THE ENHANCING CLINICAL CARE FRAMEWORK FOR ADULTS LIVING IN CARE HOMES

'REPORT OF TESTING' POSITION PAPER- QUALITY IMPROVEMENT APPROACH SEPT 2022

Department of Health
An Roinn Sláinte
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1 ACKNOWLEDGEMENTS

I would like to acknowledge the contribution and phenomenal efforts made by all involved in the ECCF testing exercises. The commitment and collaboration of stakeholders and partners, including residents and family members, from across NI HSC and Independent Care Home Sector has enabled testing to be completed across a range of critical tools, pathways and services driving health and wellbeing for people living in care home settings within Northern Ireland. I thank you all, Kerrie McLarnon Nursing Officer, ECCF testing lead.

2 INTRODUCTION

From its outset, the ECCF project has recognised that much excellent work is already being undertaken within the independent care home sector and the organisations providing support to them, focused on further enhancing the health and wellbeing of people living in care homes. This is acknowledged and reflected in the work of the project and the testing exercises.

Northern Ireland is not alone in collaborating to look at the care home sector and to utilise the learning from the Covid-19 pandemic. The initial ECCF project findings and recommendations are in line with other jurisdictions, such as the NHS England Framework, the Scottish Framework and the recommendations of the British Geriatric Society.

This 'Report of Testing' position paper - Quality Improvement approach, is to provide the ECCF Project Board with the findings and initial recommendations from the exercises conducted to test key elements of the draft Enhancing Clinical Care Framework (ECCF). The recommendations from the testing exercises will also be used to inform the final project report and Framework which we plan to submit, at the end of the project, to the Minister of Health by March 2023.

A focus on quality improvement is the driving factor for change, using clinical evidence to drive and sustain change.

To prevent duplication and ensure best use of resources, the project identified work already being planned or progressed in other fora, for example, the development of a regional Falls Pathway. The Framework has also made linkages with other relevant policy and strategy being developed by the Department of Health, such as the Reform of Adult Social Care and the Review of Urgent and Emergency Care including the No More Silos (NMS) key actions, of which ECCF was identified as one of the ten key actions.

- Some of the framework will seek to address longstanding issues across HSC and in the Care home sector that were further highlighted during the pandemic, for example around workforce and equitable access to clinical care provision for all care home residents across Northern Ireland. Though some recommendations may introduce new clinical care pathways or ways of working, many involve a regional standardisation of what is already working well so that the benefits can be realised and cascaded across all care homes and their residents. The creation of a Wellness Pathway within the ECCF project will provide regional consistency in terms of resident access to clinical care that meets identified need, with an agreed expectation for service provision for all involved through collaborative interactions

and shared decision making. This report sets to test and evidence outcomes of certain elements within the Wellness Pathway. Please see Annex A for Wellness Pathway

Some of the work being undertaken under ECCF involves innovative use of data and digital technology, focused on enhancing the health and wellbeing of people living in care homes. As this will require a longer term resolution than the timespan of this project these did not form part of the testing exercises.

3 AIM OF THE ECCF PROJECT

The aim of the ECCF project is to ensure that people who live in care homes are supported to lead the best life possible, their Human Rights and right to access equitable healthcare provision are fully observed. This includes ensuring that they have access to the right clinical care, ensuring that future surges can be dealt with effectively taking the learning from the first COVID-19 surge. The outcome is the development of a framework to be available for future COVID-19 surges and to enable continuing safe, high quality and person centred clinical care within care homes. This will include optimal clinical pathways integrated across community, primary, independent and hospital sectors with the benefit of a stronger clinical model, and a robust partnership approach post COVID-19.

4 PROJECT OBJECTIVES

The project has the following specific objectives:

1. Identify current and future demand for these services taking into account future demographic changes.
2. Review the existing policy framework, in Northern Ireland, Republic of Ireland, England, Scotland and Wales, the evidence base, developments across the UK and, taking into account service user and clinical staff views, consider how the future configuration of services can adopt advancements in technology, and new frameworks for clinical care.
3. Identify the workforce training needs, career pathways, role requirements and associated costs of future framework including the commissioning model of what is planned, purchased and monitored.
4. Identify actions required to ensure services are underpinned by effective governance and quality assurance mechanisms.
5. Produce a framework with accompanying costed implementation and investment plans setting out a resilient platform for provision of optimal clinical care in care homes.

5 PROJECT OUTCOMES

The project has identified the following outcomes by March 2023:

1. Every newly admitted resident to a care home routinely has a baseline assessment and associated health and well-being plan aligned to the regional wellness pathway;
2. A plan is in place to ensure all residents have a baseline assessment of need and associated health and well-being plan aligned to the regional Wellness Pathway.

3. There is an agreed plan for scale and spread of Restore2 & Restore2 Mini for use across the care home sector as the standardised evidence based tool for assessing a deteriorating resident, and required enablers are available, for example, training/education, and digital support;
4. There is an agreed plan for scale and spread of summary as the regional process creating personalised recommendations for a resident's clinical care and treatment in a future emergency in which they are unable to make or express choices, and required enablers are available, for example, training/education and digital support;
5. There is an agreed plan for scale and spread of a regional acuity tool to accurately assess resident need and dependency and required enablers are available, for example, training/education and digital support;
6. There is an agreed plan for scale and spread of formalised regional pathways for management of (a) falls and (b) catheters

6 DEFINITIONS

The definition of Care Homes for the purpose of the ECCF Project is those registered with the Regulation and Quality Improvement Authority (RQIA) as a nursing home or residential Care Home, in accordance with the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

7 CONTEXT FOR THE TESTING EXERCISES

Ongoing issues faced within the independent care home sector have been recognised for some time. Published in 2016, Health and Wellbeing 2026: Delivering Together, the then Minister of Health's ten year vision for health and social care, makes a commitment to reform adult care and support with the aim of bringing long-term stability and sustainability to that sector and departmental work is ongoing. Those challenges have been brought sharply into focus during the Covid-19 pandemic, which has seen a range of initiatives at regional and local level being undertaken to further support care homes and people who live there. In June 2020, the Minister of Health also asked the then Chief Nursing Officer to co-design a new framework in partnership with the Care Home sector for further enhancing clinical care for residents in care homes.

8 UNDERPINNING PRINCIPLES OF THE TESTING EXERCISES

The two principles underpinning the testing exercises, resident centred and collaborative working, mirror those of the project.

(i) **Resident centred**: Testing focused on the resident to ensure recommendations were enhancing their health, safety and wellbeing in line with their wishes, and promoting equity for people living in both residential and nursing homes. As with the overarching ECCF Project, care has been taken to ensure the recommendations around enhancing of clinical care in a care home should not deliberately or inadvertently lead to the over medicalisation of care provided in care homes that could impact on the personalised elements of care that are so critical to a resident's wellbeing. It is not the intention of the project to impact the social model of care operating in residential homes or to turn nursing homes into mini hospitals.

However, where a resident has expressed a wish to remain in their care home while receiving treatment, for example, palliative or end of life care, every effort should be made by those providing their care, where possible, to respect that wish and support their health and wellbeing in the place of their choice.

(ii) **Collaborative Working:** The Department is committed to collaborative working, as described in the Department's Co-production Guide "Connecting and Realising Value Through People". Working in partnership is critical to delivering the work of the project and to the testing exercises. People living in care homes, their families, care home providers and their staff, along with those regulating and those supporting Care Homes have all been brought together as a representative partnership to harness their individual strengths and knowledge to meet the needs of residents and the staff providing their care.

9 COMMUNICATION AND ENGAGEMENT FOR THE TESTING EXERCISES

In addition to the ongoing engagement activity of the project, specific engagement was undertaken relating to the testing exercises and associated findings, which remains ongoing. An illustrative, not exhaustive, list of activity is given below.

9.1 Engagement with Care Home Staff

Care home providers and staff working in care homes are represented throughout the structures governing the testing of the key elements of the framework and in the teams taking that work forward.

Every registered Care Home in Northern Ireland received open invitations to participate in the testing exercise along with explanatory leaflets via Regulation Quality Improvement Agency (RQIA).

The ECCF project has given presentations on the testing exercises to individual care homes, organised engagement events including General Practice Northern Ireland (GPNI), Patient Client Council (PCC) and the Care Home Clinical Care Network for Northern Ireland. The network was established at project commencement and provides a representative voice for the care home sector and enables connected learning and development around enhancing clinical care within care homes, including the work of ECCF project.

Managers of all care homes were invited to information sessions to further explain the ECCF and the testing of the Wellness Pathway. The Lead of the Testing Groups met regularly with participating care homes to provide guidance and support and to provide a forum for information sharing about the testing as it was undertaken.

Staff in the participating care homes had access to bespoke training commissioned by the project through the Clinical Education Centre (CEC) and access to ongoing support through the ECCF project team as the testing was implemented and issues identified.

Learning from the testing exercises is shared in a supportive environment through the use of the existing Extension for Community Healthcare Outcomes (ECHO) network.

Letters were coproduced with care home managers and staff and provided to all participating care homes. The letters provided key information on the project and what to

expect from the testing exercises. Script was included that care homes could use if they wished when communicating with staff, residents and their families.

9.2 Resident Engagement

The focus of the framework is the health and wellbeing of people who live in care homes and exploring their experience gives rich insight into what matters most to residents. . Where residents have the capacity to agree to participate they have the right to be involved in testing the recommendations being made about their health and wellbeing.

Every opportunity was sought to involve residents themselves, where possible, in the participating care homes. In line with established experience approaches the project adopted anonymity and residents could refuse to take part, or withdraw from taking part, in the testing at any stage, without impact on the high level of care already being provided to them because assessment and planning tools are already being used in their care home.

The PHA has provided the support of the Regional Patient Client Experience (PCE) team and a range of methods identified to access the voice of residents. Due to ongoing restrictions around access to Care Homes, gathering the views of residents has been challenging. All the Care Homes within the pilots were contacted to support residents to share experience however engagement to date has been low due to ongoing pressures within the Care Home sector, capacity and ability for a resident to share their story. A range of resources were developed including easy read documents and the PCE team within PHA continues to attend Care Homes within each pilot to speak to residents and their relatives at each possible opportunity. This approach will continue in earnest over the timespan of the project to ensure the voice of residents is central to the work of the ECCF.

Additional approaches include distribution of a letter, and an associated Easy Read version, which was coproduced for people living in participating care homes and their families about the project and the testing exercises. Further support was available through bespoke engagement sessions with the testing team to provide further information and reassurance about the project and the testing exercises.

The project recognises that residents had less direct involvement in testing some of the Wellness Pathway, for example, testing the Acuity Tool remains mostly for completion by clinical staff. This contrasts with their involvement in other elements being tested, such as the Regional Falls Pathway which has the potential for a more direct and personal impact on a participating resident. As a result, significant work continues to be undertaken by the team progressing the Regional Falls Pathway to partner with residents, their families, care home staff and other relevant stakeholders in the development of the pathway.

9.3 Commissioner for Older People in Northern Ireland engagement

The Commissioner is represented on the ECCF Project Board and a meeting is planned to discuss testing outcomes and recommendations, date of which is still to be confirmed.

9.4 Family Engagement

The Patient Client Council (PCC) is the statutory body in Northern Ireland with responsibility for ensuring the voice of citizens is at the core of decision making about health and social care services. The PCC has provided the support of their Involvement Services Programme Manager and hosted a specific engagement event with a representative group of families of care homes residents to seek feedback on the ECCF Project recommendations and proposed new ways of working.

9.5 Trust Engagement

HSC Trust staff from a range of relevant clinical backgrounds are represented throughout the project structures and also in terms of governing the testing, both as leads and members of the testing teams. Further opportunities to engage with Trust staff will be sought as the project progresses.

Letters were issued by the Project to Trust CEOs informing them of the testing exercises and requesting their support, and the support of their Directors of Older People's Services and their Care Home Support Teams.

9.6 GP Engagement

The provision of GP support to care homes is a critical element of the enhanced clinical care envisaged by the framework. GPs are represented in the structures governing the testing and the teams taking it forward. There has been engagement with GPs under the auspices of GPNI.

Participating care homes identified the GP for the new resident where they or their family agreed to participate in the testing exercises and informed them of the testing exercises and their patient's participation in it. For ease of reference and to aid common language and understanding, letters were prepared by the project for the care homes to provide the GPs of participating residents with background on the project and how to access additional information, how to find additional information about the tools being tested by the care home and the GP role envisaged under the Wellness Pathway. The tools have also been added to the resources available to GPs on the GPNI website. Letters have been issued to community pharmacists.

9.7 Patient Client Council (PCC) Engagement

As mentioned above the Patient Client Council is the independent statutory organisation in Northern Ireland responsible for ensuring the voice of the public is heard and their needs and expectations in the planning, commissioning and delivery of health and social care services through engagement with the public and HSC organisations. PCC Chief Executive is a member of the ECCF Project Board and her organisation is providing key support and advice to the work of the project, as members of the project structures and the teams involved in testing key elements of the draft framework. The Services Programme Manager (Involvement and Engagement Lead) from the PCC is working with the project to utilise their membership scheme and engagement platforms to engage with families of residents in care homes.

The Services Programme Manager (Involvement and Engagement Lead) from the PCC has also been invited to be a member of the Quality Improvement (QI) team to advise on the appropriate methodologies and support engagement with families of the care home residents.

Where required, support was available for residents and families to participate and to help them articulate their views.

9.8 Public Health Agency (PHA) Engagement

The PHA provides a range of Nursing and AHP consultant and frailty network management support across the ECCF project. The Executive Director of Nursing is a member of the Project Board. The Regional Patient Client Experience team (within PHA) ensure the voice of residents and families is heard. This also includes membership with the QI Improvement Teams for each of the FFAs being tested. Taking account of the ongoing restrictions regarding the accessibility of care homes, engagement methods include use of Care Opinion, the digital on-line feedback system for Health and Social Care Northern Ireland (HSCNI) supported by the PCE Project Lead for Care Homes to obtain the views of care home residents and their families and undertaking listening events with staff to explore how each workstream is embedded in practice.

9.9 Regulatory Quality Improvement Authority (RQIA) Engagement

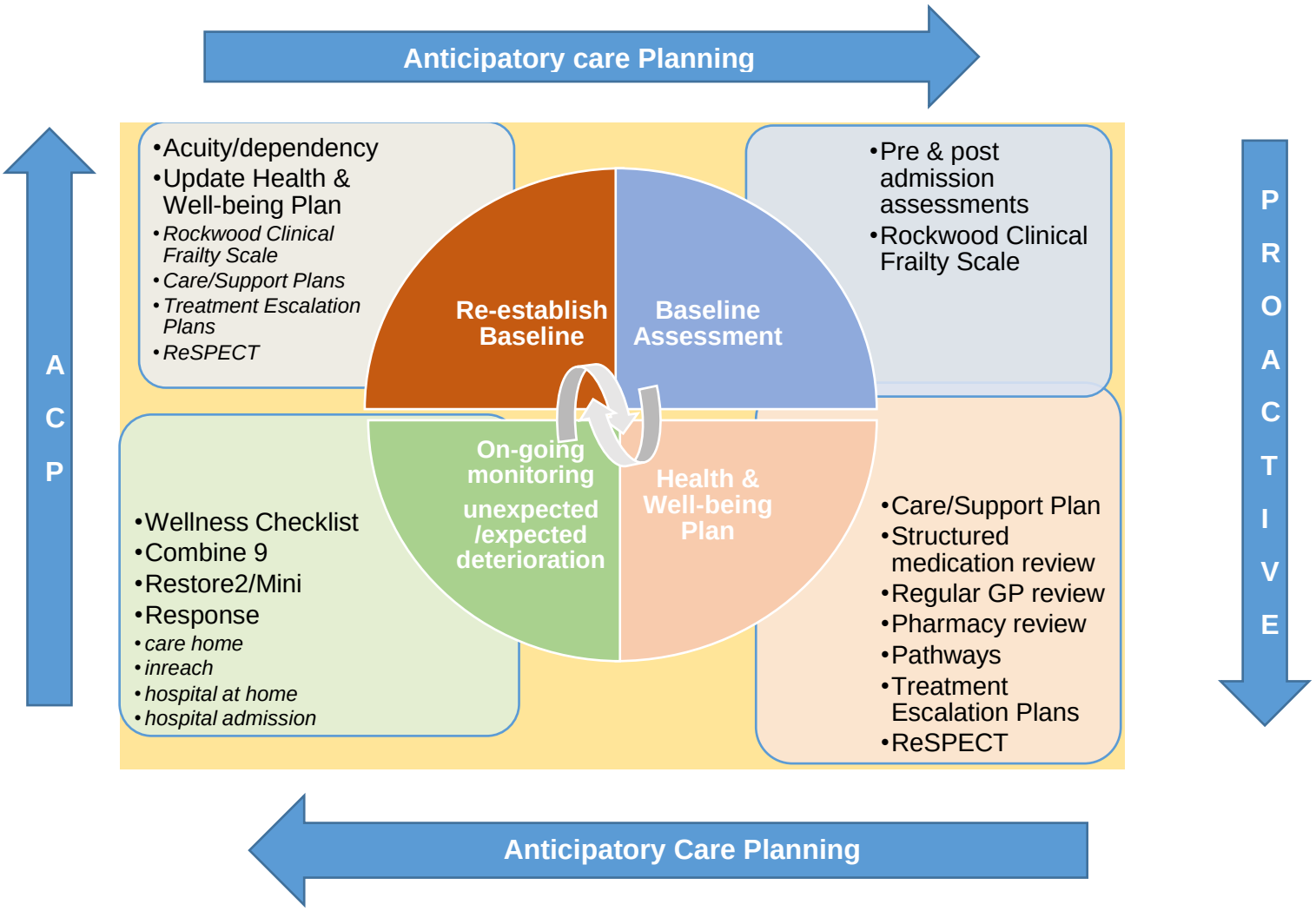
RQIA are the independent, statutory body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and for encouraging improvements in the quality of those services. As the care home regulator, their involvement is critical. The Assistant Director of Assurance is a member of the Project Board and the project governance structure established to oversee the testing exercise. RQIA inspectors were involved in the teams taking forward the testing.

10 THE TESTING EXERCISES

This section provides information on the testing and the approach taken. It is important to note that not everything described in the Wellness Pathway (diagram at 7.2 below) could be tested in the lifespan of the project and a focus was placed on those that would make the most enhancements most quickly to the health and wellbeing of residents (First Focus Actions).

10.1 Anticipatory Care Planning

Proactive, collaborative, resident centred Anticipatory Care Planning (ACP) that continues to evolve over time to reflect the needs and wants of the individual resident underpins the ethos of the draft Framework. The diagram below illustrates how the ECCF project incorporates Anticipatory Care Planning into key elements of the Framework and uses it to link elements together to benefit the resident. The centrality of Anticipatory Care Planning is woven through the Framework and is reflected in the narrative of this report.



10.2 ECCF Subgroup Deliverables

The Project governance structure is supported by three Subgroups (MDT, Workforce and Digital) to coordinate and progress the range of activity described within the Wellness Pathway. It should be noted that whilst certain elements of the Wellness Pathway have been tested and the outcomes detailed in this report, some elements are outside the lifespan of the project or being taken forward outside of the project.

10.3 MDT Subgroup

The key MDT subgroup deliverables are as follows:

- Streamlined processes and structures to provide safe, effective and person centred clinical care without boundaries in collaboration with the independent sector and HSC organisations.
- A refreshed model of personalised healthcare building on the 'frailty model' focusing on 'what matters most' to residents, families and staff.
- Participation approach to decision making regarding and access to the best suited clinical care, delivered by the right person at the right time, in the right place e.g. anticipatory care (this is the vehicle the others are the clinical pathways) rehabilitation, long-term condition management and palliative care.
- Enhanced MDT care model that meets the needs of both acutely ill residents and those with chronic healthcare and/or rehabilitative needs.
- Appropriate contribution to the Workforce subgroup to support their work to develop a workforce development policy.
- Promotion and use of data and information technology in the care home setting and contribution to the informatics and digital technology subgroup.

10.4 Workforce Subgroup

The key Workforce Subgroup deliverables are as follows:

Core Area One:

- Resident dependency assessment tool.
- Promoting and understanding the use of resident acuity data within the Independent Sector and Commission Services and its link to workforce planning in each care home context.

Core Area Two:

- Education and skills development to match the care requirements.

Core Area Three:

- A workforce model that includes normative staffing levels for care homes.
- Develop the understanding of how the regional data set informs workforce policy.

