and Watch to ensure current, relevant and accurate information is relayed ensuring effective and timely clinical decision making.

Training

Following discussion with the individual homes training dates were set and training delivered, this approach was;

- Convenient to the homes and reduced staff travel time
- Allowed a 'whole home' approach where all staff have the training in a timely manner and can support each other in its use exploring together how it fits within their home

- The trainer could build a supportive and open relationship with staff and managers to identify and address any potential challenges enabling the staff to 'own' the interventions.
- Training was delivered at times to suit staff therefore allowing more to attend at each session including night staff; delivered in short bursts of 60 – 90 minutes and face to face to allow for differentiation with staff
- Training used a 'case study' approach so that staff could see the tool 'in action'

Training was delivered using a pedagogical blended approach of underpinning theory, practical examples and discussion to appeal to the staff members preferred learning styles. The comprehensive theory element covered the importance of recognising deterioration and how a small but significant change in a resident could have an important clinical impact, for example a resident not drinking can result in dehydration and subsequent problems. The training expressed the importance of the carers' knowledge of residents and how they are best placed to recognise and respond to subtle changes. Staff were encouraged to talk freely and confidentially about incidences where their residents may have benefitted from using the Stop and Watch tool and by using a case study of a resident deteriorating over a 7 day period allowed staff to see the tool applied. Staff then practiced using the tool against the case study and were encouraged to discuss how they could use the tool and any perceived benefits or challenges and what they thought might facilitate the tools in their setting. This allowed for different levels of literacy and language challenges. The training was well received and positive comments on the quality and relevance of the training was captured in a training evaluation form. In addition to the training;

- Posters and example of tools use were left with the homes as a reminder for staff
- The project nurse continually liaised and supported the homes to address any issues and to offer encouragement and motivation on the on-going use of the tools
- Data collection of use and outcome was collated by the project nurse and analysed by the IA
- Support was offered to introduce Safety Huddles focussing on deterioration or how to adapt pre-existing communication.

Once the initial materials and methodology had been tested using the 'PDSA' approach the project team aimed to;

- Identify homes that were motivated and committed to taking part in the project as early adopters

- Survey the homes for confidence and safety culture, these results would be analysed by the IA. The importance of this is that “Safety Culture “lives” at team level and therefore has to be measured there, ‘’A team that works together well is a safe team”
- Feedback the results of the surveys in a positive manner to the homes to continue to offer support and encouragement building on the positive aspects and understanding better the community of practice
- Deliver training on the importance of recognising deterioration triggers to Care Home staff
- Ensure staff understanding of the use of the Stop and Watch prompt tool and the SBAR communication tool
- Have a collection mechanism in place for data analysis

The development of a project plan ensured achievable and measurable timescales, stakeholders were included and training and data collection schedules in place. Project information and training opportunities was disseminated through existing channels including GPs, Community Nursing Teams, Specialist Care Practitioners, Ambulance Service and the ‘Partners in Care’ network (PIC). ‘Partners in Care’ is a bimonthly forum with weekly bulletins for information sharing and discussion to bring stakeholders together in achieving the delivery of high quality care to residents. Hosted by the VOY CCG, Partners in Care is open to all care stakeholders from across the area and provides updates for providers regarding the latest developments in healthcare and provides opportunity to influence and collaborate on service and quality improvement.

The initial reaction of health care colleagues was one of positivity, encouragement and support, with all seeing the overall benefits to residents and the wider services. Subsequently an information leaflet was designed for relatives, friends and health and social care colleagues which explained the project and purpose of the softer signs and SBAR tools and how these could benefit residents. These have proven immensely useful, particularly when care staff explain to families what steps they have taken to assess their relative who find it reassuring and reduces conflict when the initial reaction is to call a GP or care professional.

Anticipated Outcomes

Based on initial findings, the following anticipated outcomes were identified;

Resident

- improved outcomes through earlier recognition of changes
- Improve adherence to preferred place of treatment/death
- Improved satisfaction and experience with care

GP / responding service

- improved accuracy and depth of information being communicated leading to improved appropriateness of responses
- improved understanding of care staff role and responsibilities
- reduce unnecessary ED attendances and hospital admissions
- Enable earlier intervention to prevent deterioration

Care Homes

- Improved levels of competence and confidence of staff in their ability to recognise deterioration and act accordingly
- Improved levels of communication within the home
- Better adherence of residents wishes re end of life care and improved palliative care planning
- Improved communication between health and care colleagues and residents relatives
- Improved job satisfaction

Spread and Adoption

As the project progressed and demonstrated early signs of impact, a further 2 residential homes in the Vale of York were recruited. All 3 homes implemented the tools, engaged with their GP's and either introduced Safety Huddles focussed on deterioration or enhanced their current handover processes to focus on deterioration. To ensure effective communication channels and to support and encourage the homes, contact was made with the GP's that support the homes and other key staff such as District Nurses, community matrons, Ambulance Service and Mental Health teams. Baseline assessment of care staff confidence in recognising deterioration and calling for help was taken and repeated once the tools were embedded.

Following appointment of a project nurse a further 4 homes and a domiciliary care agency, assisted living and a day care centre were subsequently trained and supported. The initial homes required continued support and data monitoring and collection. Three of the initial homes also required additional training to accommodate new staff or staff unable to attend the training when it was first offered. Ad hoc support and training is currently on going to facilitate embedding of practice and sustainability as part of the wider adoption plan.

Homes were approached by the project team based on their interest and ability to embed the tools and translate training into practice. Building a trusting relationship ensured the registered manager fully understood the training and data collection process and could lead the implementation. This led to managers opting to incorporate the training into induction of new staff enabling sustainability. Engagement with all staff was fundamental to success and achieving the key aims of improved care and safety[xi]

Spread continues with the aim that 100% of care homes within the VOY CCG will be offered the opportunity to participate in order to maximise impact for residents and the system.

Findings

The project has been well received by health and social care staff. Based on qualitative and quantitative data collected, introduction of the interventions has had a

positive impact in participating homes. Ambulance calls, conveyance to hospital and hospital admissions are complex and often reflect resilience of the local system and infrastructure in situ within also acknowledging national pressures. Relatives/ friends have also benefited from the introduction and have welcomed the approach.