Core Area Four:

- Career development pathway to improve recruitment and retention.

10.5 Digital Technology Subgroup

The key Informatics and digital technology deliverables are:

- to provide advice and support to other work groups in considering use of on digital and data enablers in their work
- develop care home digital plan to address
- Digital Foundations - Connectivity to, and within, the home
- Digital Foundations - Data collection, data sharing & security
- Digital Services – Access to Digital Services
- Digital Foundations - Social connections and activities for residents
- Digital Foundations - Wellbeing support for staff
- Digital Leadership & Skills - Skills and confidence of residents, staff and providers
- to scope digital literacy requirements and provide resource to meet
- to deliver a web based hub for regionally agreed resources
- to agree relevant success measures for achieving outcome

10.6 First Focus Actions (FFA)

The scope and size of the project is considerable and to progress and coordinate the various strands of work to support delivery of the project within the available timeframe, activity has been further sub-divided into workstreams for key elements of the Wellness Pathway and identified as the First Focus Actions (FFA).

These key actions to focus and deliver initial work have been identified and agreed by the Project Board and Working Group. The Actions have been assigned lead individuals/groups which report back to the Co-Chairs of the relevant workstream. Each of the Subgroups have also agreed specific work they will undertake to support the delivery of the First Focus Actions. A quality improvement approach was used, initially in two phases however the first phase was paused due to challenges associated with the Omicron variant of Covid-19 presenting. The actions agreed to be tested were as follows:

- Pre-Admission Assessment and Rockwood Frailty Model
- Deterioration Assessments – Restore2 and Restore Mini
- Regional Falls pathway
- Regional Catheter Care Pathway
- Acuity Tool

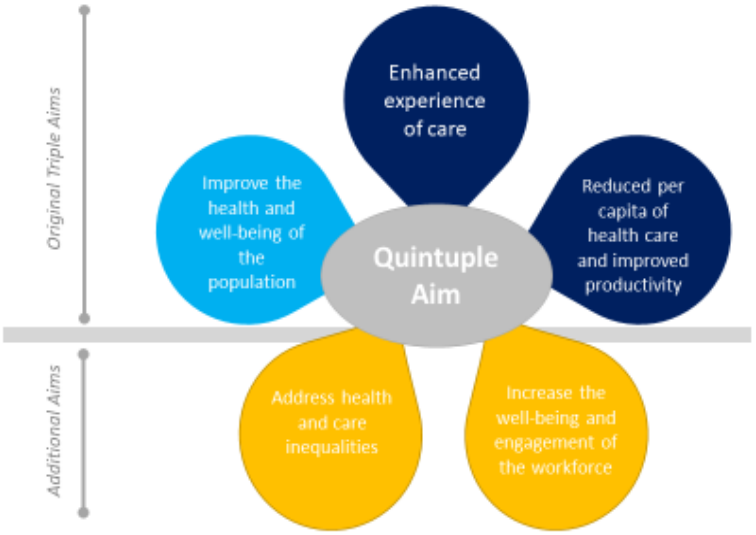
10.7 Outcome Evaluation and Quintuple Aim

The project is taking a population health approach to the evaluation of the enhanced clinical care framework outcomes. In broad terms, this approach aims to improve the health and wellbeing of residents in care homes, through a reduction of inequalities or disparities that potentially have a measurable impact on them. In so doing, this will, in turn, improve the health and wellbeing of individual residents, enabling and supporting them to respond to their challenges and changes in line with what they say, or have said they want.

In addition to effective partnership working, achieving these aims will require timely access to relevant data focused on improving outcomes, experiences and costs, rather than on processes or measures of individual data.

A consideration of data and digital enablers for care homes with a focus on further enhancing residents' health and wellbeing has been intentionally woven throughout the work of the project. Useful, accurate, and timely data is fundamental to understanding current and future needs in care homes; to better tailoring quality care and support; to designing joined up and sustainable HSC services for care homes and to making better use of public and care home resources for maximum effect.

The diagram below illustrates the Quintuple Aim:



Examples of what measures under the Quintuple Aim may look like for the testing exercises are:

1. Improving the health and wellbeing of the care home resident population through enhancing the resident centeredness, timeliness, safety and effectiveness of equitable care provision.

2. Improving the resident experience of care (quality and satisfaction).

3. Improving care home staff experience.

4. Reducing the per capita cost of providing the care - recognising the financial constraints for the public sector and the independent care home sector.

5. Address health and wellbeing inequalities

10.8 Applying a Quality Improvement Approach

NIPEC are supporting the QI leads for each FFA to demonstrate outcomes aligned to the quintuple aim.

A QI approach was adopted to create and communicate a clear, consistent vision to the wider HSC system about what the project is aiming to achieve and the key stages involved in getting there. This ensures that everyone involved in, or impacted by, the work of the project is working towards a common goal.

The model for improvement was adopted to deliver on improvement outcomes aligned to each first focus action.

10.9 The Testing Exercise in a Care Home Setting

The Framework needs to work across organisations and professions. Focused on the health and wellbeing of residents, it must be stable and robust enough to provide regional, equitable, sustainable care but also flexible enough to be able to respond to local needs and to the specific needs of residents in an individual home. It must be capable of providing the ongoing daily care required as well as responding to the most challenging of circumstances, not all of which may be predictable, as highlighted by Covid-19.

The ECCF project tested key elements of the Framework in a "live" care home environment, essential to both ensuring the ECCF project is delivering a practical Framework and to the partnership approach at the core of the project's work.

The project acknowledges the unprecedented challenges that are being faced by care homes, their residents, families and staff from the ongoing pandemic of Covid-19. Combined with the need to manage winter pressures, care homes continue to experience outbreaks and restrictions on access under existing visiting pathways, including for those engaged in ECCF project work.

Testing has remained mindful throughout of the demands placed by Covid-19 on care homes and the wider HSC system. That pressure increased by the arrival of the Omicron variant of the virus, which was prevalent during a time when elements of the framework were being tested in care homes. The project has been mindful throughout not to add to existing workloads for care homes and Trust support staff and this was factored into planning the testing exercises from the outset. We are profoundly grateful for their support and participation in the work of the testing exercise.

Care home colleagues continued to work with the project throughout testing, as circumstances permitted, however some factors presented which impeded the ability of some care homes to focus on the practicalities of the testing at all times. Other demands have rightly taken precedence, including staff resources and the need to prevent, or mitigate, the impact of an outbreak of the virus on the health and wellbeing of their residents. Care homes were however able to continue to participate in the testing as and when their situation changed and remained supportive of the aim of the project and the testing exercises. They also remain sighted of the work of the project and continue to provide advice and guidance to the project where applicable.

Organisations providing support to care homes, such as Trusts and the PHA reallocated staff and reprioritised work to manage their role and responsibilities in managing the current levels of transmission of the virus. This included redeployment of some key members of the project structures and the FFA Testing Teams which had impacted on the ability of testing exercises to proceed as originally planned.

Requests for expressions of interest in participating in the testing process were sent out to all care homes in Northern Ireland on 2nd August 2021. The testing exercise was undertaken in a total of 47 care homes who expressed an interest in taking part in a testing exercises with the project. Participating care homes come from across all five Trust areas. They include residential and nursing homes and vary in size in terms of resident numbers and organisational structure. All categories of care, as defined by RQIA, have been included.

As a result of the partnership working and ongoing engagement activity associated with the work of the ECCF project, including with the Care Home Clinical Care Network, some care homes have become aware of the tools being tested by the project. The project has become aware that some care homes in addition to those participating in the testing exercises have trialled the use of particular tools, for example, the Restore 2 tool to assess deterioration. Where results are known and can be verified as complying with the QI approach used by the project testing, they will be factored into findings going forward.

11 TESTING OUTCOMES AND RECOMMENDATIONS (Improvement Methodology, QI Charters and Driver Diagrams included)

The following sections (12-16) are compiled from the standard returns requested from the testing team Leads. All are presented verbatim. QI Charters and Driver Diagrams developed by each testing team included as Annexes.

12 TESTING OF FFA PRE ADMISSION ASSESSMENT DOCUMENT, INCORPORATING THE ROCKWOOD FRAILTY SCORE

Testing commenced on Wednesday 8th December 2021 before being paused until April 2022 due to the impact of Covid-19 on care homes and wider HSC system. The new document format builds on existing preadmission assessment documents already used by care homes and now incorporates the Rockwood Frailty Scale for completion as appropriate, to support person centred care planning. Other risk assessments are included as reference which can be completed, as appropriate, following admission to the care home. The Pre-Admission Assessment document provides an increased focus on the centrality of the resident to its completion and was widely circulated among colleagues for comment prior to testing including care home staff, social work colleagues, Trust care home support teams, RQIA, AHPs. Initial feedback was constructive and incorporated into the development of the forms. The fact the new forms encompass a more holistic approach to both the clinical health and the wellbeing of residents has been widely welcomed.

Support was provided from the outset, including the offer of virtual support sessions for participating care homes. Testing leads provided one to one support for care home managers/staff as and when required using multi-modal means of communication to target any specific concerns of participating care homes. This has been invaluable in developing and maintaining the relationships and dialogue required to work in partnership with care home colleagues, particularly during the challenges they were encountering.

Feedback from care home managers is that the support has been valued, though their ability to participate more fully remained hampered by their need to focus on the diverse challenges arising from the Omicron variant of COVID-19.

A copy of the Pre-Admission Assessment Document:

- QI Charter can be found at **Annex B.**
- Driver Diagram at **Annex C.**

12.1 Outcomes and Recommendations from the Testing Learning

Recommendations from initial findings at this stage

- The Pre-Admission Assessment document is a care home facing document however would benefit from its content being mapped against existing community and hospital discharge/transition documents (gap analysis exercises) to ensure any missing required information is available to care homes. Relationships with Trusts and RQIA will help to support this alongside a spread and sustainability workplan.
- Promoting a culture of providing full information needs fostered in wider HSC.
- Care Homes are a complex group-Independent and Trust owned. Recommend further testing of the Pre-Admission Assessment document in greater number of residential care homes.
- Shared IT platforms to enable access to required information across HSC/ Independent Sector.
- Ensuring Rockwood Frailty Model eLearning is maintained for new and existing staff.
- Continuing ECHO-Wellness Pathway Network incorporating Pre-Admission Assessment/Rockwood Frailty Model learning.
- Introduce Pre-Admission Assessment /Rockwood Frailty Model Champions
- PCC engagement; regional meeting for families and carers to promote Pre-Admission Assessment document.
- Share the News-HSCQI, Networks.
- Establish annual Wellness Pathway (including Pre-Admission Assessment/Rockwood Frailty) in care homes event-celebrate and share Learning.
- Greater family/carer involvement in assessment processes.
- Rockwood frailty scale would be completed within given timescales across all care homes (nursing and residential) to promote equity.

The underpinning rationale/evidence for that recommendation

Please see **Annex M** for bar charts, Pareto chart and run chart.

This is important to service users and carers as;

- Aims to provide a standardised pre-admission assessment data set on every newly admitted resident to Care Homes in NI which is important to service users and carers to inform a person-centred plan of care, to support wellness and detect and manage early clinical decline.

- Work completed through 10,000 more voices (lead by PHA and Age NI) in 2019 highlighted the need for better communication and involvement of families and new residents in care home admissions. Occurrence of 'failed admissions' into care homes reported for residents requiring palliative care; inappropriate admissions also reported within the ECCF Pre-Admission Assessment Improvement Group; highlighted by members of the Improvement Group that these failed admissions are directly associated with lack of pre-admission critical information and that specific clinical and personal information is required to construct a truly person centred plan of care rather than it being a rhetorical notion as we often observe can be the reality in practice. This, coupled with the challenges highlighted within the My Home Life

programme for Care Home Managers around crisis admissions, gives cause for concern.

- Service users and carers represented within the project through Patient Client Council (PCC) engagement. PCC, PCE and DoH Policy Lead colleagues, active members of Improvement Group during coproduction of the document. Engagement with family members in development of document. Work is ongoing to engage with residents and families on the process of admission to care homes.

- Care homes reported 100% of all new resident admissions were completed using the Pre-Admission Assessment document.

- 100% of staff have reported increase in confidence in shared decision making with the resident to embed person centred care planning; this is a welcome finding given the notable gaps in evidence identified by NICE (2021) as regards shared decision making.

- Initial findings extremely encouraging and positive with over 84% of staff reporting that the Pre-Admission Assessment document is helping to make an improvement in relation to the overall aim of the pilot. Staff have said:

  "the tool also encourages us to think more from the patient perspective as to what is important to them and why" – Owen Mor Care Centre Manager

  "through continued use of the document we find it to be very comprehensive with regard to identification of assessment tools and integrating these into the overall assessment, for example, MUST, BRADEN etc." –Owen Mor Care Centre Manager

  "has helped families to become more engaged" Gillaroo Lodge Nursing Home Manager

- 64% of staff have reported that the Pre-Admission Assessment document has enhanced medication management.

- Pilot data has highlighted gaps in information processes within the wider HSC systems and reflects what we have been told by care homes. We know that hospitals and other HSC systems collect a lot of information on patients but this information does not easily pass to care homes which does impact on their ability to complete any pre-admission assessment. Although this is outside of the scope of the project, it is a factor that needs to be noted
- Focus Group Workshop- held 18 August 2022 (further learning captured and shared)

Any risks, issues or challenges identified during the testing/pilot.

- Resident engagement has been difficult for PCE colleagues who are trying to find innovative workarounds

- Developing full engagement across all 8 partner care homes in terms of survey returns due to care home workforce challenges and lack of/reduced admissions.

- It was challenging to collect and analyse the Pre-Admission Assessment data due to capacity issues.

- Care Homes closed to admissions due to outbreaks and/or staff pressures.

What should happen next with your recommendation and who is best placed to take this forward including scale, spread, sustainability.

- See above under recommendations

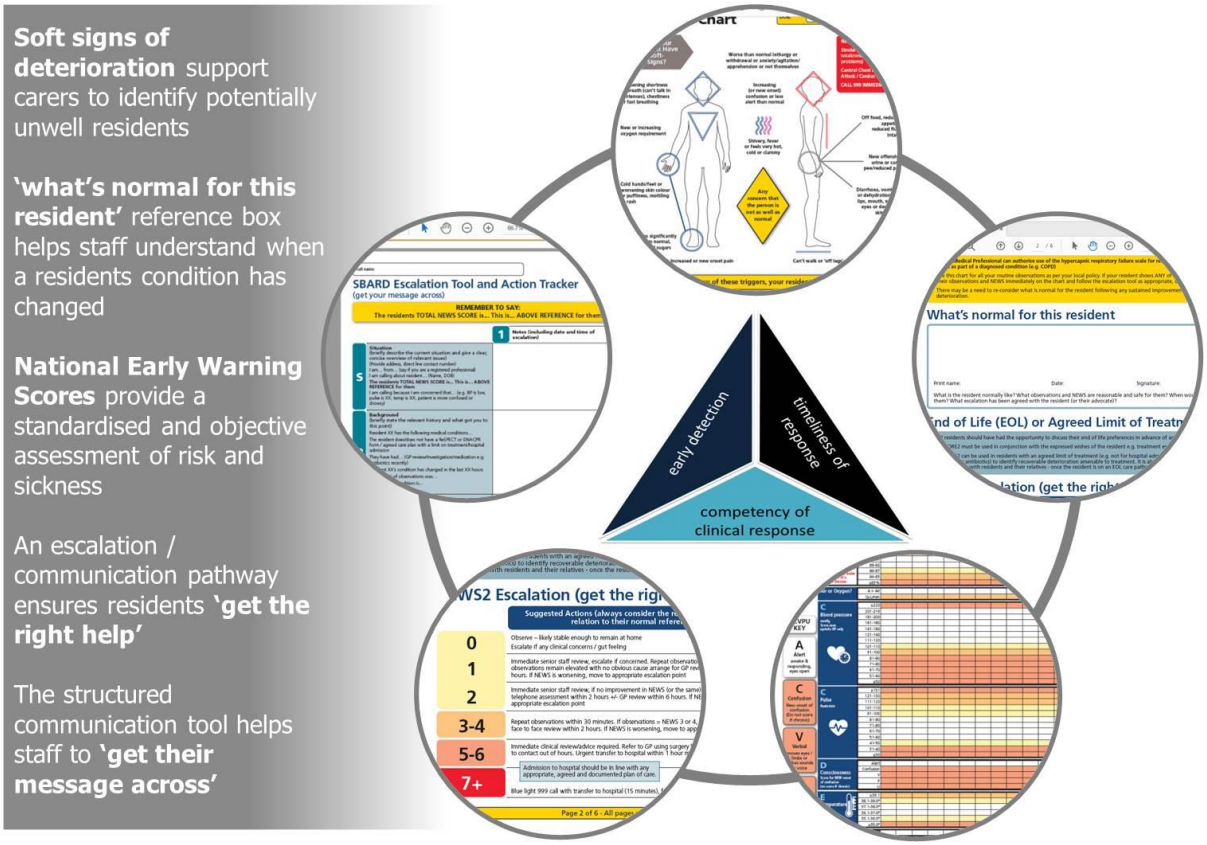
Any other narrative you feel supports your recommendation that you would like considered for inclusion in the report

Work ongoing re alignment to Quintuple Aim which will also be used for underpinning rationale/evidence.

13 TESTING OF FFA DETERIORATION TOOLS – RESTORE2 AND RESTORE2 MINI

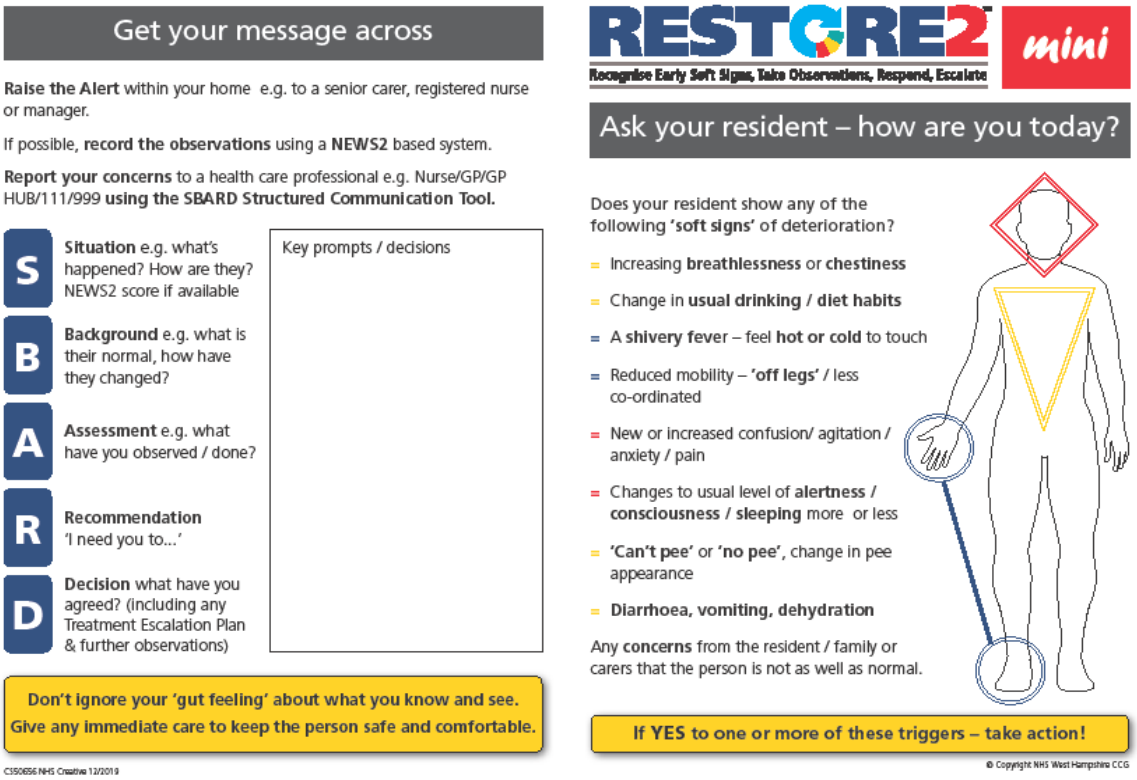
Restore 2TM / Restore2 MiniTM as the standardised evidence based tools for assessing a deteriorating resident in a nursing/ residential home across the care home sector.
RESTORE2TM is a physical deterioration and escalation tool, in most cases primarily suitable in a nursing home setting. It is designed 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 to protect and manage the resident;
- 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.



RESTORE 2 Mini TM is a condensed version of the full RESTORE2TM tool, in most cases, primarily suitable in a residential home setting for use to identify "soft signs" of a residents deterioration.

RESTORE 2 Mini TM



Get your message across

Raise the Alert within your home e.g. to a senior carer, registered nurse or manager.

If possible, **record the observations** using a **NEWS2** based system.

Report your concerns to a health care professional e.g. Nurse/GP/GP HUB/111/999 **using the SBARD Structured Communication Tool.**

		Key prompts / decisions
S	**Situation** e.g. what's happened? How are they? NEWS2 score if available	
B	**Background** e.g. what is their normal, how have they changed?	
A	**Assessment** e.g. what have you observed / done?	
R	**Recommendation** 'I need you to...'	
D	**Decision** what have you agreed? (including any Treatment Escalation Plan & further observations)	

Don't ignore your 'gut feeling' about what you know and see. Give any immediate care to keep the person safe and comfortable.

C1506856 NHS Creative 12/2019

RESTORE2 mini

Recognise Early Soft Signs, Take Observations, Respond, Escalate

Ask your resident – how are you today?

Does your resident show any of the following **'soft signs'** of deterioration?

- Increasing **breathlessness** or **chestiness**
- Change in **usual drinking / diet habits**
- A **shivery fever** – feel **hot or cold** to touch
- Reduced mobility – **'off legs'** / less co-ordinated
- New or increased confusion/ agitation / anxiety / pain
- Changes to usual level of **alertness / consciousness / sleeping** more or less
- **'Can't pee'** or **'no pee'**, change in pee appearance
- **Diarrhoea, vomiting, dehydration**

Any **concerns** from the resident / family or carers that the person is not as well as normal.

If YES to one or more of these triggers – take action!

It was originally anticipated that testing for this First Focus Action would commence during December 2021, pending the availability of the Restore2 training programme commissioned by the Department. However, the impact of managing the Omicron variant on care homes and the wider HSC meant the start date for the testing of these tools were adjusted. Challenges included the need for care homes to prioritise their focus on maintaining the health and wellbeing of their residents, the reallocation of staff resources in wider HSC, staff absence due to the transmission of Covid-19 infection and the availability of training as planned. Taking account of prevailing circumstances, coupled with lack of QI colleagues availability/FFA Lead capacity challenges, testing commenced at later date of June 2022.

A copy of the RESTORE2/RESTORE2 mini:

- QI Charter can be found at **Annex D.**
- Driver Diagram at **Annex E.**

13.1 Outcomes and Recommendations from the Testing Learning.

Recommendations from initial findings at this stage

- A collaborative approach to the implementation of RESTORE2/RESTORE 2 mini is required across all HSC services to ensure safe implementation – to include GP, NIAS, keyworkers, and community pharmacy. This will require that these professionals have a knowledge and understanding of it use.
- Development of an ongoing RESTORE 2/RESTORE 2 Mini training programme is required by CEC
- Maintaining training of RESTORE 2/RESTORE 2 Mini for new and existing staff by CEC
- Consideration is needed for the supply of colour printed versions of tool, potential concern re cost implication for Care Homes, also some homes do not have access to coloured printers
- Consideration is needed for the development of electronically accessible version of RESTORE2/RESTORE 2 Mini
- Introduction of Restore2/Restore 2 Mini Champions within Care Home settings – to review and ensure safe implementation of tool. This would benefit Train the Trainer approach to be included in the training programme
- Implementation of RESTORE 2/Restore 2 Mini in Care Homes will require ongoing support from Trust Care Home Support Teams – this may require further consideration of resources in respect of current support services to Residential Homes
- Shared IT platforms to enable access to resident information
- Successful implementation of RESTORE 2/RESTORE 2 Mini will require full commitment and adequate resources by GP, NIAS to ensure timely response to residents needs
- Successful implementation of RESTORE 2/RESTORE 2 Mini will require an increase skilled workforce to monitor residents with increased clinical acuity

The underpinning rationale/evidence for that recommendation.

- The RESTORE2 and RESTORE 2 Mini tools are designed to support care home staff in recognising when a resident may be deteriorating or at risk of a physical deterioration. The tool will
    - Inform a person-centred assessment and plan of care, to support wellness and detect and manage early clinical decline
    - Support care home staff to act appropriately and proactively to a residents condition
    - Using the tool care home staff can use a systematic and recognisable approach to escalate concerns and communicate effectively with other healthcare professionals
    - Enable care home staff to seek the most appropriate support for residents in a timely way
    - Provide a concise assessment and escalation history to inform other professionals decision making

- The RESTORE2 and RESTORE 2 Mini tools can be used in conjunction with residents and/or next of kin (if resident does not have capacity) expressed wishes for treatment escalation and/or advance care plan
- Tool has been validated for Care Home use and resources are readily available for training and implementation (– Trademarked to NHS West Hampshire CCG)
- The use of RESTORE2 and RESTORE 2 Mini links with other components of ECCF Wellness Pathways
- Principles of RESTORE2 and RESTORE 2 Mini are reflective of practices adopted in Care Homes during COVID pandemic
- The tool can improve resident safety and outcomes

Summary of data findings

- Data findings were limited during pilot due to limited responses (challenges are cited below)
- Some Care Homes had used RESTORE 2 prior to the pilot
- At baseline 100% of staff felt fairly competent to competent in using either RESTORE 2 or RESTORE 2 Mini tool
- Audit of accuracy in completing RESTORE 2 tool was 80-90% during pilot phase. (This data was not reported for RESTORE 2 Mini)

Feedback from Pilot Homes and Care Home Support Teams

Benefits

'*Better awareness of resident's baseline'*

'Felt I could give GP more clinical information than before'

'Restore2 is a good back up, previously acted on gut feeling'

'Staff have engaged well'

'Increased skill set, enhanced knowledge of deteriorating resident'

Challenges

'*Requires a lot of time' – frequency of observations*

'GP didn't know what a NEWS2 score was'

'Getting change with GPs – often send resident to ED without assessment'

Management of written record when NH only uses electronic records

Any risks, issues or challenges identified during the testing/pilot.

- Competing challenges in Care Homes to introduce new ideas
- Changing the culture of Care Home staff
- Duplication of documentation (Manual v Electronic)
- Lack of knowledge across HSC
    - Tool
    - Terminology
    - Only Care Home and Care Home Support Team have availed of training
- Time required for staff to complete baseline (pilot and initial roll out)
- Baseline required wakening residents during the night
- Ability to escalate & obtain timely response within limitations of current HSC services, for example
    - Score 3-4-Face to face GP review within 2 hrs
    - Score 5-6-Escalate to GP using 'bypass' number
    - Score >7-Transfer to hospital within 15 mins
- Increased workload for CH staff managing acutely ill resident
    - 30mins obs for score > 3
    - Continuous monitoring for scores > 7
    - No additional resource in CH's
    - May have more than 1 deteriorating resident
    - Additionally, other ECCF pathways requiring increased skilled workforce resource
- Restore 2 has copyright and therefore all resources are protected and cannot be amended in any way
- Ongoing training
    - Maintaining competence
    - Staff turnover
    - Agency staff

  * Difficulties in getting staff free to complete training due to ongoing pressures in the sector.

What should happen next with your recommendation and who is best placed to take this forward including scale, spread, sustainability.

- See above under recommendations

Any other narrative you feel supports your recommendation that you would like considered for inclusion in the report.

Please note below with our appreciation to Daniel Oliviera (CWC – Corriewood Private Clinic) feedback from their experience of implementing the RESTORE 2 tool in Wood Lodge Care Home.

We have implemented the tool in a very particular situation:

- Outbreak of COVID-19
- Young/Junior nursing workforce

We required a Tool that would be easy to understand that could provide support to the nurse's decision, under a specific set of circumstances – COVID-19. The implementation of the tool was successful and there were notorious gains specifically in a boost of clinical confidence in the workforce, and notorious gains to the patients specifically in obtaining quick access to treatment: either O2 or antibiotics, etc.

In relation to the training itself – this was completed under informal supervisions and in practice with daily debriefs. Therefore the implementation of the tool, and adherence to the same was good. I do strongly feel if the CEC is providing the training, then a Nurse/HM from a pilot Home should oversee this and ensure that there are practical examples of the application of the tool, and the challenges of the implementation of the same and how those challenges were overcome. The implementation of the RESTORE 2 tool as any other tools should always come from the principle of proactivity – we have implemented the TOOL as a resource to proactively act on changes in a condition of resident that are not picked by the daily management and monitor of their co-morbidities.

14 TESTING OF FFA REGIONAL FALLS PATHWAY

Regionally Agreed Falls Pathway and bundle. Regional falls has been identified as priorities within the No More Silos project. It should be noted that these are the areas that require a first focus to reduce care home residents' avoidable and/or frequent attendance at Emergency Departments. It is not the only area where regional pathways are currently in development (Catheter Pathway), or require development. Nor are they the only priority areas. Other priority areas for clinical pathways for care homes include delirium, depression and other chronic disease/long term condition management for residents.

Testing of the Falls First Focus Action commenced on Wednesday 8th December 2021. Initial feedback had been that participating care homes were finding the new falls pathway was making a positive difference for staff and residents.

However, the impact of managing the Omicron variant on care homes and the wider HSC, including redeployment of the Falls Steering Group, has brought readjusts of the full planned testing of the Falls Pathway. This includes the need for care homes prioritise their focus on maintaining the health and wellbeing of their residents, the reallocation of staff resources in wider HSC, staff absence due to the transmission of Covid-19 infection and the availability of training.

To this end, it was agreed that partner care homes did not have to make data measurement returns. Phase 2 of testing was then recommenced for partner homes in May 2022-July 2022 of this year. Again significant results were found in terms of improving the residents quality of life, raising staff confidence in supporting safer mobility, post falls management and learning from falls.

A copy of the Regional Falls Pathway:

- QI Charter can be found at **Annex F**.
- Driver Diagram at **Annex G.**

14.1 Outcomes and Recommendations from the Testing Learning

Recommendations from initial findings at this stage

- Regional implementation and endorsement of the Falls in Care Homes Pathway Bundle across NI-see the products in the diagram below
- Equitable access to core falls teams within Trusts
- Equitable access to equipment and technology.
- Equitable access to timely Medicine reviews and staff training
- Access to eLearning on Falls
- Focus Group Workshop-October 2022 is being planned to consider last PDSA of interventions below. This will then need to go to communications for design of a falls pathway and bundle product.
- PCC Regional families and carers meeting to share findings and thoughts for next steps
- Final Recommendation report to be written
- Scale and spread plan to support implementation and ownership beyond the partner care homes
- Sustainability-Community of Practice-to maintain and sustain the pathway (e.g. Annual Learning events, Clinical care ECHO)

Phase 3 of pathway (this will extend beyond remit and timescale of ECCF)

1. Activity Coordinator safer mobility and meaningful activity
2. Analysis of RITA
3. Regional Falls eLearning to be designed and Implemented
4. Information and communication for residents, family, carers and staff
5. Reporting of Falls regionally

The underpinning rationale/evidence for that recommendation.

The pathway has achieved many of its aims and working towards stabilisation of its process measure outcomes. Please see **Annex N** for run charts and Pareto chart.

Project Specific Aims:

Aim	Status	action
To improve resident experience and quality of life to 80% in partner care homes	Achieved with less than 20% having a fear of falling	Further improvements still required to empower residents to support their safer mobility (Phase 3 of project starting September 2022)
To reduce falls by 30% in partner care homes	This is not stable only 4 homes have returned data at this point phase 3 will support this	Prompt for other partner homes to return data. Phase 3 will further support this
To improve staff confidence in safer mobility to 80% Management of falls Learning from falls	Achieved for safer mobility Other areas still need stabilising- phase 3 will support this	Phase 3 will further support this, e.g. CEC Falls eLearning
To reduce NIAS call outs regarding falls	Reduced by 37%	Falls care pathway to be shared with Clinical support desk and GPs Regionally
To conduct an audit on neurosurgical status of residents presenting at ED with a fall on anti-coagulants	Audit Completed: No Nursing Home patient's received Neurosurgical Intervention during study period.	Discussion with appropriate Clinicians re management of residents with minor head injuries on anticoagulants.
MOOP	Intervention = *"activity by a pharmacist directed towards improving the quality use of medicines"* • ***131*** *graded as significant or v. significant (EADON Scale)* • ***4*** *potentially life saving* • ***27*** *specifically to reduce falls and fracture risk* • ***101*** *changes to meds (start / stop / change dose)* • ***8*** *referrals to other health services* • Pharmacist training • Mean knowledge quiz score **54%** before training **84%** post training	Progression of Pharmacy technicians to support and ensure accessible and timely annual medicines reviews and staff training

Any risks, issues or challenges identified during the testing/pilot

- Resident engagement was hampered as interviews had to be conducted virtually.
- Developing full engagement and collaboration across all 18 partner care homes- there were core homes who were early adopters.

- The collection and analysis of the falls data due to limited capacity within the steering Group.
- IT infrastructure within care homes is often insufficient and many only have 1 computer and poor internet access. This affected the access to staff survey monkey accessibility.
- Shared IT Platforms were also a challenge.

Challenges going forward;

Mandating the falls pathway is currently not possible-continued partnership working with all stakeholders will support a spread and sustainability work plan.
Care Homes are a complex heterogeneous group-Independent and Trust owned.
Shared IT platforms are also a challenge.
Ensuring Falls eLearning is maintained for new and existing staff.

What should happen next with your recommendation and who is best placed to take this forward including scale, spread, sustainability

The Frailty Network have agreed to maintain work on falls in care homes pathway to further add to the pathway. It is envisaged that the existing structures of Oversight and 3 task and finish groups will continue to support this work. Regards to scale, spread and sustainability the steering group are aiming to develop a workplan to support this. For example;

- Falls Champions
- Training-CEC Falls in Care Homes eLearning, levels 1 and 2, QI for care Home staff
- ECHO-CCN, Wellness Pathway Network, Activity Coordinator
- Share the News-HSCQI, Falls Awareness Week, Networks, My home life, Nationally, Falls Collective NI
- RQIA and key stakeholder care homes workshop
- Thematic review of SAIs related to falls in care homes-learning letter
- Annual Falls in care homes event-celebrate and share learning
- Equitable resource-RITA across all care homes
- Equitable access to Falls Trust services

Our main recommendation is that care homes in NI should use the regionalised falls in care homes pathway. This is mainly cost neutral, however funding should be considered and identified for equipment, technology, workforce and training.

Any other narrative you feel supports your recommendation that you would like considered for inclusion in the report

For recommendations to be implemented this will require some financial support.
For true implementation of the falls in care homes pathway we would ask the Board to consider how these pathways can be fully embedded and mandated across all care homes in NI.

15 TESTING OF THE FFA REGIONAL CATHETER CARE PATHWAY

The impact of managing the Omicron variant on care homes and the wider HSC had affected the work of this FFA and work to develop the pathway. Testing subsequently commenced May 2022.

Regional Catheter Care piloted in ten care homes who have been identified as having frequent attenders of the Emergency Department (ED). All care homes in the pilot have been attended either by a continence specialist nurse or a member of the care home support team.
A Urinary Catheter Passport Tool and Troubleshooting Guide has been developed with complete transferability to anyone across Northern Ireland.
One downside of the project has been the ability of care homes to fully engage due to the significant and numerous operational issues they continue to face.
It has been found throughout the ten homes that there can be confusion as to the rational for the catheter being started in the first place. There also needed to be very clear plan for individuals coming out of hospital with a catheter once they get home. To this end the team have been engaging with consultants and GPs and in many instances have very successful trial removal of catheters.

A copy of the Regional Catheter Care Pathway:

- QI Charter can be found at **Annex H.**
- Driver Diagram at **Annex I.**

15.1 Outcomes and Recommendations from the Testing Learning

Recommendations from initial findings at this stage

- Design a regionally branded Urinary Catheter Passport and Troubleshooting Pathway
- Introduction of Urinary Catheter Passport in all acute/non-acute hospitals.
- All hospital discharges of Care Home residents with a urinary catheter to be accompanied with a Urinary Catheter Passport.
- Additional Trust resources required to roll out Urinary Catheter Passports in all Care Homes.
- Agree a regional urinary catheterisation training programme and define training frequency.
- Urinary Catheterisation Competency Training to be available for Care Home staff.
- All Trusts to provide support to Care Home Staff using a ‘buddy’ system in clinics.
- Regionally agreed information leaflets for urinary catheters.
- Care Home staff would benefit from access to details from Northern Ireland Electronic Care Record (NIECR) and other medical records.

- Provision of a urinary catheter pack upon discharge from acute setting to accommodate next urinary catheter change.

- All Care Home residents with a new urinary catheter should be notified to the appropriate Trust Nursing Team.

- Development of a Urinary Catheter database.

- Urinary Catheter Passport accompanies the Care Home resident to ED or GP. This should be updated and returned back to the Care Home.

- Recommence regional Continence group where teams come together to support each other and to share learning.

- Consider rolling out Urinary Catheter Passport to District Nursing Teams.

- All Care Home residents to have a person centred catheter care plan completed.

- All Care Home residents to have the same access to support from Trust teams.

- Urinary Catheter Passport to be completed for all Care Home residents with urinary catheter in situ.

- All Care Home residents were applicable to be consideration for trial removal of catheter

- All Care Home residents to have a Troubleshooting Pathway in situ.

The underpinning rationale/evidence for that recommendation

This is important to service users and carers as:

- Introduction of Urinary Catheter Passport in all acute/non-acute hospitals will facilitate faster discharges and provide essential information to Care Home Staff.

- All hospital discharges of Care Home residents with a urinary catheter to be accompanied with a Urinary Catheter Passport as 45% of Care Home residents/carers did not know the reason for urinary catheterisation; 78% of Care Home residents /carers did not know the date of first urinary catheter insertion; 30% of Care Home care plans did not state the frequency of urinary catheter changes required.

- The pilot project identified inconsistent urinary catheter training across the Care Home sector. The training frequency range was Annual - 34 years.

- Trust nursing staff identified the need for urinary catheterisation practical skills training for Care Home Staff.

- Care Home staff attending Trust clinics would provide opportunities to enhance practical competencies.

- Through the pilot study it was established that a regionally agreed information pack would be beneficial for Care Home residents/carers to explain urinary catheter management.

- NICER access is required to complete a Urinary Catheter Passport. Care Homes don't currently have access to this resulting in Trust staff having to access information on their behalf.

- Urinary Catheter Passport should accompany the Care Home resident to ED or GP. This should be updated and returned back to the Care Home to facilitate continuity of care.

- The Urinary Catheter Passport has improved the safe, effective, timely care of residents with a urinary catheter.

- The Urinary Catheter Passport has improved communication between Care Home Staff and Trust Nursing Staff to better inform person centred care plans.

- The Troubleshooting Pathway has identified Urinary Catheter Management Training for Care Home Staff.

- The Troubleshooting Pathway has informed the person centred care plan.

- Some Residents have had successful removal of their catheter negating the need for any further catheter management.

- "*Our pilot homes in the WHSCT have seen a 100% reduction in ED catheter related attendances during the course of the pilot and each resident with a problematic catheter is now known to the continence team with relevant investigations underway*."

- *"Project has been beneficial to me in that it has enabled me and my colleagues in the Continence Team to forge closer links with Care home staff and offer greater support & guidance in managing patients with indwelling catheters."*

- *"Through development of the patient passport and promoting the troubleshooting guidelines, it has also improved the patient journey, quality of care, promoting safety, continuity of care, reducing risk. It has also allowed us as professionals regionally, to forge friendships, share knowledge and good practice."*

- *"We agreed on a Urinary Catheter Passport and a Trouble shooting Pathway which was a result of co-production involving valuable members of first focus action group. We strongly believed that this would reduce the number of ED attendances and the current data are the proof of the improvement achieved by the project. We were also able to identify issues faced by nursing homes in getting complete past medical history of their residents as they do not have access to NIECR. And that is where I as part of REACH team stood as a support for them."*

Any risks, issues or challenges identified during the testing/pilot

- Care Home residents with new Urinary Catheterisation are not routinely reported to Trust Nursing Team

- There is no locally held database for Care Home residents with Urinary Catheters

- Passports not updated when Care Home residents attend ED.

- A small number of Care Home residents had urinary catheter changed with no follow up information/ details to the Care Home Staff.