Collecting data within care homes is challenging for a variety of reasons. Hospital attendances and/or admissions of those from care homes or in receipt of domiciliary care is not currently coded. This makes demonstrating quantitative impact difficult however, one pilot home that has provided robust and reliable data has been able to demonstrate a recent step change in reduction of unplanned attendances/ admissions to the hospital. This is testament to the engagement of the team and leadership from the home manager and senior carers. This result is encouraging and coupled with other measures hints at the possible system wide impact if all care homes were supported to adopt use of the tools and we achieved a critical mass of those engaged.

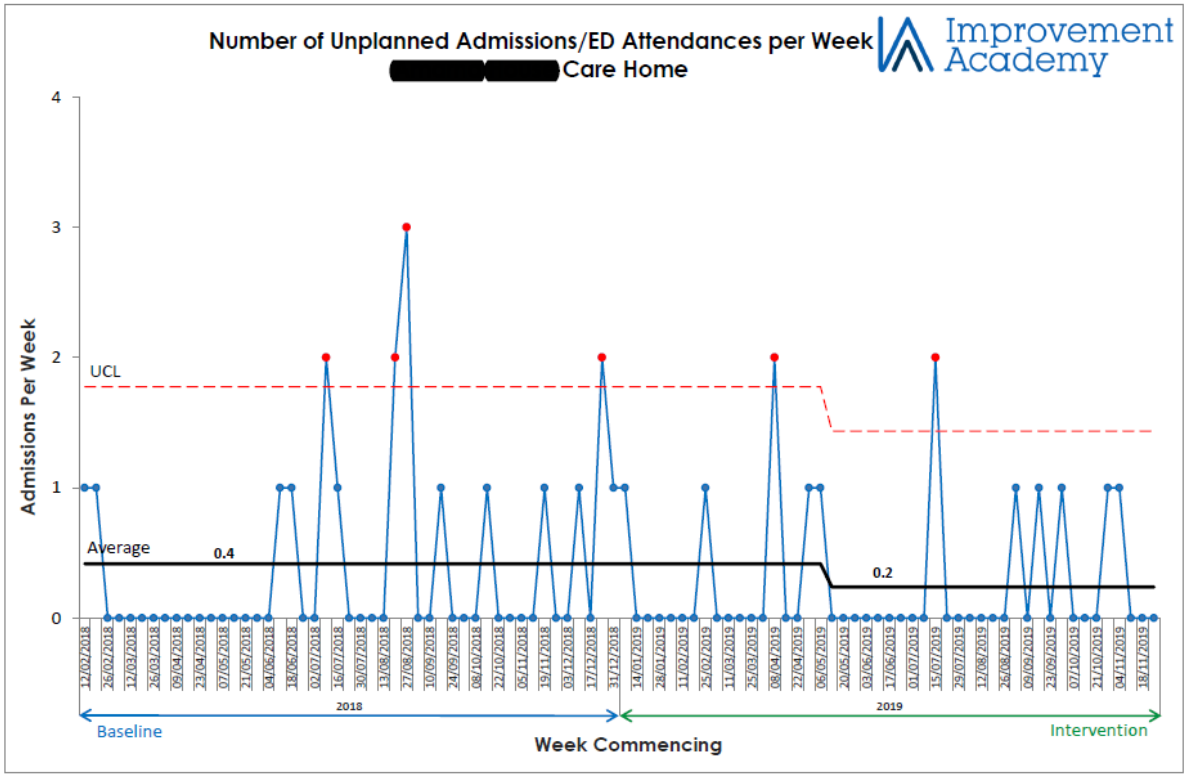


Figure 1

Overview of key findings

Usability of Tools	Communication	Improved Care	Other

Quickly adopted and evidence use tracked	Using the tool has allowed one home to monitor the residents of concern more closely and improved handover between shifts	Staff were empowered to track deterioration and improvement more closely	Training positively received, real appetite for learning practical skills that can be instantly applied in practice
Staff understood the benefits of the tool and easy to use in practice	Most staff feel more confident in speaking up as they can now speak a common language with other health professionals	Better, more complete assessments of the resident's condition which is in a standardised structure	Greater job satisfaction
Incurred no cost to the homes and not generally perceived as extra work to complete	Better communication between team & useful at handovers & safety huddles	Quicker information gathering prior to calling for help	Used introduction of the tool to prompt review of internal processes
Intuitive, easy to use even for staff who have English as their second language	Improved communication between home, Primary Care, Urgent Care practitioners, and Ambulance Service when staff use the SBAR	Improved response from other health professionals	Tools links with other pathways and referrals
Useful not only for physical deterioration but also can be used to detect deterioration in mental health		Staff feel they make a more positive contribution to residents' care	

Staff Knowledge and Confidence Before and After Interventions

Feedback from home managers and staff indicates that staff confidence in responding and escalating to the relevant health services has increased. Staff report they feel greater job satisfaction by being able to make a positive contribution to residents' care and feel able to communicate with more confidence.

All those trained either strongly agreed or agreed the training was relevant to their role (figure 2) and felt confident to demonstrate their new knowledge (figure3).