- While recognising the importance of Stakeholder engagement it was challenging and membership changed regularly during the course of this project which resulted in additional meetings and follow up required to bring all members up to date only for them to never return. Due to the short duration of the project the group progressed with a small number of key Trust staff to deliver on the objectives.

What should happen next with your recommendation and who is best placed to take this forward including scale, spread, sustainability.

- See above under recommendations

Any other narrative you feel supports your recommendation that you would like considered for inclusion in the report.

Work ongoing re alignment to Quintuple Aim which will also be used for underpinning rationale/evidence.

This project progressed without any additional financial support from the outset. To scale up and support all Care homes financial support and investment in key staff is required.

16 TESTING OF FFA ACUITY TOOL

A copy of the Acuity Tool:

- QI Charter can be found at **Annex J.**
- Driver Diagram at **Annex K.**

16.1 Outcomes and Recommendations from the Testing Learning

Acuity Tool: An assessment tool for uniform use across the care home sector to assess resident need and dependency accurately and to inform care home staffing models
Planning to progress the testing of an Acuity tool was advanced, however, the impact of managing the Omicron variant on care homes and the wider HSC had paused the commencement of that testing until March 2022.

Recommendations from initial findings at this stage

- Care Home Equation Safe Staffing (CHESS) Model and Scottish Care Home Model was tested and shows there is merit in development of an acuity tool for the care home sector to capture staffing against complexities being nursed. The Scottish Care Home Tool is from 2008 and is outdated with gaps and the CHESS Model was developed 2015 but has been updated and this was devised by Four Seasons healthcare, however Four Seasons Healthcare which has had a takeover no longer have access to the IP to this tool.

- The underpinning rationale/evidence for that recommendation.
  Feedback from pilot homes- briefing report available at **Annex O.**

- Any risks, issues or challenges identified during the testing/pilot.
  No access to Intellectual Properties of CHESS Model
  Scottish Model free to use but would need to be built upon for complexities
  CHESS Model was developed by a private provider so even if available would-be procurement issues

- What should happen next with your recommendation and who is best placed to take this forward including scale, spread, sustainability.
  Recommend a project is taken forward to develop a bespoke tool for the sector based on the principles of both the Scottish Tool and CHESS tool. This would be best taken forward by a data analyst who would understand how to develop algorithms in relation to development of complexities versus staffing. We could see this as a separate project run by DOH.

- Any other narrative you feel supports your recommendation that you would like considered for inclusion in the report
  MDT in reach model tested by Mary Emerson* in line with supporting the staffing model for care homes – **See Annex P.**
  Pharmacy Technician role to be explored- findings by Carmel Darcy and Jayne Adair regarding this pilot. - This would need costed.
  Activity Role to be considered extended on behalf of the care home sector to support the staffing model- this would need costed.

*Mary Emerson is the Lead Allied Health Professionals Consultant Older People, Mental Health, Learning Disability and Healthcare in Prisons in the PHA.

17 CONCLUDING RECOMMENDATIONS TO PROJECT BOARD

17.1 SPECIFIC Recommendations from the Testing Exercises:

- Introduction of Pre-Admission Assessment Document, incorporating the Rockwood Frailty Score, as the regional standardised tool.
- Introduction of RESTORE2/RESTORE2 mini as the regional standardised tool for assessing deterioration of care home residents.
- Work continues to develop around the Regional Falls Pathway and associated products.
- Introduction of Urinary Catheter Passport and Troubleshooting Guide Pathway.
- Consideration should be given to the development of a bespoke acuity tool for Independent Sector based on learning from the Scottish Model and the CHESS Model from the testing exercise.

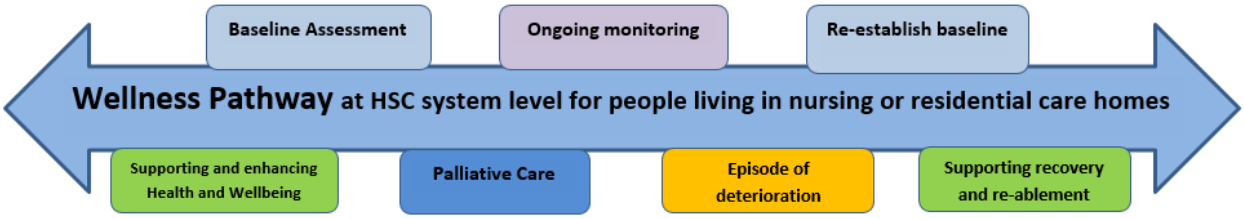
17.2 GENERAL points to note from the Testing Exercises:

- The benefits of the Independent Sector having access to the training and development they need is reinforced.
- There will need to be communication about these tools and about their use via appropriate platforms.
- Resources will continue to be a challenge including when these tools are being introduced and will need to be taken account of.
- Change should be sustainable and how that will be supported needs to be considered.
- Partnership working should continue. Cross boundary; cross organisational working was fundamental for the testing exercise with the voice of residents' and their families at its core. This will require further changes in culture and practice across a range organisations and professions.
- Where not readily apparent, roles and responsibilities will need further definition.
- There may be a need for existing community and hospital documentation to be mapped against the recommended documentation from the testing. This is to ensure that content of community and hospital documentation meets what care homes said in the testing they need as a minimum for the resident's data set.
- Managing the impact of Covid-19, including the rebuild of services, will continue to be a challenge for care homes and the wider HSC system.
- The importance of having underpinning data and digital technology for care homes was reinforced in the testing.
- Testing clearly demonstrated the importance of commonality of language across organisations and professions when focusing on the health and well-being of a resident.
- The importance of meeting the needs of residents in both nursing and residential home settings was reinforced by the testing.
- The testing reinforced that GP and NIAS involvement is also critical to benefit health and wellbeing outcomes for the residents.

NEXT STEPS

Engagement needs to continue over the findings. For example, COPNI; GPNI; PCC events are planned. Testing should continue where appropriate. NIPEC are mapping Wellness Pathway testing exercises against the overarching Quintuple Aim for the project. ECCF_Wellness Pathway ECHO to be further embedded to help inform future recommendations.

Annex A - THE WELLNESS PATHWAY



Gateways	Tools and resources to support assessment, monitoring and intervention						
Baseline Assessment	Rockwood Frailty Scale	Advance Care Plan	Dependency / Acuity				
Ongoing monitoring	Wellness Checklist	Care Home Support Teams	Long Term Condition management	RESPECT	GP review of residents	Advanced Practitioner for Care Homes	
Episode of deterioration	Combine 9	Restore 2 Nursing Home	Restore 2 Mini Residential Care Homes	Nursing Home In-reach	MDT Care Home Support Teams	Hospital at Home	
Supporting Health and Wellbeing	Emotional wellbeing	Mobility and exercise	Community and voluntary Sector support	Nutrition and Eating Well	My Home Life: Leadership support	Self-determination / Advocacy	MDT support: physio, dietetics
Palliative Care	Long Term Condition Management	Palliative Care in Partnership resources	DN / Hospice / Marie Curie	Symptom control	End of Life Care		

System Enablers	Effective communication	Data and informatics	Digital interface	Encompass			
Workforce enablers	Access to funded training	Clinical skills enhancement	Management & leadership development	Career Pathway	Positive culture	Workforce model to meet acuity and dependency	

The overarching model for the draft framework has been designed as a “Wellness Pathway”. The Wellness Pathway describes a resident “journey”, providing regional consistency for all involved in terms of resident access to needs based clinical care to support their health and wellbeing from the Multi-disciplinary team (MDT) team and thereby an agreed expectation for seamless service provision for all involved. Most critically this includes the resident and their family.

The resident journey moves both ways across the pathway to reflect the fact that, depending on their circumstances, an individual resident’s journey will not necessarily be a linear one.

The Wellness Pathway is about ensuring that care home residents continue to be supported through responsive, personalised care that is sustainable and equitable, effectively and safely meeting the appropriate level of care in line with the resident’s wishes/needs and with the necessary level of clinical in-reach when required.

Annex B – PRE ADMISSION ASSESSMENT QI CHARTER

Team: First Focus Action Pre-Admission Assessment/Rockwood Frailty Model Improvement Group
Project: Pre-admission assessment tool to inform person centred care.
Sponsor: Chief Nursing Officer NI
Project Start Date: November 2021
Last Revised: 15 August 2022

What are we trying to accomplish?
Problem - Describe in 2 to 3 sentences the existing condition you hope to improve (i.e., the gap in quality).

The care home sector has a range of varied pre-admission assessment documents. We aim to promote the quality of care and enhance the resident experience by developing a pre-admission assessment tool which informs a shared plan of care to support wellness and detect and manage early clinical decline. Older people living in care homes have increasing complexity and dependency levels, than has ever been the case to date, having implications for all who assess and recognise the need to deliver safe effective timely person centred care to care home residents in their preferred place of care.

Project Description (defines *what*)
Document your current thinking about the activities of the project (e.g., design a new process, improve an existing product or service, etc.). Note the subsystem, pilot population, and/or demonstration unit where the work will take place. Consider including your long-term vision and short-term project goals.

Evidence shows us that the system needs an updated pre-admission assessment tool in order to provide an enhanced reflective and responsive service that delivers high quality of person centred care for residents.

Rationale (defines *why*)
Explain why the current process or system needs improvement. If possible, include baseline data and other benchmarks.

From Covid-19 and the pandemic it was clear how unsupported the system was and the shortfall in need identified how much support the care homes required.
ECCF sub group 1 Multi-Disciplinary Team planning, has identified that a regional standardised pre-admission assessment is a key deliverable for the sector.
Tools have been explored and a pre-admission assessment document including Rockwood Frailty Scale, when adapted for the care sector could provide a solution to inform a person centred care model that will meet assessed needs of the population we are caring for. The current system is no longer best practice and we wish to address this.

Expected Outcomes and Benefits
How will this improvement benefit the team, the organization, customers, and/or the community? What is the business impact, such as reduced costs or other financial benefits?

- For residents- person-centred care model determined on level of assessed need so that care is given at the right time in the right place, by the right person, within the right situation. To enhance resident experience and enhance quality of life.

- For staff- clear guidance on person-centred care as per assessed needs of residents. To raise awareness, training and improve skill of staff to develop safer management and learn from pre-admission assessment/Rockwood Frailty Model in NI
- To reduce deaths in NI by optimizing safer management and follow up of deterioration in care homes
- To reduce unnecessary call out to NIAS
- To reduce unnecessary journey to ED
- To provide consistent pre-admission assessment/ Rockwood Frailty Model pathways and bundle across NI.
- The pre-admission assessment tool supports the delivery of person centred care, enabling person centred care planning, for each Care Home in the pilot.

Aim Statement
What outcome are you hoping to achieve? Specify how good, for whom, and by when (a specific date).

To enhance proactive, safe, person centred care planning through a standardised pre-admission assessment document with 100% of new residents across 8 care homes by 25th July 2022.

How will we know that a change is an improvement?
When defining your project-level measures, provide operational definitions, which specify unambiguously how to derive each measure, and be sure to define numerators and denominators in measures such as percent or rates.

Outcome Measure(s)
List the measure(s) you ultimately want to affect as a result of this project.
For all 8 pilot care homes:
- % of new residents using the standardised pre-admission assessment document
- % of staff reporting confidence on shared decision making with the resident to embed person centred care planning.

Process Measure(s)
List the measure(s) that will tell you if the system is performing as planned to affect the outcome measure.
- % of sections in the pre-admission document not completed. (If we find that the pre-admission assessment document has not sufficient info on it to inform a plan of care then we will need to involve acute where we are sourcing this information at the hospital assessment visit OR community colleagues where we are sourcing this information from community services/GP etc.)
- % of residents requiring a Rockwood frailty score, will have one completed.
- % of staff completing the pre-admission document are trained in its use in participating homes.
- % of staff completing the Rockwood frailty score trained in its use in participating homes.
- Qualitative feedback on the use of the tool from residents, relatives, and staff.

Balancing Measure(s)
List the measures that will tell you whether you are introducing problems elsewhere in the system.

- Time taken to complete assessment.
- % of Rockwood scores that have been followed up where required.
- % increase of referrals.
- Mix use of digital and paper based tool.

What changes can we make that will result in improvement?

Initial Activities
Consider starting by exploring the process or system you are trying to improve with tools such as interviews, direct observation, cause and effect diagrams, driver diagrams, and process maps/flowcharts.

To identify the care homes to participate in the pilot
To raise awareness with the Senior Nurses and Deputy Managers in each care home.
To provide training on the use of the pre-admission assessment tool.
To inform and involve families as well as residents: co-production; what the tool is for, how it is done and the where information is used.
To identify incomplete sections within the pre-admission documentation.

Change Ideas
What ideas do you have for initial tests of change (Plan-Do-Study-Act cycles)?

- Provide training for staff to complete new standardised Pre-admission assessment document
- Use the pre-admission assessment document for all new residents
- Staff workshops fortnightly to feedback on use of new document within pilot homes

Key Stakeholders
Whose input and support will this project require? How will you engage these key stakeholders?

- DoH - CNO
- Trusts
- IHCP
- RCN/NISCC
- Residents and Families representation- coproduction
- Hospital/community colleagues
- GPs
- Pharmacists
- Relevant AHPs

All of above will be engaged as members of First Focus Action Improvement Group.

Barriers
What barriers do you predict to your success? How will you overcome these barriers?
Funding this tool
Existing pre-admission assessment model may need to change or need supplemented to support this tool
Roles need defined

Boundaries

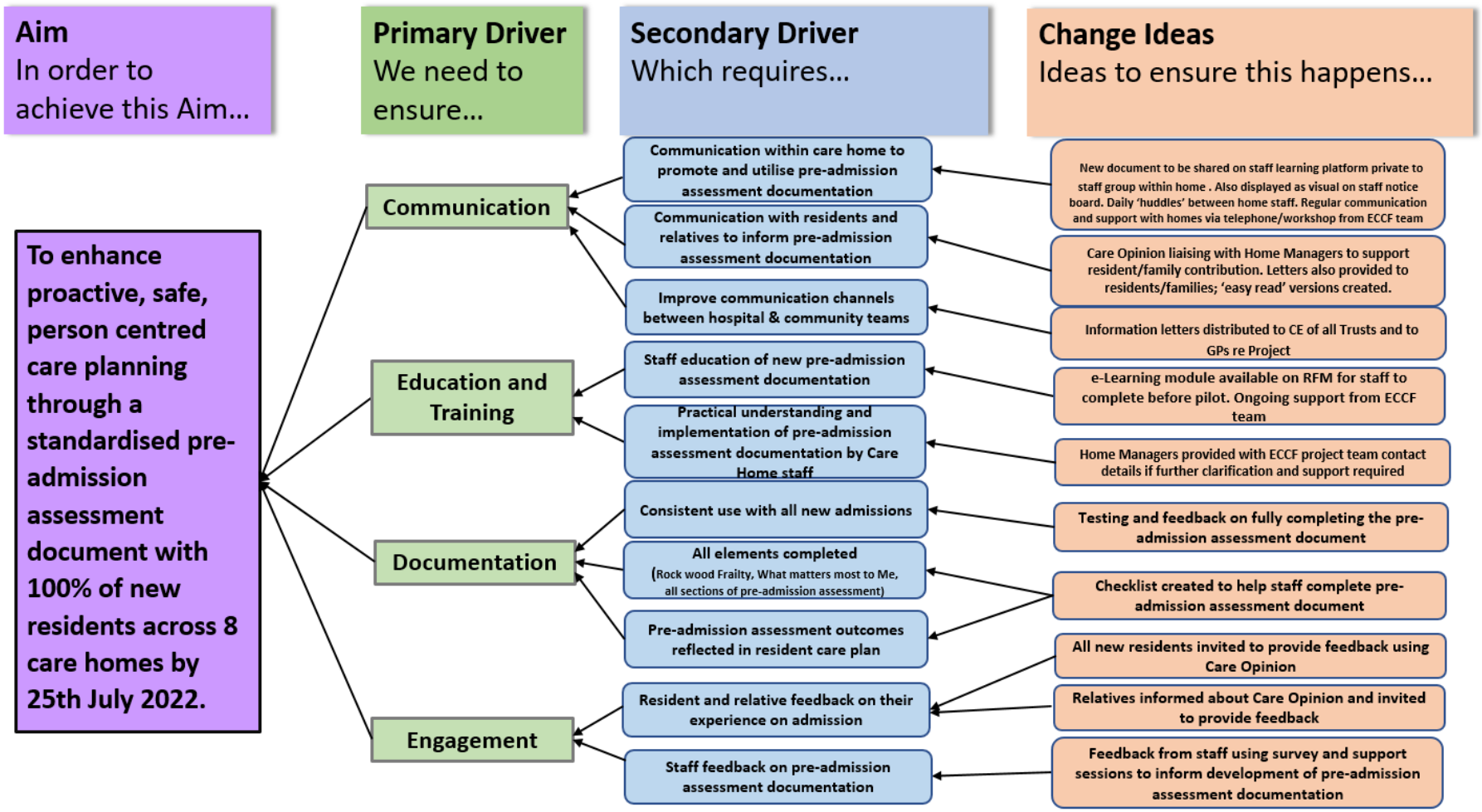
List any guidelines for the team, including project constraints, rules or procedures, technology considerations, what is out of scope, etc.

Is this research and evidence based?

Format: Co design at the start with engagement of all stakeholders
Interviews with residents
Engagement with relatives and carer
Project Oversight Group with key stakeholders
Task and Finish groups with key stakeholders
Feedback/communication with ECCF and subgroups-MDT and Digital

Partners: Project is being developed through the ECCF, mandated from MOH-DOH-CNO. ECCF 3 subgroups. This is a co-designed project by residents, relatives, care homes (nursing and residential) PHA, Trust staff, GPs, Independent sector and HSCB.

Annex C – PRE ADMISSION ASSESSMENT DRIVER DIAGRAM



Annex D – RESTORE2/RESTORE2 mini QI CHARTER

Team: First Focus Action Deterioration Assessments Restore2/R2 mini Improvement Group

Project: Deterioration Assessment tool to inform development of a person centred care plan/shared plan of care

Sponsor: Chief Nursing Officer NI

Project Start Date: 6th **June 2022**

Last Revised: 8th Sept 2022

What are we trying to accomplish?

Problem:
Describe in 2 to 3 sentences the existing condition you hope to improve (i.e., the gap in quality).
The care home sector has a range of varied deterioration assessment tools. We aim to promote the quality of care and enhance the resident experience by using a deterioration assessment tool which informs a shared plan of care to support wellness and detect and manage early clinical decline. People living in care homes have increasing complexity and dependency levels, and it is important that there is a shared language to promote an efficient and effective way to recognise, assess and respond to deterioration. This will support the delivery of safe, effective, timely person centred care to care home residents in accordance with the resident's wishes.

Project Description: (defines what)
Document your current thinking about the activities of the project (e.g., design a new process, improve an existing product or service, etc.). Note the subsystem, pilot population, and/or demonstration unit where the work will take place. Consider including your long-term vision and short-term project goals.
To pilot the use of an evidence based assessment tool for resident deterioration in care homes in NI. The preferred assessment tool is Restore2 (Nursing Homes) /Restore2 mini (Residential Care Homes), which will enable staff to quickly recognise and assess deterioration and follow up safely and effectively. This work will be part of the ECCF project and sits within the Multi-disciplinary Subgroup.

Global Aim:
To enable staff to confidently assess deterioration at the earliest point possible, manage appropriately, and follow up safely and effectively in line with a resident's wishes.

Specific Aim:
What outcome are you hoping to achieve? Specify how, for whom, and by when (a specific date).

- To increase staff confidence level by 50% relating to decision making in recognising and reporting deterioration using the Restore2/Restore2 mini within each pilot care home by 6th September 2022

Objectives:

- Enhanced staff confidence in
    - Recognising soft signs of deterioration
    - Undertaking clinical observations
    - Knowing when to complete Restore 2 / Restore2 mini
    - Knowing when to escalate and to whom
    - Effective communication with the range of Care Home Support
    - Professional judgement and autonomy for decision making to enhance the care of the resident

Key Stakeholders: An illustrative, not exhaustive list, includes:

- Restore2 FFA group
- Project Oversight Group with key stakeholders
- Task and Finish groups with key stakeholders
- Feedback/communication with ECCF and subgroups-MDT and Digital
- Care homes staff (nursing and residential)
- PHA
- Trust staff (including NIAS),
- GPs
- Community Pharmacy
- HSCB
- Residents

Rationale/Reason for the Effort (defines WHY):

Explain why the current process or system needs improvement. If possible, include baseline data and other benchmarks.

- Utilising a variety of assessment tools has the potential to create variation in both assessment and interpretation of the information collated
- NEWS2 is the regionally accepted tool for assessing deterioration in a hospital setting and a commensurate tool is needed for community settings such as care homes
- Quality of care, treatment and support provided in response to deterioration will be enhanced by the use of a regionally consistent model for assessment of deterioration
- Deterioration that is recognised early enables a standardised approach supported by a shared language to initiate appropriate care and treatment.

Expected Outcomes and benefits (defines WHAT specifically, still not HOW):

How will this improvement benefit the team, the organization, customers, and/or the community? What is the business impact, such as reduced costs or other financial benefits?

- A regionally agreed standardised tool will streamline language used and interpretation of clinical information thereby contributing to a person-centred and appropriate clinical response.
- The testing of a regional evidence based tool will inform an implementation plan that describes the steps required to progress the rollout of RESTORE2 within Nursing Homes and RESTORE 2 Mini within Residential Care Homes across Northern Ireland.
- Obtaining a complete set of physical observations to inform escalation and conversations with health professionals will identify deterioration at the earliest possible point maximizing safe and effective care and treatment.
- Increasing confidence and competence of staff in recognising deterioration enhancing staff skill and supporting and empowering their clinical decision making abilities
- Enhanced resident experience through earlier detection and appropriate action.
- People are involved in decisions about their care and treatment in a principle of shared decision making
- Appropriate referrals to health and social care support services

How do we know that a change is an improvement? (Project Measures)

When defining your project-level measures, provide operational definitions, which specify unambiguously how to derive each measure, and be sure to define numerators and denominators in measures such as percent or rates.

Baseline:

There is currently NO regionally consistent approach to the assessment of deterioration

Outcome Measure:

List the measure(s) you ultimately want to affect as a result of this testing.

- 50% increase in pilot Care Home staff confidence in decision making relating to the assessment of deterioration

Process Measures

List the measure(s) that will tell you if the system is performing as planned to affect the outcome measure.

- % of All elements of the Restore 2 tool is completed when used
- % of Restore 2 / restore 2 mini completed as a baseline for new admissions to care home (on admission, 6 hourly for 72 hours, twice in next 24 hours),
- % of all nursing and / or care staff trained in recognising deterioration
- Restore 2 / restore 2 mini completed as a baseline for appropriate residents within the pilot care home (resident who is generally unwell)
- When appropriate, Restore2 / Restore 2 mini are completed

Balancing Measures

List the measures that will tell you whether you are introducing problems elsewhere in the system.
An illustrative, not exhaustive list includes:

- Costs (e.g. training, resources, workforce, models)
- Staff time taken to complete training, complete paperwork etc.
- Potential increase in referrals to GP/MDT / care home support teams

What changes can we make that will result in improvement?
Initial Activities Consider starting by exploring the process or system you are trying to improve with tools such as interviews, direct observation, cause and effect diagrams, driver diagrams, and process maps/flowcharts.

- To identify the care homes to participate in the pilot
- To raise awareness with the Senior Nurses/ managers in each participating care home.
- To provide training on the use of the deterioration assessment tool.
- To develop a Driver diagram
- To undertake a session where staff may provide on feedback on the use of the tool
- To undertake staff training and competence evaluation

Change Ideas What ideas do you have for initial tests of change (Plan-Do-Study-Act cycles)?

- Provide training for staff e.g. CEC, aide memoire for staff
- Use the deterioration tool for all appropriate residents in participating care homes
- Identify a 'Champion;' within each pilot care home
- Support sessions for care home staff – weekly 'drop-in' call by zoom
- Use of Restore 2 Audit Tool – completed by each care home

Key Stakeholders Whose input and support will this testing require? How will you engage these key stakeholders?

Meetings and feedback

- Restore FFA group meetings held fortnightly
- Feedback/communication with ECCF and subgroups-MDT, Workforce and Digital
- Project Oversight Group with key stakeholders at DoH level

List of key stakeholders

- Care homes staff (nursing and residential)

- PHA
- Trust staff
- NIAS
- GPs
- Pharmacy
- HSCB
- DOH
- PCC

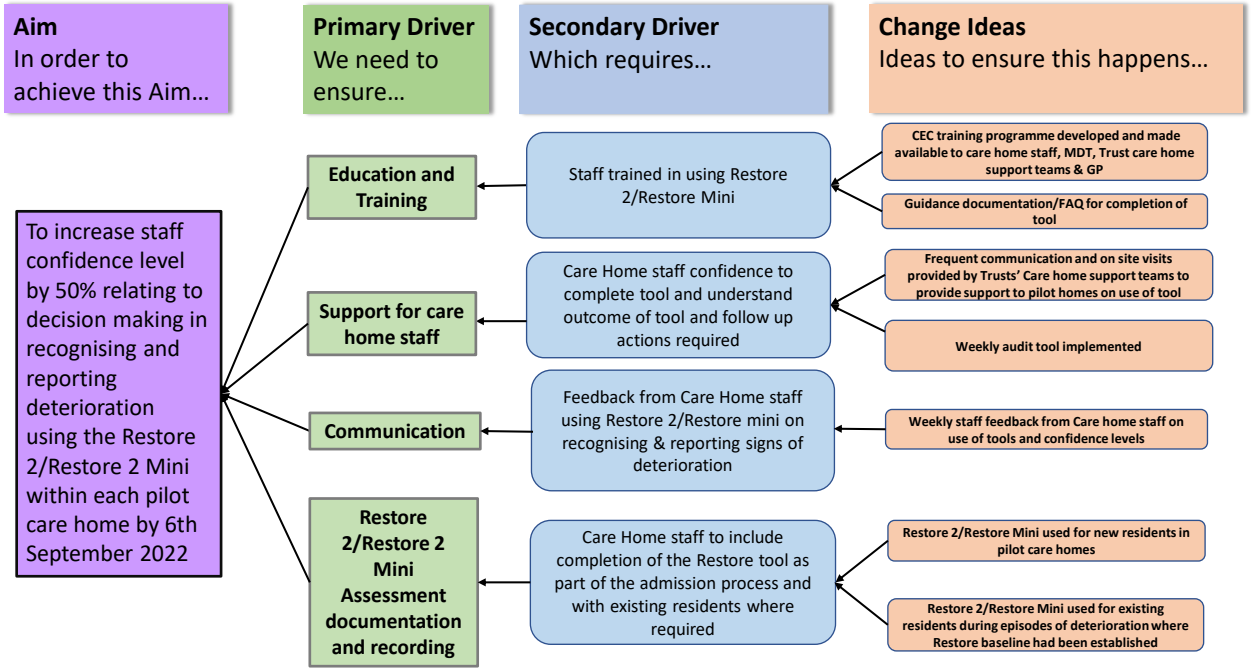
Barriers What barriers do you predict to your success? How will you overcome these barriers?

- Current COVID pressures in care homes, overcome by liaising with pilot care homes and supporting their involvement and extending the timeline of the overall project
- Lack of awareness and understanding of QI methodology overcome by care home access to QI e-learning module on HSC e-learning site

Boundaries List any guidelines for the team, including project constraints, rules or procedures, technology considerations, what is out of scope, etc.

- Treatment Escalation Plans are out with the scope of this project

Annex E – RESTORE2/RESTORE2 mini DRIVER DIAGRAM



Annex F – REGIONAL FALLS PATHWAY QI CHARTER

What are we trying to accomplish?

General Description: To develop a co designed regionalised approach to falls in care homes in NI through safer mobility, immediate management and follow up of fall. This mandate comes under the work of the ECCF MDT Wellness pathway and is being led by the Frailty Network.

Global Aim-To improve resident's quality of life and reduce falls in care homes in NI

Project Specific Aim:

To improve resident experience and quality of life by 80% in 18 NI Care Homes (nursing, residential, Dementia and Learning Disability) and reduce falls by 30% by March 2023 by developing a regional care pathway and bundle for falls.

Objectives:

- To improve resident wellbeing
- To reduce falls
- To develop a consistent regional person centred care pathway and bundle for safer mobility, immediate management and follow up of falls within care homes in NI
- To co design the regionalised approach
- To ensure clear equitable access to people, policy, procedures, systems and resources

Format: QI Framework

Co design at the start with engagement of all stakeholders

Understand the system

Interviews with residents

Engagement with relatives and carers

PDSAs

Project Infrastructure;

Project Steering Group-Co-chairs and frailty network

Project Oversight Group with key stakeholders

Task and Finish groups with key stakeholders

Feedback/communication with ECCF and subgroups-MDT and Digital

Partners: Project is being led by the Frailty Network, mandated from MOH-DOH-CNO. ECCF 3 subgroups. The Falls project sits under the MDT sub group. This is a co-designed project by residents, relatives, care homes (nursing and residential) PHA, Trust staff (including NIAS), GPs, Independent sector and RQIA.

Reason for the Effort (defines WHY):

Rationale:

- To decrease falls in NI and reduce harm and reducing death by improving safer mobility.
- Falls are one of the biggest reasons for NIAS call outs to CHs and transference to ED. Indeed 30% of NIAS call outs are estimated as inappropriate.
- Need to improve resident experience and quality of life
- Need for a consistent innovative equitable response to falls in NI
- ECCF-COVID-19 highlighting the need for better support and collaboration between HSC, Care Homes and 3rd sector
- No more silos (6&9) need for true collaboration and joined up working
- We know that the projection of our NI population is on the increase with inherent challenges and as we know people over 65 years of age are more at risk from falls;
- NISRA-2043-56.2% of population will be over 65
- 2/3 65+ will have a comorbidity
- More 75yrs+ in 2040, but more will have a comorbidity
- Nursing Homes were identified as a priority for improvement work by the Northern Ireland Health and Safety Forum in 2011
- Health and Wellbeing 2026:Delivering Together advocates for joined up collaboration across systems
- Programme for Government- outcome 4: We enjoy long, healthy, active lives
- Making lives Better 2012-23
- In December 2015 a PHA Thematic Review was published which analysed and identified the numbers and types of Serious Adverse Incidents (SAIs) relating to patients with a fall resulting in moderate to severe harm and reported as SAI, across all programmes of care. SAIs are still prevalent for falls.
- COVID shone a light on care homes- in 2020 the Minister of Health Mandated CNO to lead an overarching Enhanced Clinical Care Framework (ECCF) for Care Homes in NI. The falls in care homes project is a First Focus Action.

Expected Outcomes (defines WHAT specifically, still not HOW):

- To improve resident experience and improve quality of life
- To reduce falls in NI by optimizing safer mobility, management and follow up of Falls in care homes
- To reduce unnecessary call out to NIAS
- To reduce unnecessary journey to ED
- To reduce unnecessary onward referral to core services
- To raise awareness, training and improve skill of staff to develop safer mobility, manage and learn from falls in NI
- To provide consistent Falls pathways and bundle across NI

How do we know that a change is an improvement? (Project Measures)

Baseline

BASELINE-There is currently NO regionalised approach to falls in NI

NI Care home survey Monkey baseline March 2021;

- 90% were aware of a Falls policy/procedure
- 25-32% had no training in falls
- 46% had no training on the assessments that they were using
- 14% has access to equipment regarding Falls
- MDT-inequitable access to care home HSC MDT across the region
- 100% staff make onward referrals to GP and Falls Team (where available)

Resident semi structured Interviews;

- 50% felt only sometimes confident with their mobility
- 33% were extremely unhappy
- 50% felt sometimes to extremely unhappy
- 50% were upset when they fell
- 50% had a fear of falling.

NIAS

- Falls are a significant reason for NIAS call outs.
- Approximately, It is estimated that annually, 30% of call outs result in non-conveyance

Improvements could be made;

Regional equitable access to Falls Trust Team-currently Western Trust have no bespoke service
Regionally agreed referral form with agreed criteria
Consistent sharing of MDT reports and action plans
Regional adoption of a consistent falls in care homes pathway

Pre testing Survey with partner homes;

Communication with staff regarding falls-57% said good-excellent
Communication with residents regarding falls-21% said good-excellent
Communication with family and carers regarding falls-64% said good- excellent
36%-50% offer activity coordinator training on falls

<u>Outcome Measure</u>

- Improved resident experience to 80%-quality of life measurement tool developed from resident interviews with support from PCE PHA. E.g. fear of fall, mood, and confidence in mobility.

<u>Process Measures</u>

- Increase in Care Home staff confidence and support to 80%
- Reduction in near misses and falls in care homes by 30%- Monthly dashboards-recording run chart of near misses and falls
- Improved rate of appropriate NIAS Ambulance calls. Reduce 30% of inappropriate call outs-monthly run charts from March 2021.
- Reduction in ED admissions/seriousness of fall rates

Balancing Measures

- need to be mindful of potential challenging outcomes-e.g. Costs (e.g. training, resources, workforce, models)
- Time taken for staff to complete training, complete paperwork etc.
- IT-access to ECR, some care homes have different IT platforms (still awaiting Encompass)
- Potential increase in falls getting people on their feet and encouraging mobility
- Less movement of residents to achieve targets and prevent falls in this manner
- Potential increase in referrals to MDT-Trust capacity issues
- Positive outcomes-MDT working, residents able to maintain Rockwood score or indeed improve if it is possible, to return home more safely (intermediate bed CHs)
- PH awareness, staff training in Trusts etc.
- Long WLs for cataracts, hips, access to Specialist professionals etc.
- Impact of COVID-further deconditioning of residents, staff shortages and redeployment

Project Scope

1. Regional-all 6 Trusts
2. Residents (service user) and relatives/carers
3. Nursing, residential, dementia, learning disability and intermediate care homes
4. Trust and Independent care homes
5. All systems/touch points to resident/care home
6. Multidisciplinary staff
7. Test ideas in identified partner pilot homes;18 across NI-all Trusts-and across all scope above in points 1, 3, 4

What specific processes will you need to change in order to achieve your goals?

- Collective Leadership-Co ownership and cultural changes
- Co design and co-production
- Safer Mobility-Immediate management-follow up of falls-Regionalised pathways and toolkit
- People-what who when how where
- Systems-regionalised falls bundle-policy/procedures/toolkit
- Resources-equipment/innovation/digital
- Environment
- Communication
- Regionalised Training (CEC leading on this aspect of Project)

How long will it take to achieve results?

- Some pilots already done or underway (e.g. Northern and SET pilot)-use learning-scale and spread
- Phase one- testing of the Falls care pathway-Dec 2021-February 2022
- Phase two- testing of the Falls care pathway-May 2022-July 2022
- Phase three-innovations/bundle/toolkit/activity coordinator training and sessions-August2022-March 2023

- Data analysis-August-September 2022 of care pathway
- Write up of falls care pathway and recommendations-October/November 2022
- Full write up, including phase 3 June 2023
- Launch of ECCF-March 2023

Project Structure
Project is led by a Steering Group from the Frailty Network
Multi key stakeholder membership within;

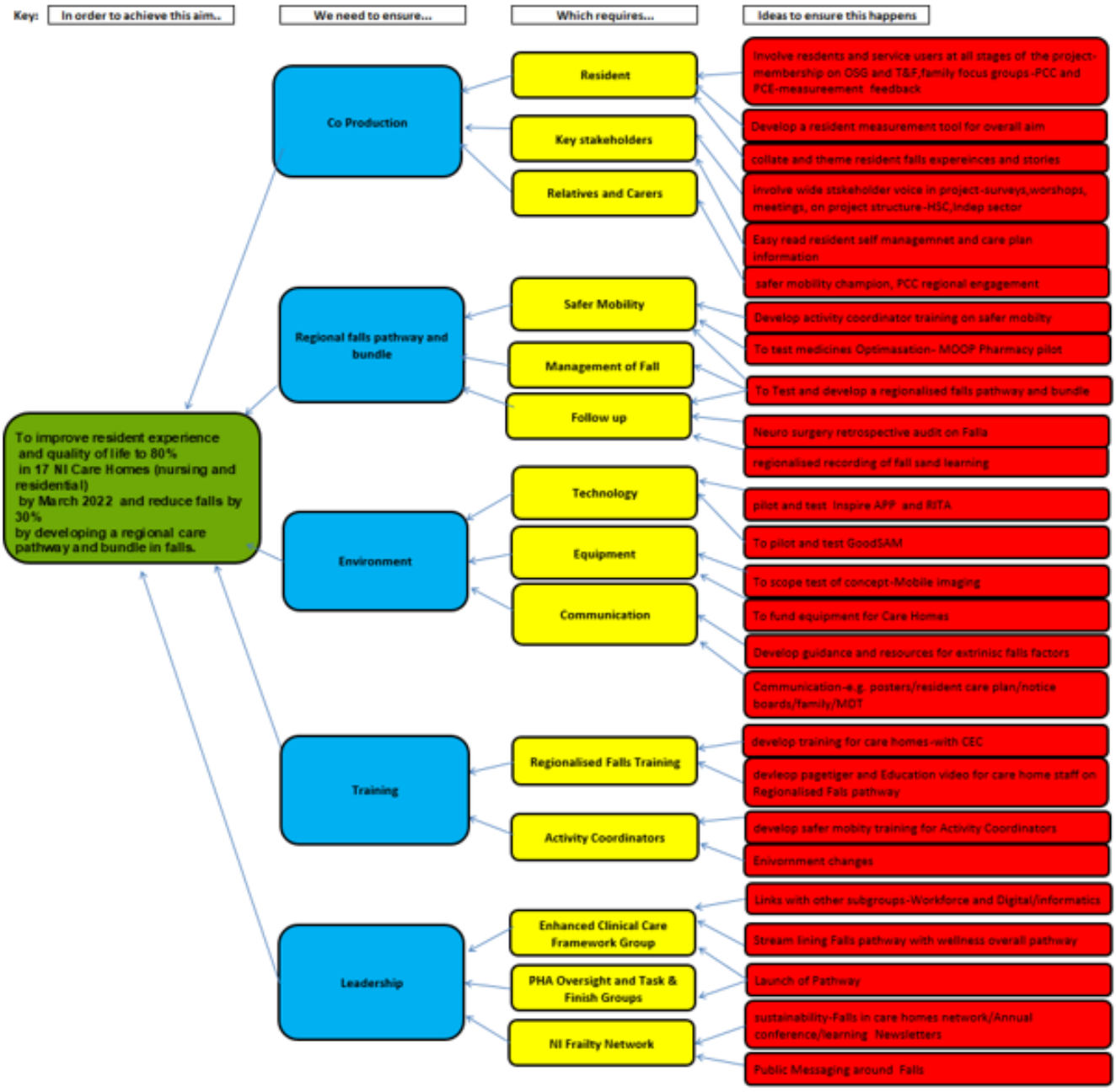
- Oversight Group
- Task and Finish Group membership –3 groups;
- Safer Mobility
- Immediate Manage of falls
- Follow up

Sponsorship: Sponsor is DOH CNO ECCF

Follow up/Implementation/sustainability
Evaluation of Outcomes
Further recommendations
Phase 2 and 3

- Public Health Campaign alongside PHA HI- Public Health Messaging. Share the learning into the communities.
- Undergrad raising awareness
- Falls at home-pre-care home, early intervention and prevention. /Transition from home/hospital to Care home-identified as a high-risk area
- Sustainability-Falls Champions/mandatory training/CH ECHOs/Key stakeholder meetings beyond the 18 partner homes
- Thematic review of falls SAIs

Annex G – REGIONAL FALLS PATHWAY DRIVER DIAGRAM



Template: QI Project Charter

Team: Monica McAlister, Regional Continence Leads, QI Advisor

Project: FFA Regional Catheter Care

Sponsor: Department of Health

Project Start Date: October 2021

Last Revised: 12/09/2022

What are we trying to accomplish?

Problem
The baseline data collected identified 220 Care Home residents who attended ED due to catheter complications over 6 months (April 21 to Sept 21) period. An initial review of ED attendances by Continence leads identified that majority of them could have been avoided.

Project Description (defines *what*)
Our aim is to reduce the number of avoidable catheter-related ED attendances by piloting a catheter passport management plan. We intend to pilot a catheter passport in 10 Care Homes across the region.

NHSCT

1. **Kintullagh PNH, Ballymena**
2. **Jordanstown**

WHSCT.