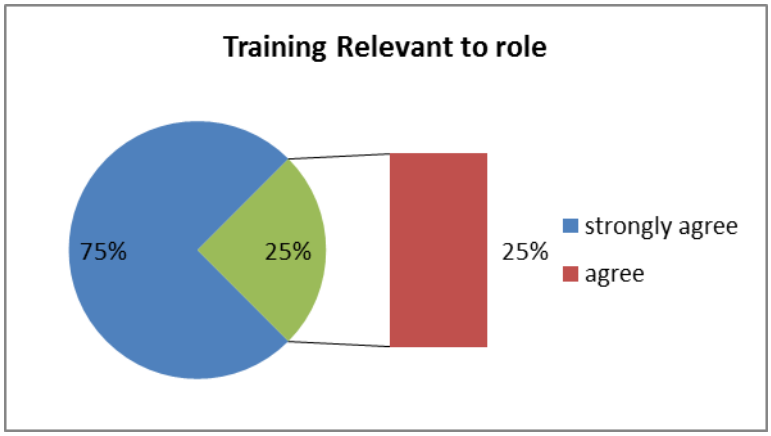


Figure 2

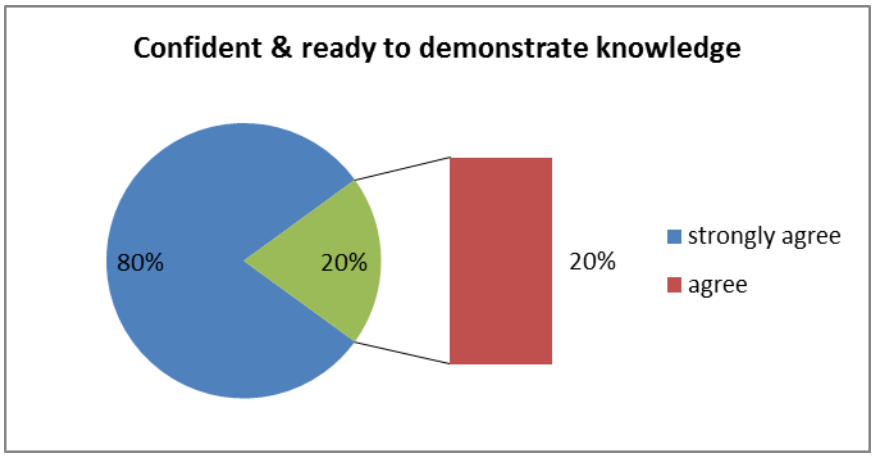


Figure 3

Interestingly when comparisons were made after the training and tool was embedded there was a positive change in scores between the first and second surveys. This has been discussed with staff who report that they now feel more aware and that previously they were unconsciously conscious of their knowledge gaps. The staff now identify how much more they are aware of knowledge gaps that existed. This is a positive result in increasing confidence.

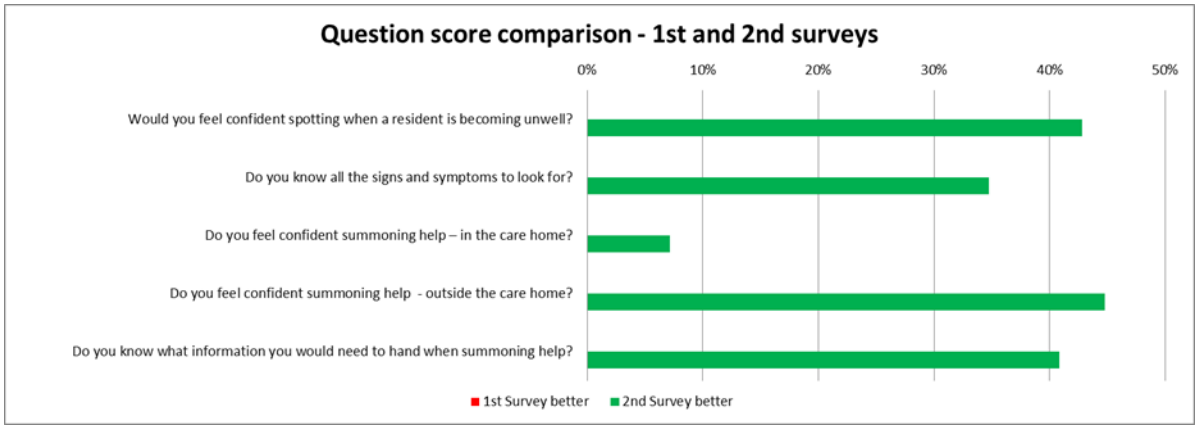


Figure 4

Staff also reported the following;

- Staff feel they are recognising subtle changes early and through monitoring and care planning
- Staff report they feel more empowered when they call for help as 'they know what we are talking about' when communicating using SBAR and the Softer Signs Tool
- Feel they can put measures in place themselves (when appropriate) instead of calling a GP or whilst waiting for advice/ a visit
- use the SBAR in preparation to have all information at hand before calling for help rather than searching for information whilst making the telephone call
- Have used the tool when discussing needs with responders even when an advance care plan is in place- this has aided communication and the responder is clear regarding expectations and ceilings of care. One resident was supported to die in the home because of the quality of communication between the out of hours GP service and home that carers felt was made possible due to the Softer signs and SBAR tool.
- use the SBAR with ambulance crews and 999 who have reported improved communication when this has been used
- have used the SBAR to help overcome language barriers for staff whose first language is not English and this has enabled a more effective communication exchange, initially it looked daunting to some as it appeared to look like a script but once used carers liked the structure and have used it with other professionals such as the pharmacy when querying orders.
- Staff state they use the information from the tool to help ask for advice rather than a GP visit
- have used the tool over an 'out of hours' period to monitor a resident and then been able to contact the residents own GP rather than have a locum GP which often results in unnecessary hospitalisation

Impact on Culture and Teamwork

Celebrating milestones and ensuring visible achievements is important to keep staff motivated and engaged. The project team have always adopted a positive stance and 'approach with curiosity' as it is strongly believed for a QI programme to work those who live and breathe the environment have the solutions. The approach was not to tell care home staff what to do, but to introduce tools that might be of use and learn how they best work in the different settings.

The Culture and Teamwork survey results from the Care Homes have proved positive and when compared with NHS settings there is learning to be gained from how the independent sector foster a culture of teamwork despite the same workforce challenges and pressures. Job satisfaction surveys have been performed with some of the care homes in more recent cohorts and have shown exceptional results as shown below.

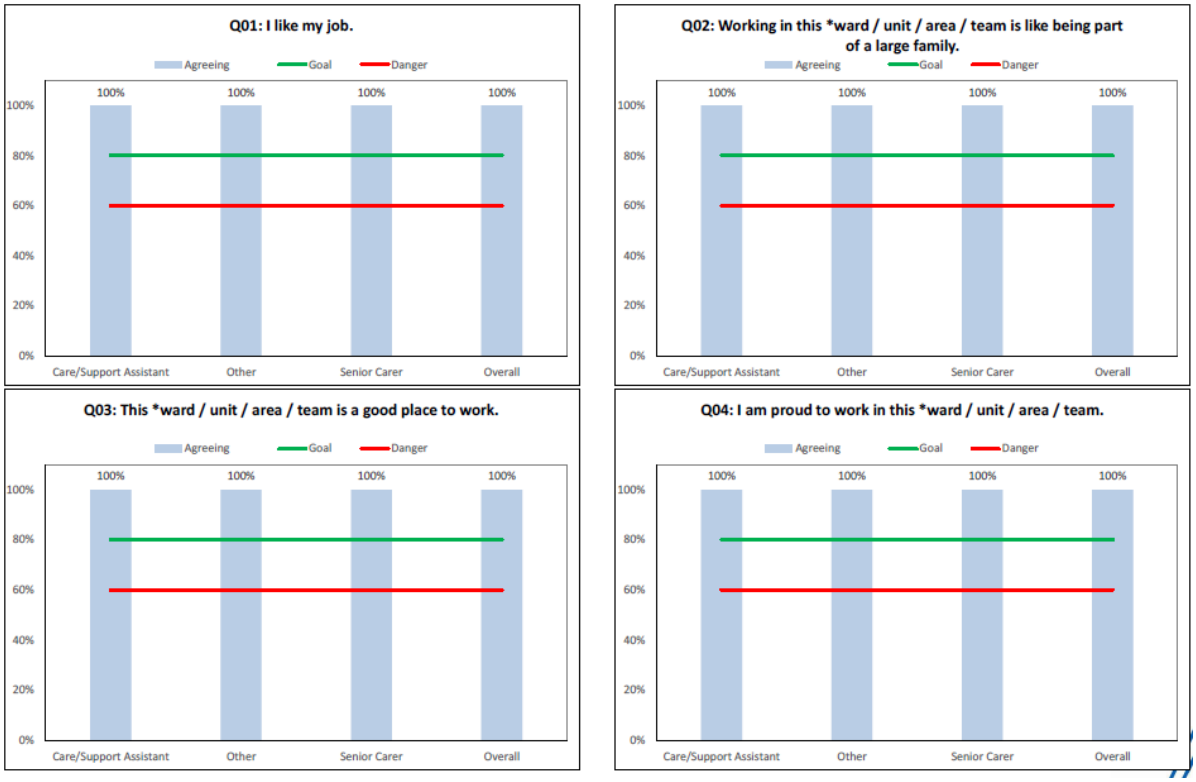


Figure 5

Results from culture and safety surveys are being used by homes as evidence for CQC of positive leadership and working on team and safety culture. The surveys above show one home having 100% staff job satisfaction. Turnover of care home staff in the VOY CCG tends to be lower than the national average. GPs and community specialist practitioners, Urgent Care practitioners and YAS have all

reported on the benefits of homes using the tools and have complimented homes in the use which has led to improved communication and relationships which can often

be challenging. It has challenged the often negative perception of Health and social care colleagues as they are now able to speak using the same language.

Both care staff and GPs have reported better communication and relationships with the homes they visit. One GP practice in particular is using the softer signs tool to triage visits when calls in the SBAR format are received for the weekly round. This is allowing for more appropriate visits; increasing time spent with residents and allowing the GP to complete certain tasks in the surgery where the computer system facilitates more timely completion and preventing safety incidents such as medication errors. In the first week of screening calls for visits by the GP to the home, the number of residents reduced from 14 to 3 and the GP was able to complete all the required asks from the team with a more coherent approach. This has subsequently fluctuated depending upon the quality of information given by carers but overall has had a positive impact. Practice Reception staff have also been trained in the use of the SBAR and the softer signs tool. There is a potential for this to be transferable to other practices and perhaps cohorts of patients.

The tool is not solely for use with residential teams, some nursing staff have also embraced to tool and in one home all Stop and Watch tools are used across all nursing and residential floors, they are collected daily and monitored by the Home Manager as part of the assurance process when a resident has become unwell to oversee that appropriate action was taken. The graph below demonstrates an example of a small care home who graded their unit on resident safety.

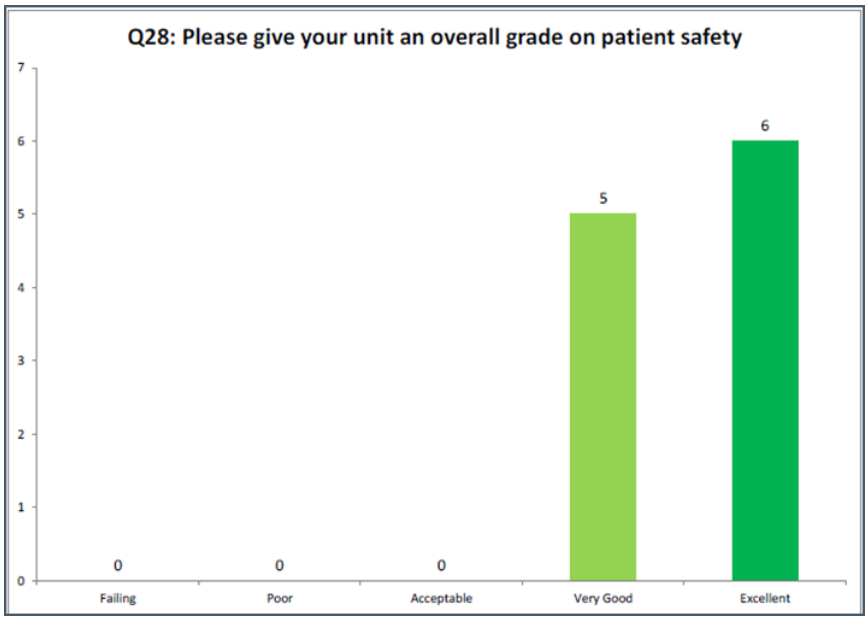


Figure 6

Unintended consequences

One of the measures the project team wanted to monitor was referral to health care professionals and in particular the concern that by virtue of raising awareness there would be a rise in GP referrals. Thankfully the opposite has been shown which is positive when encouraging new teams to participate and coupled with no resulting incidents supports the rationale for the use of the tool.

The tools are useful not only for physical deterioration, but also can be used to detect deterioration in mental health and have been supported by the Mental Health Team within the VOY CCG. The Care Home and Dementia Team have supported this work and there may be the option in future for referral processes to adapt to removing the need for GP referral if stop and Watch is used in the first instance to confirm absence of physical reason for change in behaviour.

One home has used introduction of the tool to prompt review of internal processes for deterioration once residents trigger and to think through how this links with pathways and referrals and escalation in care packages.

Staff are also using the softer signs tool to monitor improvement from initial deterioration. This has been particularly useful for night staff who now have a better understanding of the residents status over the preceding hours before their shift started.