1. **Knockmoyle**
2. **Parkview**

SHSCT

1. **Nightingale NH, Dungannon**
2. **Sandringham, Portadown**

BHSCT

1. **Jason court**
2. **Castleview NH**

SEHSCT

1. **Beverly Lodge**
2. **Croagh Patrick**

Rationale (defines *why*)
Explain why the current process or system needs improvement. If possible, include baseline data and other benchmarks.

The level of disruption that is caused to a Care Home resident at ED is not appropriate for the well-being of an elderly patient.

Expected Outcomes and Benefits
How will this improvement benefit the team, the organization, customers, and/or the community? What is the business impact, such as reduced costs or other financial benefits?

- **Reduction in ED attendances.**
- **Agreed troubleshooting pathway.**
- **Person-centred management plan (anticipatory care plan).**
- **Improved communication between trust support teams, Hospitals and Care Homes.**
- **Reduction in Antisocial hours ED attendances**
- **Cost to the economy**
- **Reduction in the number of catheter related Blue light ambulances**
- **Contributes to overcrowding**
- **List of recommendations to inform future quality improvements**

Aim Statement

Our aim is to reduce the number of avoidable catheter-related ED attendances from Care Homes by 50% by Sept 2022.

How will we know that a change is an improvement?

When defining your project-level measures, provide operational definitions, which specify unambiguously how to derive each measure, and be sure to define numerators and denominators in measures such as per cent or rates.

Outcome Measure(s)

List the measure(s) you ultimately want to affect as a result of this project.

- **Number of ED attendances from pilot homes.**
- **Number of residents developing UTIs.**
- **Number of residents giving alternative care pathways**

Process Measure(s)

List the measure(s) that will tell you if the system is performing as planned to affect the outcome measure.

- **Number of patients with a catheter passport.**
- **Number of staff trained on catheter passport.**
- **Number of times the troubleshooting pathway was used.**
- **Review of catheters.**

Balancing Measure(s)

List the measures that will tell you whether you are introducing problems elsewhere in the system.

- **Patient experience.**
- **Staff experience.**
- **Number referrals to other services.**

What changes can we make that will result in improvement?

Initial Activities

Consider starting by exploring the process or system you are trying to improve with tools such as interviews, direct observation, cause and effect diagrams, driver diagrams, and process maps/flowcharts.

- **Survey of Care home.**
- **Coalition of ED attendances.**
- **Interventions and outcomes.**
- **Identification of pilot Care Homes.**
- **Baseline details from pilot Care Homes.**

Change Ideas

What ideas do you have for initial tests of change (Plan-Do-Study-Act cycles)?

- **Catheter passport**
- **Agreed troubleshooting pathway.**

Key Stakeholders

Whose input and support will this project require? How will you engage these key stakeholders?

- **Residents.**
- **Care Home Managers / Care Home Nurses.**
- **Continence leads.**
- **Care Home Support teams.**
- **OUTREACH**
- **GP practices**
- **Out of Hours.**
- **District Nurses.**
- **Clinical Education Centre (CEC)**
- **Marie Curie**

Barriers

What barriers do you predict to your success? How will you overcome these barriers?

- **COVID restrictions**
- **Staff shortages.**
- **Operation priorities**
- **Data collection**

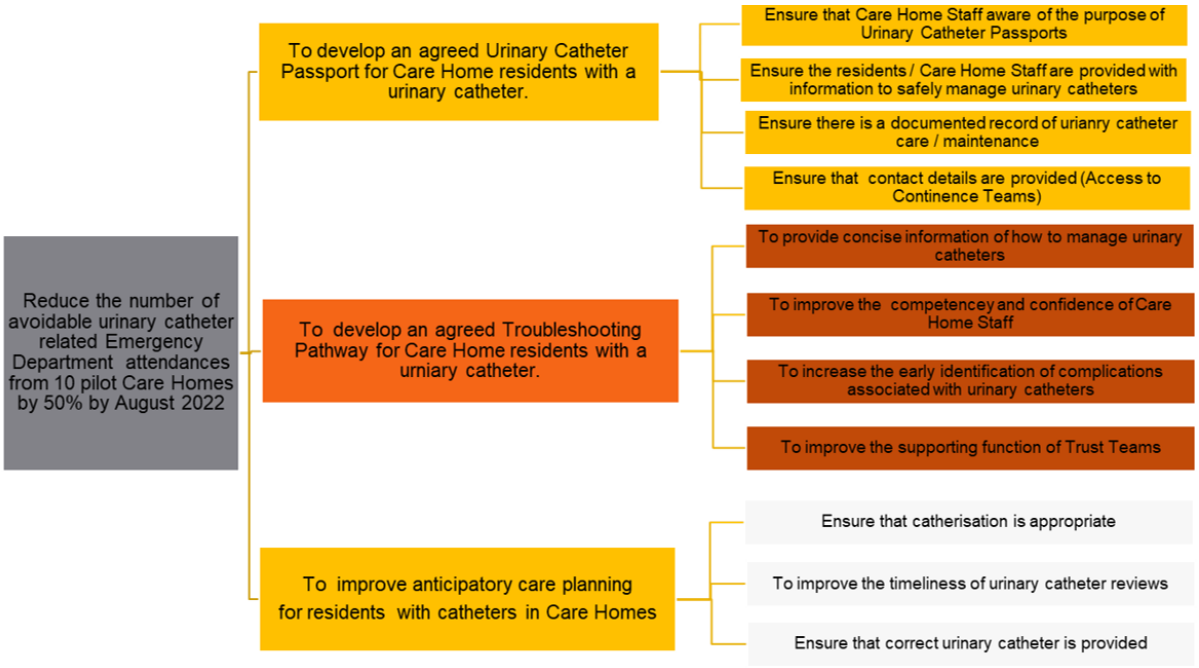
- **Admin support.**
- **Care Home engagement.**
- **No financial resources.**

Boundaries

List any guidelines for the team, including project constraints, rules or procedures, technology considerations, what is out of scope, etc.

- **Care Home residents only.**
- **Hospital processes out of scope.**
- **NICE guidelines and Passport/troubleshooting pathway should be complimenting each other.**

Annex I – REGIONAL CATHETER CARE PATHWAY DRIVER DIAGRAM



Annex J – ACUITY TOOL QI CHARTER

Project: Acuity Tool for Care Homes to inform safe staffing

Sponsor: CNO

Project Start Date: March 2022

Last Revised: 25 August 2022

What are we trying to accomplish?

Problem
Describe in 2 to 3 sentences the existing condition you hope to improve (i.e., the gap in quality).

The care home sector does not have an acuity tool that captures the high complexities being cared for in the care home sectors. The Rhyns Hearn Tool that is in use was developed in 1974 and is now out of date. As the older generation age the complexities that are being nursed in the sector has increased. We hope to have an acuity tool that informs safe staffing and captures frailty and complexities.

Project Description (defines *what*)
Document your current thinking about the activities of the project (e.g., design a new process, improve an existing product or service, etc.). Note the subsystem, pilot population, and/or demonstration unit where the work will take place. Consider including your long-term vision and short-term project goals.

Evidence shows us that the system needs an updated tool in order to sustain the sector and provide good quality of care for residents and a change in how care is delivered. The acuity tool will help support the care delivery to residents.

Rationale (defines *why*)
Explain why the current process or system needs improvement. If possible, include baseline data and other benchmarks.

From covid 19 and the pandemic it was clear how fragile the workforce system was. From the rapid learning initiative and ECCF framework sub group workforce, acuity is a key deliverable for the sector. Suitable acuity tools are being explored to determine if able to be adapted for the range of categories of care provided in the independent sector in Northern Ireland. A suitable acuity tool is required as a solution to inform a staffing model that will meet assessed needs of the population we are caring for. The current system in use is out of date and needs updated.

Expected Outcomes and Benefits
How will this improvement benefit the team, the organization, customers, and/or the community? What is the business impact, such as reduced costs or other financial benefits?

For residents- development of staffing model aligned to the complexities of assessed need so that care is given at the right time in the right place by the right person.
For staff- clear guidance on staffing aligned with complexities as per assessed needs of residents.

Aim Statement
What outcome are you hoping to achieve? Specify how good, for whom, and by when (a specific date).

Key deliverable - To enhance the confidence of care home managers in identification of safe staffing against assessed complex needs by 50% through the use of a bespoke acuity tool within six care homes by Aug 2022.

How will we know that a change is an improvement?

When defining your project-level measures, provide operational definitions, which specify unambiguously how to derive each measure, and be sure to define numerators and denominators in measures such as percent or rates.

Outcome Measure(s)
List the measure(s) you ultimately want to affect as a result of this project.

% increase in care home managers confidence to identify staffing against complex needs.
% increase in use of bespoke acuity tool.
% increase in identification of safe staffing

Process Measure(s)
List the measure(s) that will tell you if the system is performing as planned to affect the outcome measure.

% compliance from the Care Homes selected to participate in the pilot testing.
% of Senior Nurse Managers and Deputy Managers trained in the use of the acuity tool in participating homes.

Balancing Measure(s)
List the measures that will tell you whether you are introducing problems elsewhere in the system.

Staffing levels identified through use of tool
Alignment with Delivering Care Phase 8
User friendliness and completion time of the tool
Potential cost of procurement of tool after pilot phase

What changes can we make that will result in improvement?

Initial Activities
Consider starting by exploring the process or system you are trying to improve with tools such as interviews, direct observation, cause and effect diagrams, driver diagrams, and process maps/flowcharts.

To identify the care homes to participate in the pilot
To raise awareness with the Senior Nurses and Deputy Managers in each pilot care home
To provide training on the use of the acuity tool
Development of Driver Diagram

Change Ideas
What ideas do you have for initial tests of change (Plan-Do-Study-Act cycles)?

Provide training for staff on use of bespoke acuity tools
Apply the use of new acuity tool to current and new residents within the pilot homes
Use of a bespoke nursing home tool to assess complex needs
Feedback sessions from staff on use of tool and confidence levels

Key Stakeholders
Whose input and support will this project require? How will you engage these key stakeholders?

DOH- CNO
Trusts
Patient Client Council
PHA Regional Patient Client Experience Lead
RQIA
Care home managers

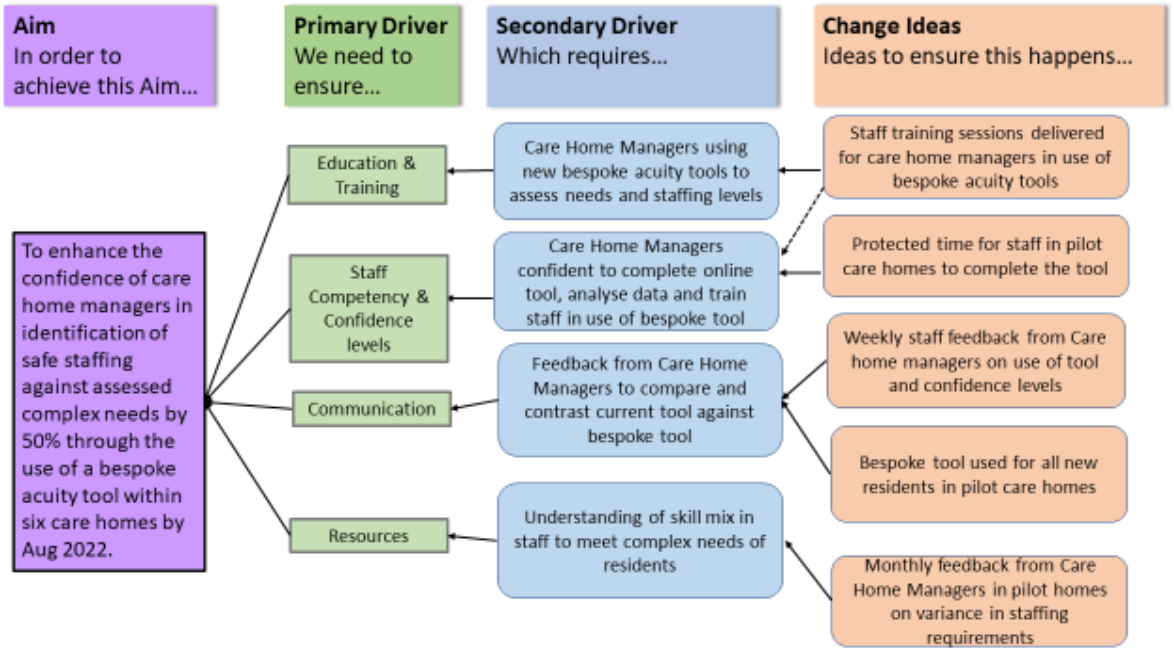
Barriers
What barriers do you predict to your success? How will you overcome these barriers?

Funding this tool
Tecnology - Software Limitations and Technical Support
Staffing model may need to change or need supplemented to support this tool
Roles need defined

Boundaries
List any guidelines for the team, including project constraints, rules or procedures, technology considerations, what is out of scope, etc.

Limitation of how many amendments can be made to the tool
Evidence base for the original development of the tool

Annex K – ACUITY TOOL DRIVER DIAGRAM



Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Wellness
at the heart of your home

Pre-admission Assessment form for Admission to Care Home in Northern Ireland

(To be completed by receiving Care Home)

Pre-admission Checklist

Page	Date & time Completed	Section(s)	Y	N	NA	Action to be followed up
3		1. Personal information				
3		2. Medical/Surgical history & reason for admission				
4		3. Advance Care Planning - Including ReSPECT element				
4		4. The person's 'story'				
5		5. Spiritual/religious/Cultural				
5		6. Communication				
5		7. Airway / Breathing/ Circulation.				
6		8. Infection prevention and control risk assessment.				
6		9. Elimination				

7		10. Eating & Drinking				
8		11. Mobility				
9		12. Personal Care				
10		13. Psychological wellbeing & mental Health				
11		14. Sleep				
11		15. Social/support/recreation.				
12		16. Pain				
12		17. Medications				
13		18. Valuables				
13		19. Death & Dying				
13		20. Risks				
Appendices						
14		Rockwood Frailty Score – Required to be completed where appropriate (on admission)				
15		*Advance Care Planning				
16		*MUST Assessment				
17		*Moving & Handling Risk Assessment				
18		*Bed Rail Risk Assessment				
19		*Skin Integrity and assessment				
20		*Braden Scale				
21		*Audit C				
22		Additional Information/Notes Pages				

* included for reference

Pre-admission Assessment form for Admission to Care Home in Northern Ireland

Section 1 – PERSONAL INFORMATION

Use addressograph – otherwise write in capitals

Surname: _____

First Names: _____

I would like to be called:

_____

Address: _____

_____

H&C number: _____

DOB: _____ Age:_____

Telephone/ mobile number(s):_____

Is the assessed person able to participate in the assessment: ☐ Fully ☐ Partially ☐ No

If Partially /No, details of information source:

_____

HSC passport for people with learning disability:

Yes ☐ No ☐

Date & time of arrival to care home:_____

Gender: _____

Sexual Orientation: _____

NEXT OF KIN (NOK)	**CONTACT DETAILS OF CARER/PERSON THAT KNOWS ME BEST**
Name: _____ Relationship: _____ Address(if different): _____ _____ Contact number:_____ **NOK to be first contact:** Yes ☐ No ☐	Name:_____ Relationship:_____ Contact number:_____ Second contact (if required):_____ Name:_____ Relationship:_____ Contact number:_____

GP Name and Practice: _____ Contact number:_____

Address:

_____

ROOM AVAILABILITY

E.g. types of rooms available , facilities available

Section 2 – MEDICAL /SURGICAL HISTORY AND REASON FOR ADMISSION

Please include current level of frailty as guided by Rockwood Clinical Frailty Scale IF AVAILABLE pre-admission

Pre-admission

Rockwood Clinical Frailty Score: _____

Section 3 – Advance Care Planning – including ReSPECT elements

Do **N**ot **A**ttempt **C**ardiopulmonary **R**esuscitation **(DNACPR)** in place: Yes ☐ No ☐ Not known ☐ I have had advance care planning conversations and have a written plan about: see appendix 2 Yes ☐ No ☐ Clinical Yes ☐ No ☐ Legal Yes ☐ No ☐ Finance Yes ☐ No ☐ Personal	Details/Specific requirements regarding an advanced decision:

Section 4 – THE PERSON'S 'STORY'/UNDERSTANDING OF ADMISSION/AWARE OF DIAGNOSIS.
What matters most (*e.g. family, friends, lives alone/with other, childhood memories, religion/spirituality, work life, hobbies, interests, what makes you feel happy and well, proud moments/accomplishments in your life).Please provide detail provided by NOK/Family*

Section 5 – RELIGIOUS/SPIRITUAL/CULTURAL	
Person – About Me	**What matters most to me**
Do you have particular religious/spiritual/cultural needs that we need to take into account: Yes ☐ No ☐ If Yes, Details: _____ _____ _____ Any status regarding administration of clinical interventions e.g. blood products: Yes ☐ No ☐ If Yes, Details: _____ _____ _____	*(E.g. attending religious/spiritual/cultural services/events, preference for Chaplain visit, observing certain practices/holidays, following religious-based hygiene practices, observations of specific cultural needs, preference for prayer before bed)*

Section 6 – COMMUNICATION	
Person – About me	**What matters most to me**

Have you any difficulties with: Speech ☐ Details:_____ ___ Hearing ☐ Vision ☐ None ☐ Communication aids:_____ **Hearing aid(s):** Right ☐ Left ☐ None ☐ Present on arrival: Yes ☐ No ☐ Most recent audiology appointment: _____ Have you an eye condition? Yes ☐ No ☐ **Registered Blind:** Yes ☐ No ☐ Do you communicate using Braille? Yes ☐ No ☐ Recent ophthalmology appointment: _____ **Partially sighted**: Yes ☐ No ☐ Difficulties with eyesight: Yes ☐ No ☐ Glasses: Yes ☐ No ☐ Contact lenses: Yes ☐ No ☐ Preferred language_____ Interpreter required_____ Alert: Yes ☐ No ☐ Drowsy: Yes ☐ No ☐ Confused: Yes ☐ No ☐ Orientated to time: Yes ☐ No ☐ Orientated to Place: Yes ☐ No ☐ Orientated to Person: Yes ☐ No ☐	*(E.g. staff wearing a visor over a surgical mask to facilitate lip reading)*
Section 7 – AIRWAY/BREATHING/CIRCULATION	
Person – About me	**What matters most to me**
Have you any difficulties with: ☐ Airway ☐ Breathing	*(E.g. sleeping with a window open, sleeping in an upright position)*

☐ Circulation ☐ No difficulties Details (e.g. oxygen, nebulisers, CPAP, NIPPY, tracheostomy, laryngectomy): _____ Oxygen: Concentrator ☐ Cylinder ☐ Hours per day? _____ Inhalers prescribed Yes ☐ No ☐ Times per day_____ Nebuliser prescribed Yes ☐ No ☐ Times per day_____ Any equipment required? _____ Date ordered: _____ Do you smoke: Yes ☐ No ☐ Smoking details: _____	

Section 8 – INFECTION PREVENTION AND CONTROL	
COVID-19 – The Person	
Has any COVID-19 symptoms	Yes ☐ No ☐ Unknown ☐
Details of symptoms:	
Result of pre-admission COVID test.	Pos ☐ Neg ☐ Date of test:_____
Is isolation required on admission to care home?	Yes ☐ No ☐ Unknown ☐
If isolation is required, provide details including duration:	
Vaccination status if known; dates: COVID-19 Vaccine 1: _____ COVID-19 Vaccine 2: _____ COVID-19 Booster/s: _____ COVID-19 Booster date/s- _____ Flu vaccine date: _____	
Any current infection for example, Clostridium Difficile, MRSA (Methicillin Resistant Staphylococcus Aureus), or other?	Yes ☐ No ☐ Unknown ☐

Section 9 – ELIMINATION	
Person – About me	**What matters most to me**
Are you able to use the toilet: Independently ☐ Help required ☐ Full assistance of___ staff (how many staff required to assist) Any difficulties with: Bladder: Yes ☐ No ☐ Bowels: Yes ☐ No ☐ Urgency to eliminate: Yes ☐ No ☐ Any other details (*e.g. nephrostomy tube, urostomy, stoma type/management and products required, drains, usual bowel/bladder pattern day/night, continence appliances, any specific pad orders required*): _____ _____ __ _____ __ Is continence nurse involved? Yes ☐ No ☐ additional comments _____ _____ __ Catheter: Yes ☐ No ☐ Size_____ Date Inserted _____ Date due change _____ Reason for Catheter _____ Type of Catheter _____ Catheter Passport completed Yes ☐ No ☐	*(E.g. what helps to keep your catheter flowing and comfortable? Do you have a preference for a female or male carer? Do you have a preferred continence product?)*
Section 10 – EATING AND DRINKING. MUST SCORE =_____	
Person – About Me	**What matters most to me**
Are you able to eat and drink: Independently: Yes ☐ No ☐ Help required for example assistance with cutting up of food: Yes ☐ No ☐ Assistance required when eating/drinking: Yes ☐ No ☐ Difficulty swallowing/risk of choking: Yes ☐ No ☐ Nil by mouth: Yes ☐ No ☐	*(e.g. do you prefer finger foods or using cutlery, using a brightly coloured plate or plate guard, do you need adapted crockery such as a cup with a lid/handle, do you prefer tea or coffee, dentures required, what helps to keep your PEG tube comfortable)*