Staff have recognised the value of communication and will use 'live' Stop and Watch for handovers prioritising those residents who are a priority for observation and additional care needs- resulting in improved quality of care.

Care homes have also started to use the softer signs tool and SBAR for routine GP and community specialist visits (as well as urgent visit requests) as this gives the GP a comprehensive narrative of a residents condition resulting in better informed clinical decisions.

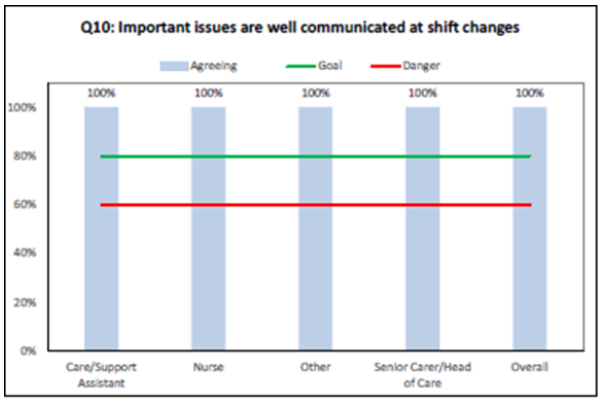


Figure 7

Use of the Softer signs Tool

Between March and September 2019, 9 homes returned 70 Stop and Watch reports. These were for a range of health issues and deterioration of residents including symptoms of urinary infections, blocked catheters, skin conditions, constipation and related pain. These problems were escalated to services including District Nurses, GPs, Urgent Care Practitioners and YAS with a variety of responses including prescribing antibiotics, laxatives and skin treatments and dressings.

The chart below demonstrate of incidences that were reported using the stop and watch who the report was escalated to. 'Not reported'- refers to the care home staff monitoring at a senior level and managing the residents care within the home.

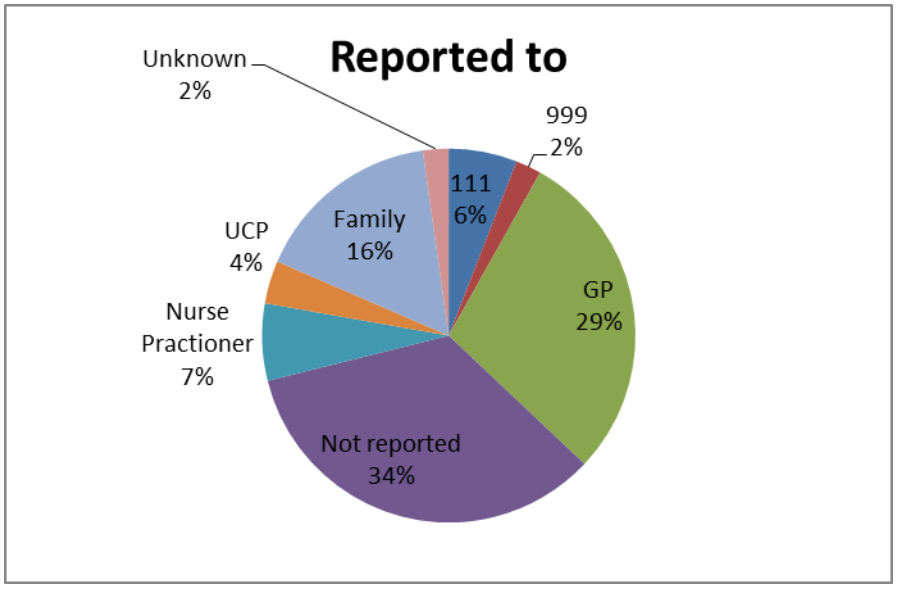


Figure 8

Of those who required escalation to a health professional;

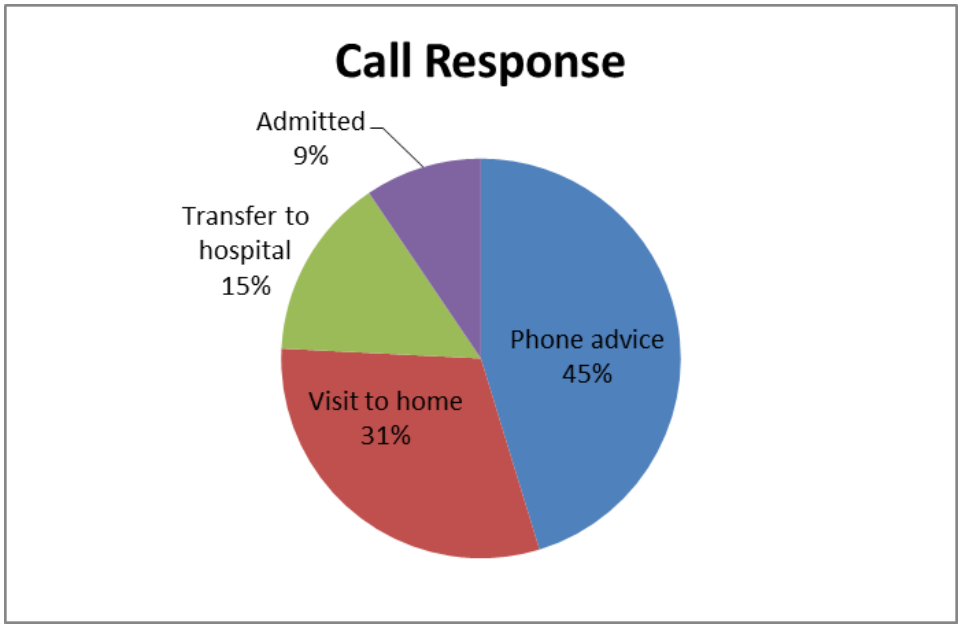


Figure 9

The chart below shows the outcome of those who were seen by the health care professional;

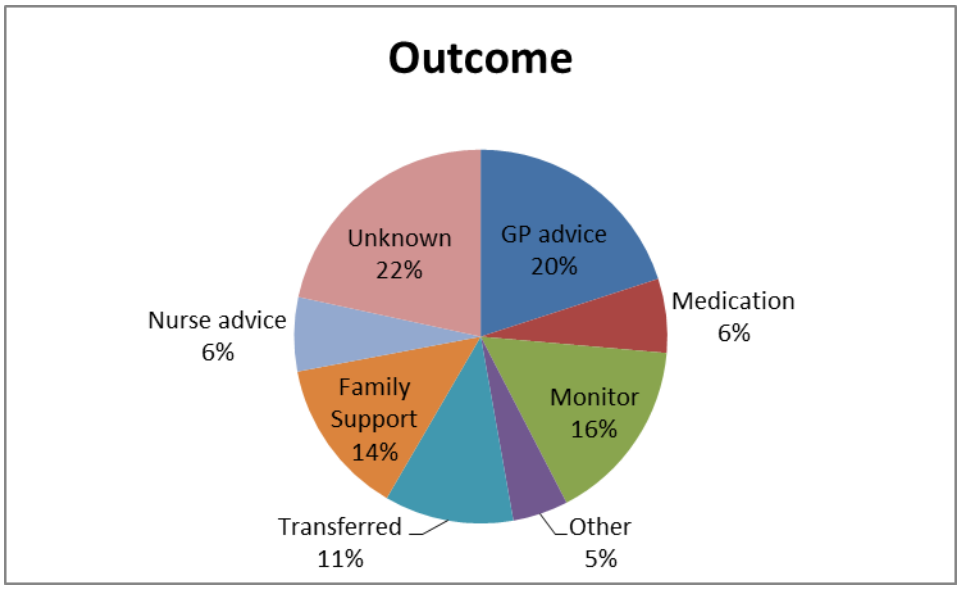


Figure 10

Example of initial Challenges within 3 Homes

Homes valued the input of the project nurse through the training and data collection visits which allowed for support and guidance of continued use of the tool, identified further training and clinical issues which were resolved with a non-judgemental, supportive approach. Following training and support from the project nurse the use of the tool in home 1 (figure 11) initially increased although a dip in August may be explained by staff holidays and less experienced or temporary staff not always completing the tool or that during good weather the residents were all in better health. Home 2 (figure 12) has shown initial usage of the Stop and Watch and also a seasonal dip. Home 3 reported that some staff were becoming complacent about using the tool even though they were recognising and responding to deterioration of residents the manager felt that although they were providing the necessary care there was no evidence if a Stop and Watch was not completed. The managers intervention at team meeting promptly addressed this issue. For any resident who requires GP input the stop and watch form is used as part of the discussion on the round.