Do you have diabetes: Yes ☐ No ☐ Do you require help choosing from a menu? Yes ☐ No ☐ Dietary Requirements/Modifications including religious, cultural: _____ __ _____ __ Other details (e.g. appetite, preference for small/large portions, special or modified diets, any eating difficulties requiring extra time for meals, enteral/parenteral nutrition, requires insulin, ongoing nausea/vomiting problems): _____ __ _____ __ IDDSI (international dysphagia diet standardisation initiative) requirements: _____ __ _____ __ Recommendation/report by Speech and Language Therapist: Yes ☐ No ☐ NA ☐ If Yes please give details: _____ ___ _____ ___ Weight:_____ Date: _____ Any pain when eating: Yes ☐ No ☐	

Section 11 – MOBILITY	
Person – About Me	**What matters most to me**

Mobilises independently: Yes ☐ No ☐ Supervision required: Yes ☐ No ☐ Any assistance required: Yes ☐ No ☐ If Yes please give details including number of staff required: _____ Are hand rails required? Yes ☐ No ☐ Is a special chair or cushion required? Yes ☐ No ☐ Details: _____ Any other equipment required (e.g. walking stick; rollator; walking frame; hip protectors)? Yes ☐ No ☐ Details: _____ Other details (for example, any assistance required for transfer in/out of bed; up/down the bed; across the bed; rolling; lying to sitting; sitting at edge of bed; sit to stand; standing balance; if bedrails needed). _____ ___ _____ ___ _____ ___ _____ ___ _____ ___ _____ ___ _____ ___ Weight: _____ Height: _____ Hoist required: Yes ☐ No ☐ If required type of hoist and sling, including sling size: _____ ___ Specialist bed required: Yes ☐ No ☐ Specialist mattress: Yes ☐ No ☐ Commode: Yes ☐ No ☐ Urinal: Yes ☐ No ☐ Any equipment required to support admission to care home: Yes ☐ No ☐ If Yes please give details:	*(E.g. Do you like to have your feet raised to make you comfortable? Do you require reassurance and support during transferring to feel safe; preferred footwear.)*

_____ ___ _____ ___ _____ ___ _____ ___ Date ordered_____ Delivery date_____ FALLS RISK; low ☐ medium ☐ or high risk ☐ History of falls: Yes ☐ No ☐ Fear of falling: Yes ☐ No ☐	

Section 12 – PERSONAL CARE – BRADEN SCORE = _____ *PURPOSE-T SCORE (if available) = _____	
Person – About Me	**What matters most to me**
Are you able to wash and dress: Independently ☐ Help required ☐ Full assistance ☐ Assistance of how many carers required: _____ Do you have your own natural teeth or dentures? Natural ☐ Dentures ☐ Both ☐ Are you able to brush your own teeth? Yes ☐ No ☐ If applicable, what communication aids/equipment helps enable your independence (e.g. walking aid, glasses)? _____ ___ Does your skin damage or bruise easily? Yes ☐ No ☐ Details: Skin condition; any issues Yes ☐ No ☐ If yes details_____ Tissue Viability referral required Yes ☐ No ☐ Any pressure ulcers? Yes ☐ No ☐	*(E.g. do you have a preference for any of the following: a male or female carer, a shower or bath, washing at a certain time, personal preferences for grooming, hairdressing, cosmetics, etc., a preference for brands of hygiene products?)*

If Yes Site_____ Grade_____ Dressings required Yes ☐ No ☐ How often _____ Mattress type _____ Low Risk ☐ Medium Risk ☐ High Risk ☐ Or other, please specify _____ Cushion type_____ Low Risk ☐ Medium Risk ☐ High Risk ☐ Position change frequency_____ Any wound management details _____ Are there any wounds? Yes ☐ No ☐ If yes details_____	

***PURPOSE-T (Pressure Ulcer Risk Primary or Secondary Evaluation – Tool)**

Section 13 – PSYCHOLOGICAL WELLBEING AND MENTAL HEALTH	
Person – About Me	**What matters most to me**
How do you view your mental health: Good ☐ It varies ☐ Quite bad ☐ Very bad ☐ Is there a recent event affecting your psychological wellbeing and/or mental health: Yes ☐ No ☐ If Yes, Details:_____ _____ _____ Diagnosis of specific mental illness: Yes ☐ No ☐ If yes by whom:_____ Diagnosis of dementia: Yes ☐ No ☐ If yes by whom:_____ Suspected or assumed dementia: Yes ☐ No ☐ Diagnosis of delirium: Yes ☐ No ☐ If yes by whom_____ Known to psychogeriatrician/psychiatrist: Yes ☐ No ☐ If yes, name_____ Any issues with comprehension/cooperation: Yes ☐ No ☐ Details including formal test; name of test; score of test _____ _____ Mental capacity/cognitive function; detail any concerns. _____ _____ Referral to memory clinic Yes ☐ No ☐ Has a Mental Capacity assessment been completed? Yes ☐ No ☐ Has Deprivation of Liberty and Safeguards (DoLS) assessment been completed? Yes ☐ No ☐ If Yes, Review Date:_____ Any behaviours of concern identified or any supervision required e.g. 1:1? Yes ☐ No ☐ If Yes, Details:_____ _____ _____	*(E.g. include things that may help to relieve feelings of worry, such as comforting words, music, or TV, does it help to have company or do you prefer quiet time alone?)*

Does a depression assessment need to be completed? Yes ☐ No ☐ NA ☐ Has a comprehensive geriatric assessment (CGA) been completed? Yes ☐ No ☐ NA ☐	

Section 14 – SLEEP	
Person – About Me	**What matters most to me**
What is your usual sleep pattern? _____ _____ Are medications prescribed to aid sleep? Yes ☐ No ☐ Is a call bell required? Yes ☐ No ☐	*(E.g. preferences for naps throughout the day, preferred rising and bed times, preferences for a warm drink/supper before bed, preference for bedroom window/door being open or closed at night preference for nightwear such as socks, preference for white noise or other sleep aid techniques)*

Section 15 – SOCIAL/SUPPORT/RECREATION	
Person – About Me	**What matters most to me**
What activities and interactions do you partake in that enhance your wellbeing (e.g. engagement with staff, music, activity therapist)? _____ _____ Are you comfortable in large gatherings: Yes ☐ No ☐ Do you prefer more solitary activities: Yes ☐ No ☐ If Yes, Details: _____ _____ Any safeguarding concerns around activities and recreation (e.g. risks regarding equipment_____ _____ _____	*(E.g. impact of admission on dependents/work/family, favourite TV shows/radio channel, any continued interests in prior hobbies, preference for keeping a memory box, doll therapy, rummage box, preferred mode of communication with family if/when visiting is restricted)*

Section 16 – PAIN	
Person – About Me	**What matters most to me**
Pain: Acute ☐ Chronic ☐ None ☐ Pain Assessment tool used:_____ Pain Assessment Score:_____ Pain management strategies: Yes ☐ No ☐ If Yes, Details: Location of pain_____	*(E.g. pain tools, coping methods that help alleviate any pain)*

Any palliative care needs_____ _____ Is specialist palliative care team involved: Yes ☐ No ☐	

Section 17 – MEDICATIONS

Person – About Me	What matters most to me
Have the GP and practice pharmacist been notified of admission to care home and current prescriptions? Yes ☐ No ☐ Any documentation relating to covert administration? Yes ☐ No ☐ Is patient independent with administration? Yes ☐ No ☐	*(E.g. consider clinical trial drugs, impact of medicines currently taken, consider safe storage of medications)*

Time Critical Medications refers to medications where timeliness of administration is crucial to minimise harm for patients. Please follow the guide list at:
http://www.medicinesgovernance.hscni.net/secondary-care/safety-documents/safety-toolkits/omitted-and-delayed-medicines-material/ to identify whether the person is on any of the medicines listed. Please note this list is not exhaustive.

Is the person on **any** of the medicines listed (through link above): No ☐ Unable to establish ☐ Yes ☐
List of current medications available Yes ☐ No ☐
Compliance issues identified Yes ☐ No ☐
Allergies Yes ☐ No ☐

_____

INR last result_____ INR penultimate result_____

TED stockings Yes ☐ No ☐ duration stockings required_____

Are antibiotics currently prescribed Yes ☐ No ☐
Medication groups currently prescribed

- ☐ Insulin;
- ☐ Warfarin or other anticoagulant;
- ☐ Clexane;
- ☐ Nebuliser;
- ☐ Inhaler;
- ☐ Liquid medicines;
- ☐ Patches for analgesia;
- ☐ Syringe driver;
- ☐ Eye drops;
- ☐ Ear drops;
- ☐ Nasal spray;
- ☐ Nasal drops;
- ☐ Creams/lotions

Section 18 – VALUABLES

Person – About Me	What matters most to me
Any valuables brought in: Yes ☐ No ☐ NA ☐ Valuables kept at own risk Yes ☐ No ☐ NA ☐ (Policy explained, copy of policy given to resident and/or family): Yes ☐ No ☐	*(e.g. details of valuables and if they have been sent home, details of any possessions you like to have nearby e.g. photographs)*

Section 19 – DEATH AND DYING

Person – About Me	What matters most to me
Is advanced care plan in place?	*(e.g. specific wishes)*

Section 20 – RISK
Consider any risks e.g. allergies, choking, falling, pacemaker, dialysis fistula, tracheostomy, immunocompromised, any complex care needs.

Pre-Admission Assessment completed by:_____ Date:_____
Time:_____

Thank you for completing the Pre-Admission Assessment Document.

Please complete the below Rockwood Clinical Frailty Scale (Appendix 1) upon the resident's admission to care home, where appropriate; **please note there are some occasions where it is <u>NOT</u> recommended for use, such as:**

- **People below 65 years of age**
- **People with a learning disability**
- **People with stable long term disability such as cerebral palsy, whose outcomes might be very different compared to older people with progressive disability**

Appendices 2-7 below are examples of other documents for reference

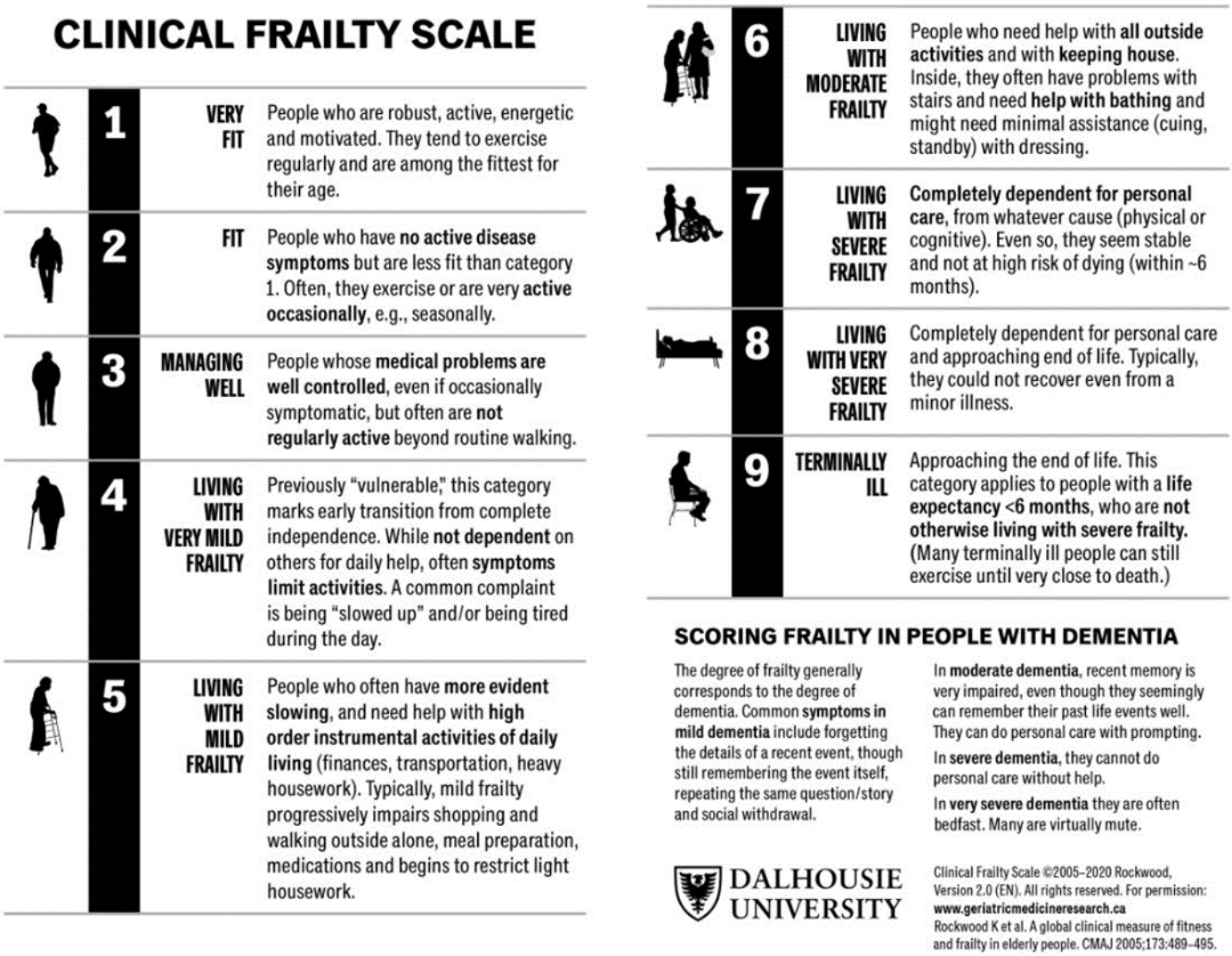
Rockwood Frailty Score

The Clinical Frailty Scale was developed by Professor Kenneth Rockwood, Dalhousie University Canada – it is often referred to as the Rockwood Scale, or a Rockwood Score.
It is an internationally recognised and validated tool to measure how vulnerable someone might be to poor outcomes. It should be used as part of a holistic assessment and should never replace clinical judgement.

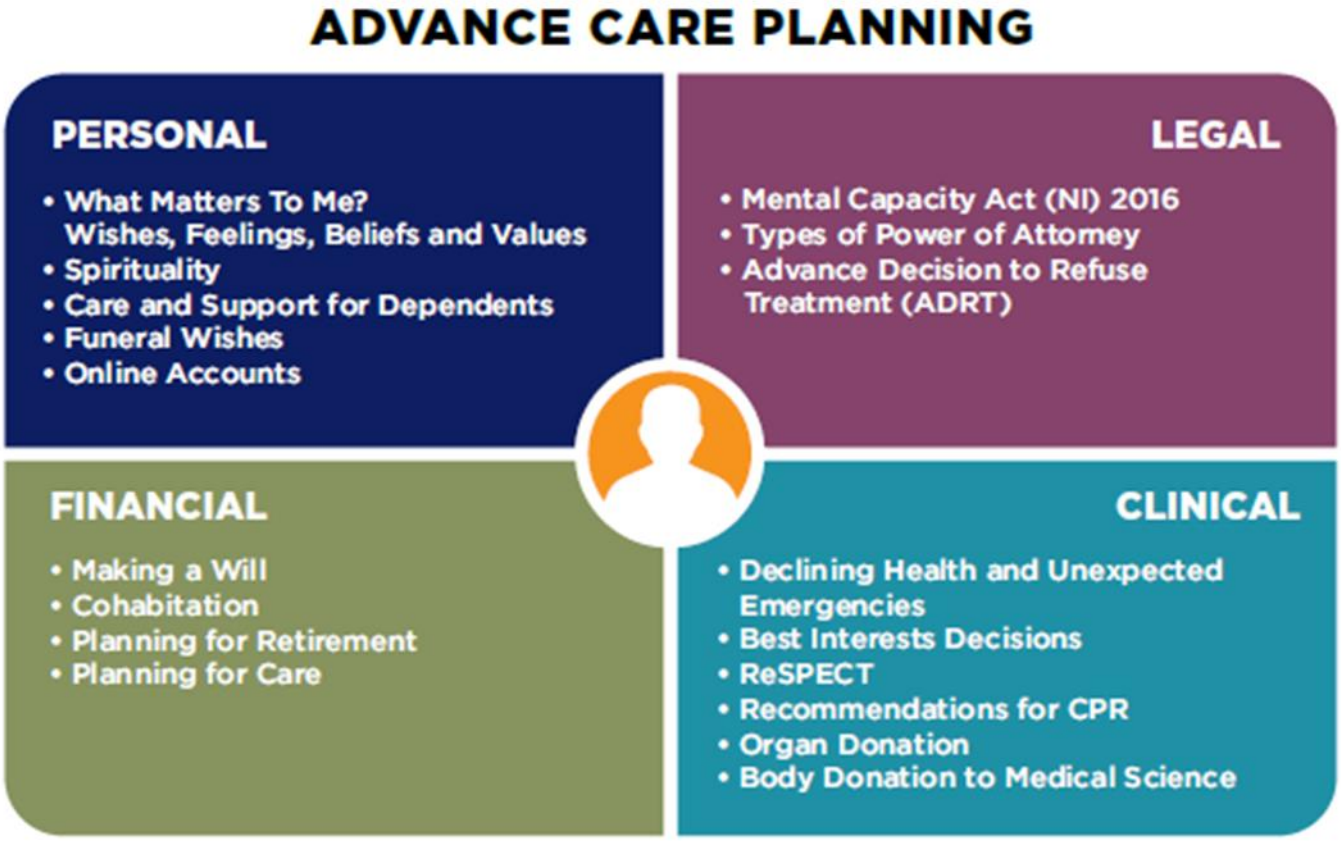
There are some occasions where it is **NOT** recommended for use, such as:

- People below 65 years of age
- People with a learning disability
- People with stable long term disability such as cerebral palsy, whose outcomes might be very different compared to older people with progressive disability

On admission, Residents Rockwood Frailty Score = _____



Please use to assist with completing section 3 – Advance Care Planning – including ReSPECT elements



MUST©		
Weight: ☐ Actual ☐ Recalled ☐ Unable to weigh/ recall Reason:_____ **If unable to calculate BMI:** MUAC (Mid-Upper Arm Circumference): *(MUAC less than 23.5 BMI likely less than 20, greater than 32 BMI likely more than 30)*		
Height: ☐ Actual ☐ Recalled ☐ Unable to measure/recall Reason:_____ ☐ Ulna length:		
Step 1: Body Mass Index (BMI) score - BMI kg/m2		**Score**
• Over 20 (over 30 obese)	0	
• 18.5 to 20	1	
• Less than 18.5	2	
Step 2: Unplanned weight loss in last 3 – 6 months		**Score**
• Less than 5%	0	
• Between 5 – 10%	1	
• More than 10%	2	
Step 3: Acute disease effect score		**Score**
• If the person is acutely ill and there has been OR is likely to be no nutritional intake for more than 5 days	2	
Total MUST Score:		

Low Risk MUST Score = 0	**Medium Risk MUST Score = 1**	**High Risk MUST Score ≥ 2**
• Record MUST details • Recommend a well- balanced diet	• Record MUST details • Recommend a high protein/energy diet • Monitor intake for 3 days (record on food chart)	• Record MUST details • Refer to Dietician • Recommend a high protein/energy diet • Monitor intake as per dietician (record on food chart)
• Rescreen weekly	• Rescreen weekly/refer to dietician if risk status changes	• Rescreen weekly