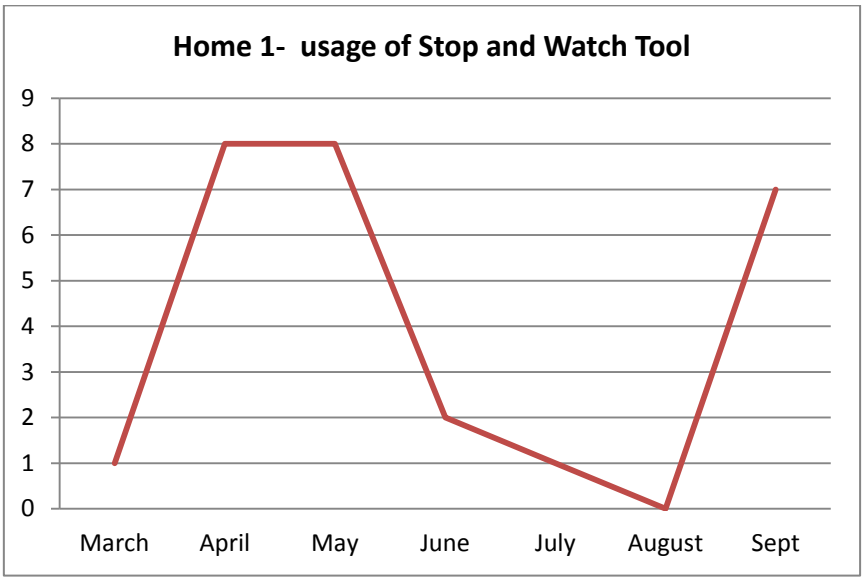


Figure 11

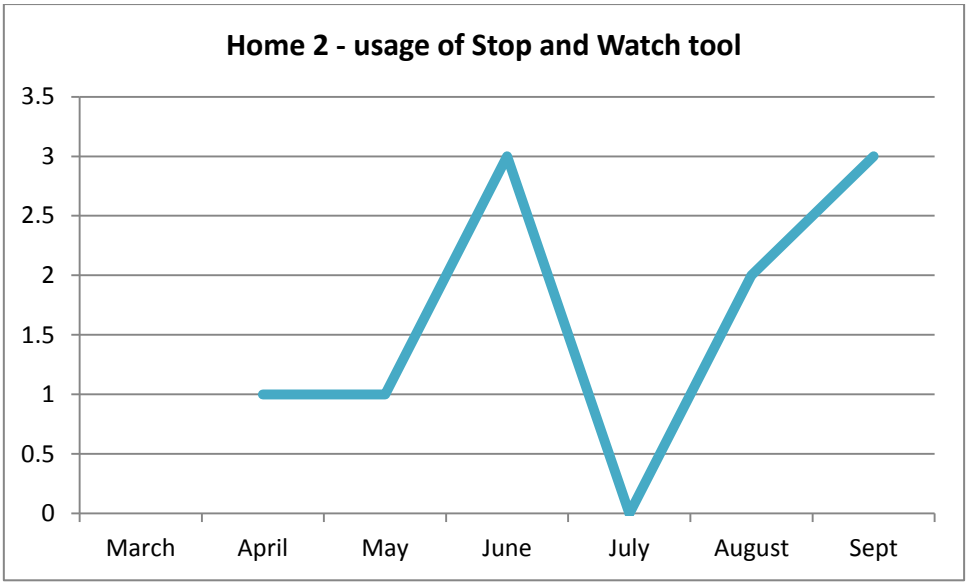


Figure 12

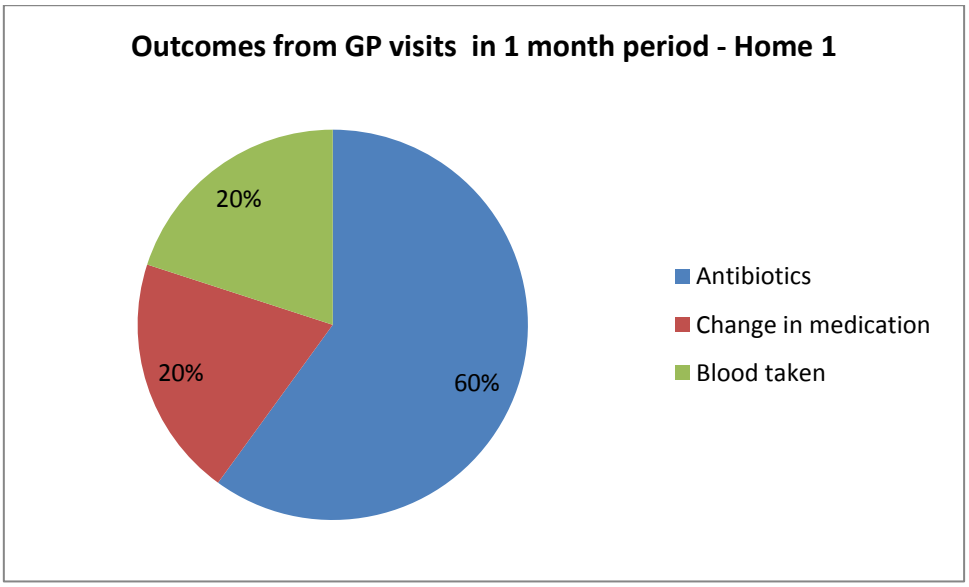
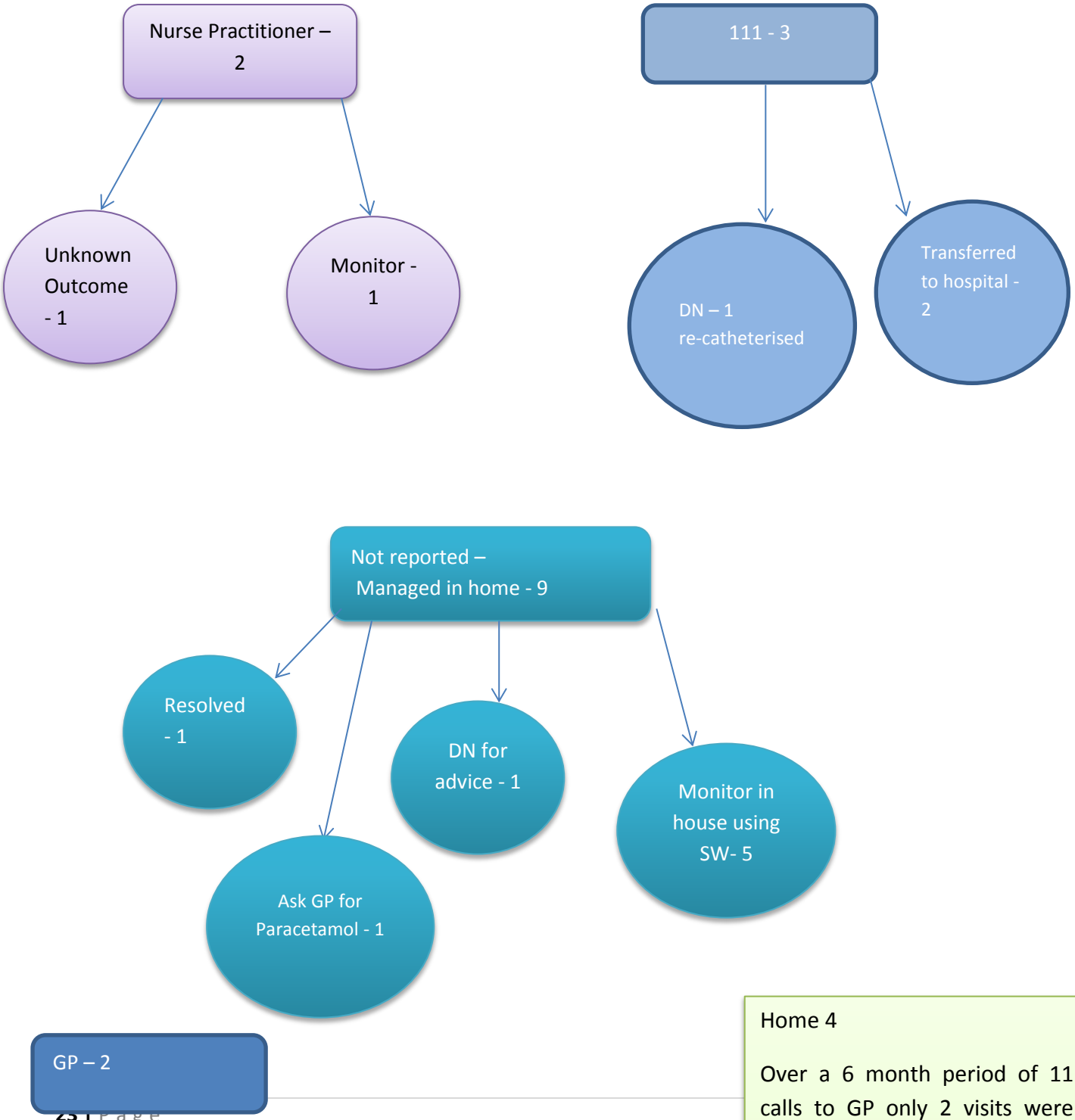


Figure 13

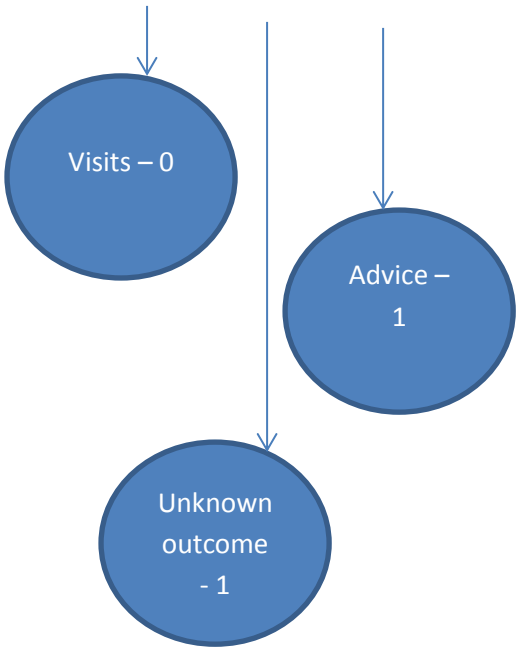
Home 1

Over a 5 month period shows escalation response following stop and watch observation and subsequent outcomes. This home has shown that the increase in observation through using the Stop and Watch tool has enabled them to monitor and resolve issues with the residents themselves rather than immediately call their GP which has



Home 4

Over a 6 month period of 11 calls to GP only 2 visits were required with 5 requests being dealt with 1 over the phone prescription and 4 other



Learning from challenges

The project has been well developed and organised, resulting in smooth implementation and positive results. Challenges have been few and easily overcome largely due to the appetite from Care home staff to engage and build relationships with the project team. The project team and homes have built a motivational and supportive relationship which has been found to address wider issues of resident care and flow across services. This has allowed a lens into some important issues that the CCG have been able to support.

Challenge	Solution
Staff not attending training Training cancellation	Flexibility of project nurse (PN) allowed for small numbers to be trained Managers & PN worked together with a flexible training

	programme
Use of tool – some homes found that in using a single form to monitor deterioration was time consuming and was confusing as over a period of monitoring several forms might be activated	PN redesigned form to allow for multiple observations to be recorded on a single easy to read page (appendix 5). This was trialled with 3 homes with positivity resulting in better use of the tool and the new version is now embedded in these homes
Storage of tool usage – 2 homes were not meticulous in maintaining records of stop and watch use	PN worked with homes to develop a recording system to allow for data collection ease and improved governance and record keeping
Data collection	Collected manually by the PN was time consuming but had the benefit of continued support and engagement with the homes which they valued
Not embedding tool after training	Despite continued contact and offers of help from the PN 1 home has disengaged and 1 has recorded 0 in Stop and Watch usage
Lack of Engagement	While 3 homes showed initial interest this was not followed through by them , again despite continued efforts form the PN they have shown no sign of taking up the offer

Discussion

The project plan target and timescales were all met. Data collection of tool use has continued. Monthly data collection and analysis during this timescale has yielded positive results as seen in this report. Support will continue with spread and adoption planned.

This project has demonstrated homes that received training have improved the quality of their care, by and report feeling more confident in both recognising and responding appropriately to. Initially three homes piloted the training and continue to use the tools demonstrating a positive change in practice and safety culture. At this time further homes and a large domiciliary care agency have received training and have or are currently embedding the tools. All homes that have embedded the tools have received certificates to celebrate and recognise the achievement. This is important to staff and recognises the effort the teams have made in supporting each other and the residents in their care.

In a short time results have proved positive and encouraging and compared to cost of hospital admissions or ambulance attendance and conveyance the training and support is a cost effective method of supporting and improving care in care homes

and GP workload. Care homes report that training is being put into practice and has empowered and educated staff benefiting residents living in the of VOY CCG. In order to see significant impact on the system it is recommended that this approach is adopted by all engaged care homes and for system partners to consider the use of

the prompts at critical handovers such as point of discharge. Findings from the domiciliary and day care/ independent living project (Fiori & Johnson, 2019) corroborate these findings and underline the importance of unpaid carers/ relatives contribution in the early identification of deterioration. The softer signs prompt has been found to be a valuable tool in supporting and standardising approach to communicating change in condition.

At the time of writing (December 2019) the original home in the pilot study remains engaged and continues to use the tool effectively over a year later demonstrating sustainability.

Approximate 260 staff have attended training which is now incorporated into new staff induction in the participating care homes. Homes that have completed training include those registered to care for adults with learning disabilities, frail elderly care (including those with complex care needs) and Dementia. Since the start of the project 1 home has disengaged, 3 other homes have been approached but not taken up the offer. The remainder homes have embedded the training and tool and results have proved positive, showing that staff are putting their training and use of the tool into everyday practice. The training and use of the softer signs/ SBAR tools are not mandatory as the homes are independent providers but Home Managers have embraced the interventions because of their commitment to improvement in quality of care. Homes remain engaged and are completing the data collection to demonstrate impact

From the initial project, work has developed to include working with 3 CCG partners- VOY CCG, Sheffield and Bradford. Work with City Health, Hull is due to commence, supporting 25 homes to implement across the region

Findings to date are being presented at key forums facilitated by the CCG's and other regional care homes workshops. Presentations nationally including the Health Foundation's Q community event, where a joint bid from Vale of York CCG and the Improvement Academy was successful leading to a further project stage allowing test the intervention with a domiciliary care provider (evaluated in a separate paper). The learning from this is transferable to a variety of care settings both formal and informal. It is anticipated that there will be spread and adoption of the project across VoY Care homes, further information to be gathered to add to the body of knowledge working within and across health and social care.

Working with colleagues from the Independent Sector, across health and social care systems provided opportunity to gain valuable insight into the diverse set of knowledge and skills that care staff possess and how if systems work together and learns from each other quality of care can flourish. With an ageing population who

have complex needs working together can ensure the most vulnerable in our communities are protected from avoidable harm and care is dignified and compassionate to the end. This work has and will contribute towards further continuous development of QI programmes to ensure the VOY CCG supports Independent care providers in working collectively to promote optimal health and wellbeing of residents.

Key Points

Positive impacts on resident safety and quality of experience

Step change in reduction of unplanned attendances/ admissions in one home demonstrated

Role of project nurse pivotal

Improves monitoring and communication between team

Can be integrated with Technology but effective paper based also so fits with both environments

Leadership is pivotal in implementation, role modelling at all levels

Peripatetic training approach better suited to the care home environment for this type of training

Supports Internal process change and that of other Health and Social care colleagues i.e. GP triage

Closing the loop and learning is encouraged amongst the care team by use of the tools at handover/ huddles

Role of family, can it be used in discharge advice and other settings? Early results indicate yes for domiciliary care and day care centres/ assisted living.

Lack of data is a challenge in Care Home/ Domiciliary Care Sector but qualitative data is impactful and this should not dissuade others from making the case to engage in QI with the care home setting.

Role of family is important and they are able to engage with this tool. Can help in sensitive situations where families are anxious that medical help is called when it is not appropriate.

For further information including examples of the tools and resources developed for use by the VOY CCG please contact sarah.fiori@nhs.net

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ii Age UK 2018 April: Later life in the United Kingdom https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/later_life_uk_factsheet.pdf

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