MOVING AND HANDLING ASSESSMENT
Is the person's weight within safe working load of equipment e.g. bed, chair, hoist, wheelchair ☐ Yes ☐ No ☐ Unknown. If No/ Unknown, details:
Is the equipment wide enough for the person's safety and comfort e.g. bed, chair, hoist, wheelchair ☐ Yes ☐ No ☐ Unknown. If No/ Unknown, details:
Does the person use a mobility aid e.g. walking frame, wheelchair ☐ Yes ☐ No ☐ Unknown. If Yes/Unknown, details:
The mobility aid is available: ☐ Yes ☐ No ☐ NA If Yes, person's own ☐ Yes ☐ No
Is the person experiencing handling constraints e.g. pain, external attachments, fractures, behaviour, environment, posture ☐ Yes ☐ No ☐ Unknown If Yes/Unknown, details :
Is the person independent for all moving and handling activities ☐ Yes ☐ No If Yes, no requirement to commence care pathway/care plan for the moving and handling of the person If No, commence care pathway/care plan for the moving and handling of the person

BEDRAILS ASSESSMENT				
☐ NA Reason (e.g. person on chair):				
Use bedrails risk assessment in conjunction with clinical judgement and discussions with the person/family				
MOBILITY				
MENTAL STATE		**Person is very immobile (bedfast /hoist dependent)**	**Person unable to mobilise independently**	**Person can mobilise without help from staff**
	Person is confused and disorientated	Use bedrails with care	Bedrails NOT recommended	Bedrails NOT recommended
	Person is drowsy	Recommend Bedrails	Use bedrails with care	Bedrails NOT recommended
	Person is orientated and alert	Recommend Bedrails	Recommend Bedrails	Bedrails NOT recommended
	Person is unconscious	Recommend Bedrails	NA	NA
Bedrails Assessment Outcome		**Decision making details/comments**		
☐ Recommend Bedrails				
☐ Use bedrails with care				
☐ Bedrails NOT recommended				

SKIN INTEGRITY AND ASSESSMENT

☐ Actual skin check ☐ Verbal skin check Details:

_____

_____

All skin observed and intact unless indicated on map: ☐ Yes ☐ Unable to check skin, reason:

_____

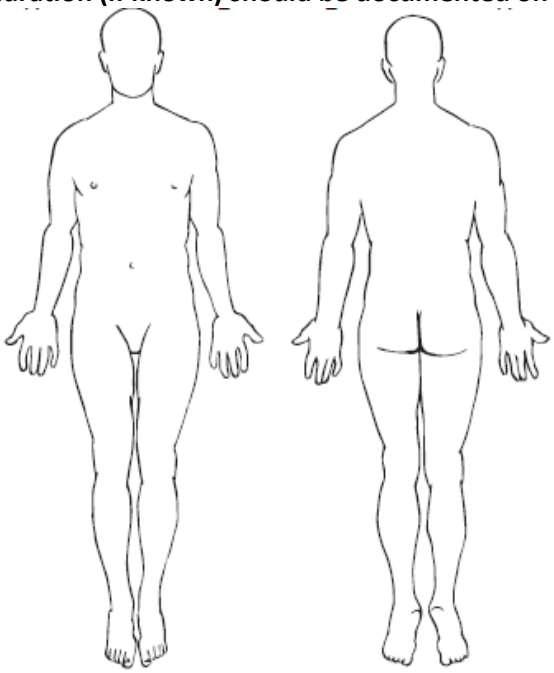
What pressure relieving equipment is required? _____

If required, is this equipment available? _____

Document on the map and table below:
Pressure damage - check over bony prominence /around devices and use codes in descriptor box
Tissue damage - marks, bruising, rashes, skin conditions or any other wounds then write description

People with diabetes - check both feet: is there a skin break below the ankle: ☐ Yes ☐ No

Type of tissue damage and reason/duration (if known) should be documented on map:



Wound assessment chart commenced: Yes ☐ Not Required ☐

Descriptors and Codes	
S/G1 **Stage/Grade 1** - Non blanching erythema. Non blanchable redness of intact skin of a localised area usually over a bony prominence.	**S /G4** **Stage/Grade 4** - Full thickness skin loss with exposed bone, tendon or muscle slough or eschar may be present on some parts of the wound bed. The depth varies by anatomical location.
S /G2 **Stage/Grade 2** - Partial thickness skin loss of dermis presenting as a shallow open ulcer with a pink wound bed, without slough. May also present as an intact or ruptured serum filled blister.	**US /UG** **Unstageable/Ungradable** Depth unknown. Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.
S /G3 **Stage/Grade 3** - Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. The depth varies by anatomical location.	**SDTI** **Suspected Deep Tissue Injury** Purple or maroon localised area of discoloured intact or blood-filled blister.

MU – Mucosal Ulcer	**ML** – Moisture Lesion	**IAD** – Incontinence Associated Dermatitis

Appendix 7 - THE BRADEN SCALE©

THE BRADEN SCALE©				
Sensory perception – Ability to respond meaningfully to pressure-related discomfort				
COMPLETELY LIMITED Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation **OR** Limited ability to feel pain over most of body surface.	**VERY LIMITED** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** Has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**SLIGHTLY LIMITED** Responds to verbal commands but cannot always communicate discomfort or need to be turned **OR** Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**NO IMPAIRMENT** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	
1	**2**	**3**	**4**	
Moisture – Degree to which skin is exposed to moisture				
CONSTANTLY MOIST Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned.	**OFTEN MOIST** Skin is often but not always moist. Linen must be changed at least once a shift.	**OCCASIONALLY MOIST** Skin is occasionally moist, requiring an extra linen change approximately one a day.	**RARELY MOIST** Skin is usually dry: linen only requires changing at routine intervals.	
1	**2**	**3**	**4**	
Activity – Degree of physical activity				
BEDFAST Confined to bed.	**CHAIRFAST** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**WALK OCCASSIONALLY** Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair. **SLIGHTLY LIMITED** Makes frequent though slight changes in body or extremity position independently.	**WALKS FREQUENTLY** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	
1	**2**	**3**	**4**	
Mobility – Ability to change and control body position				
COMPLETELY IMMOBILE Does not make even slight changes in body or extremity position without assistance.	**VERY LIMITED** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**SLIGHTLY LIMITED** Makes frequent though slight changes in body or extremity position.	**NO LIMITATIONS** Makes major and frequent changes in position without assistance.	
1	**2**	**3**	**4**	
Nutrition – Usual food intake pattern				
VERY POOR Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is NIL Per Orally and/or maintained on clear fluids or Intra Venous for more than 5 days.	**PROBABLY INADEQUATE** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement **OR** Receives less than optimum amount of liquid diet or tube feeding.	**ADEQUATE** Eats over ½ of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal but will usually take a supplement if offered **OR** Is on tube feeding or Total Parenteral Nutrition regime which probably meets most of nutritional needs.	**EXCELLENT** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat or dairy products. Occasionally eats between meals. Does not require supplementation.	
1	**2**	**3**	**4**	
Friction and Shear				
PROBLEM Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair requiring frequent repositioning with maximum assistance. Spasticity contractures or agitation leads to almost constant friction.	**POTENTIAL PROBLEM** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**NO APPARENT PROBLEM** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		
1	**2**	**3**		
			Total Score	
			Date	
			Time	

Signature	

IF PERSON SCORES 18 OR BELOW, PERSON IS AT RISK OF PRESSURE DAMAGE. COMMENCE A PRESSURE ULCER PREVENTION PLAN OR SKIN BUNDLE

Use professional judgement and critical thinking in relation to risk of damage to skin integrity and ensure appropriate pressure relieving equipment is used.

Appendix 8 - AUDIT-C

AUDIT-C						
Questions	**Scoring System**					
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
Score	0	1	2	3	4	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
Score	0	1	2	3	4	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Score	0	1	2	3	4	
					Total Score:	

4 and under	**5-7**	**8+**
No further action required	**Harmful drinkers:** Advice, Leaflet available	**Dependent drinkers:** Advice, leaflet available and consider onward referral to Alcohol and Substance Misuse Liaison Nurse

Consider interaction with medications (seek GP opinion).

Appendix 9 - Additional Information/Notes

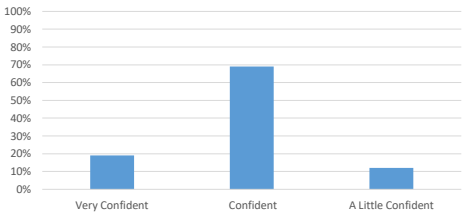
Section	Additional Information/Notes i.e. Onward Referral(s)/Pending Medical Appointment(s)/Expanding on a section

Annex M – PRE ADMISSION ASSESSMENT CHARTS

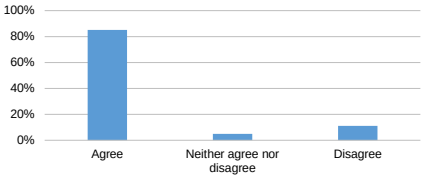
Pre-Admission Assessment Pilot- Care Home Staff Feedback

Feedback from Care Home staff over the 12 week pilot period

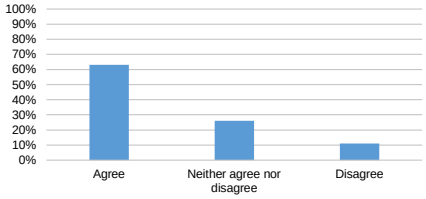
Increase in Staff Confidence in Shared Decision Making with Residents through use of the Pre-Admission Assessment Document



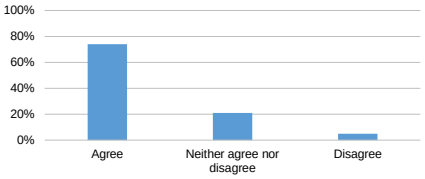
The new Pre-admission Assessment Document is helping to make an improvement

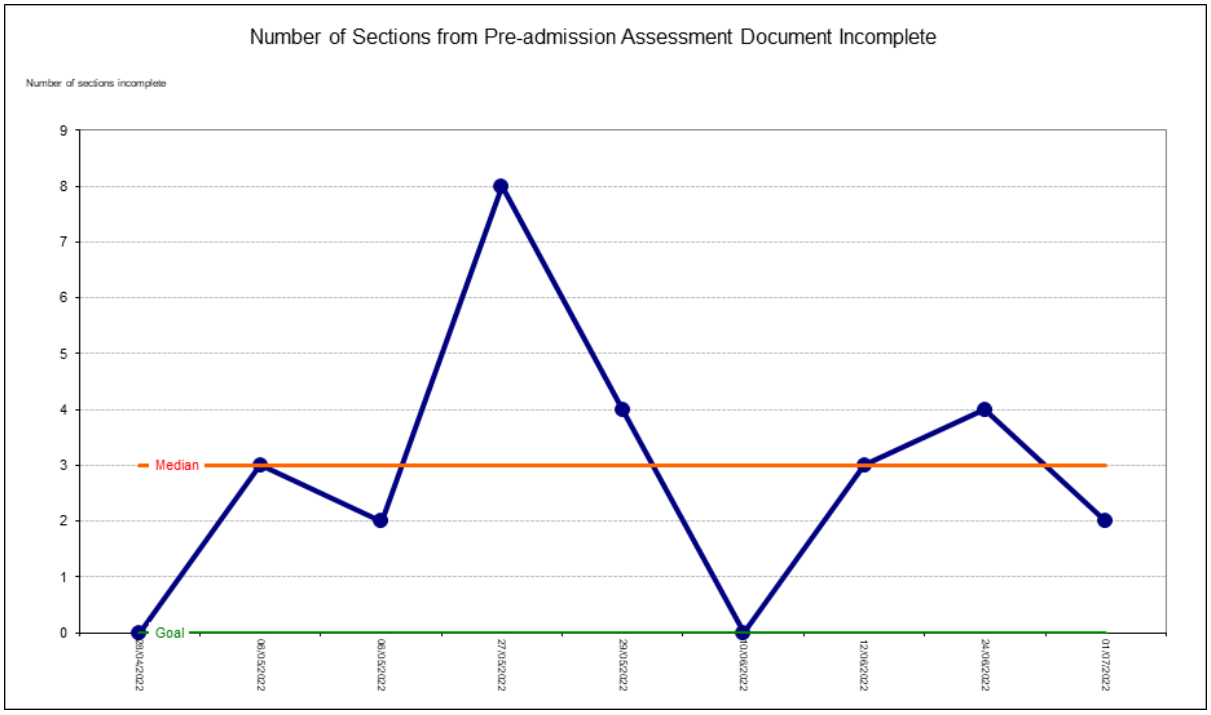


The new documentation has enhanced medication management.

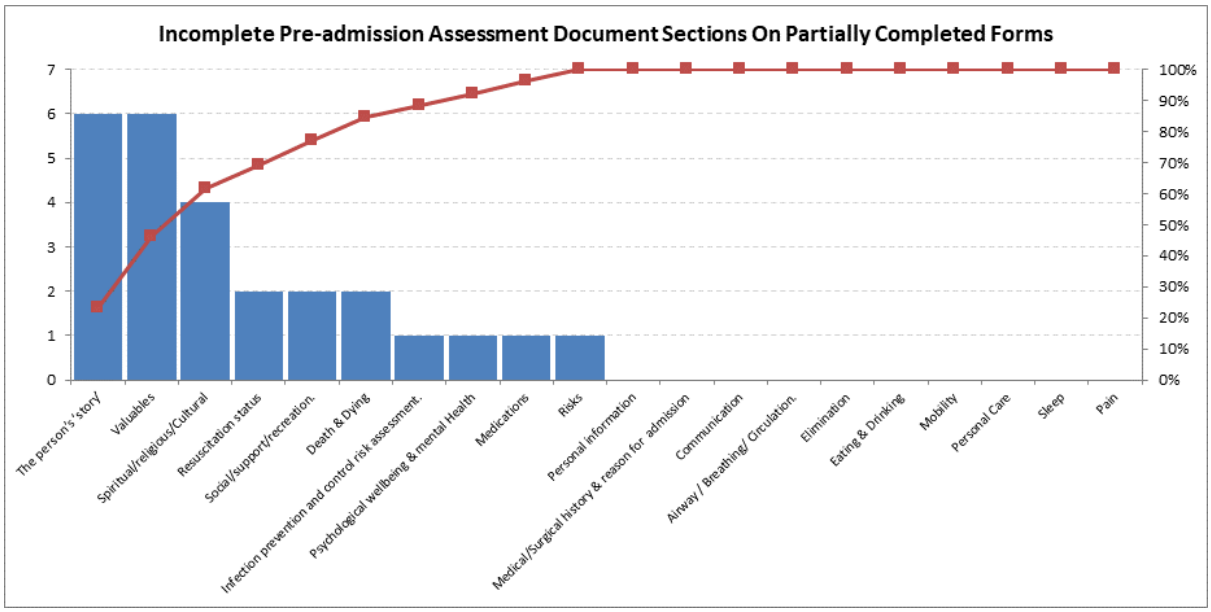


The new documentation has enhanced shared care planning with other services (if applicable for the resident)

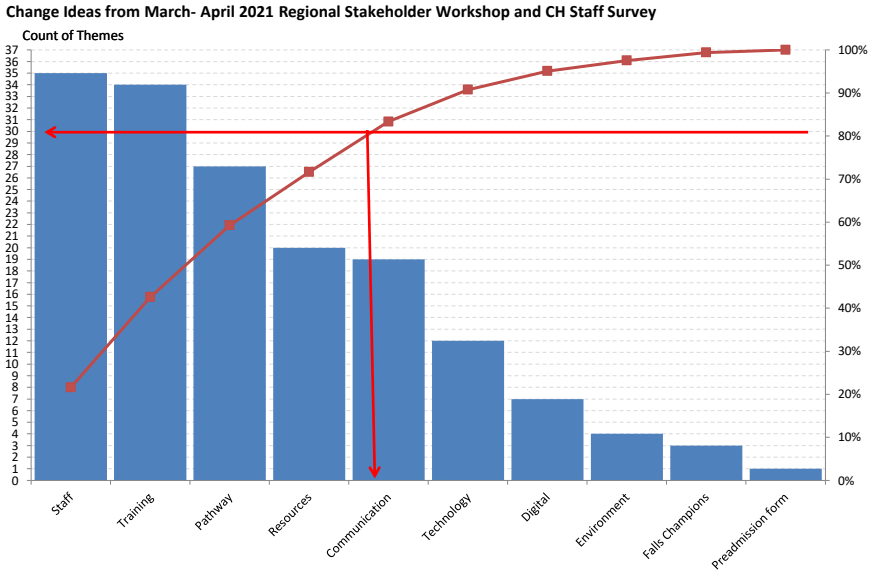




100% of Care Homes completed the Pre-Admission Assessment document for all new admissions. Some sections were completed more fully than others and further learning took place to identify what would help enable staff to complete more fully.

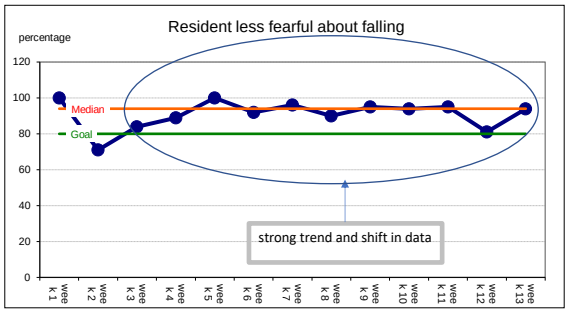


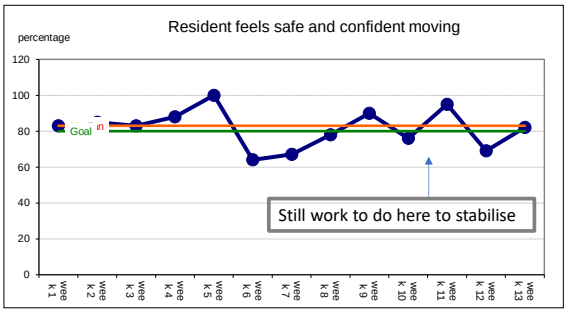
Pareto Chart-the critical few



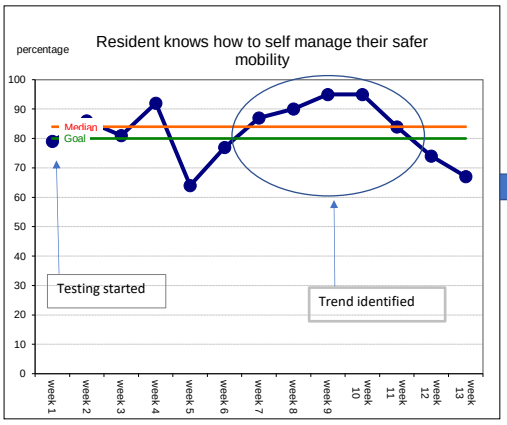
Resident Outcomes

- Aim-To improve resident experience and quality of life to 80%
- Reduction in falls- decreases risk of long lies, better health and well being



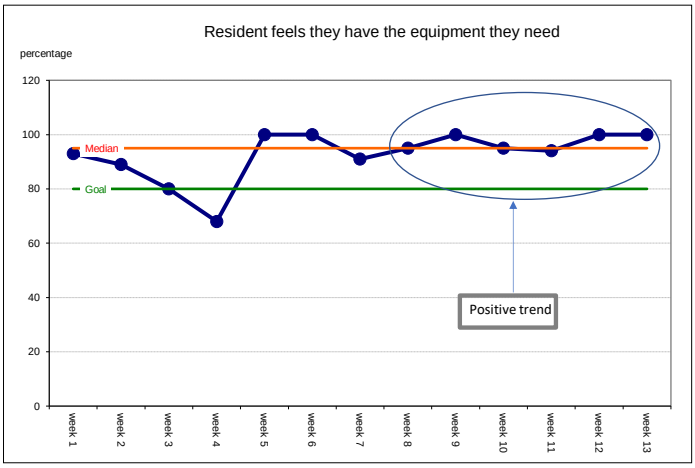


Resident Outcomes-continued



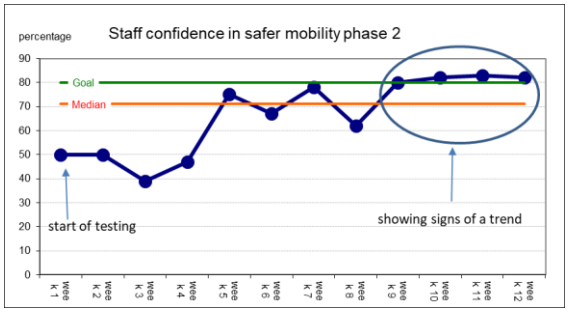
- Exercise
- equipment
- Footwear
- Self manage
- Remove clutter
- Physio
- medicines

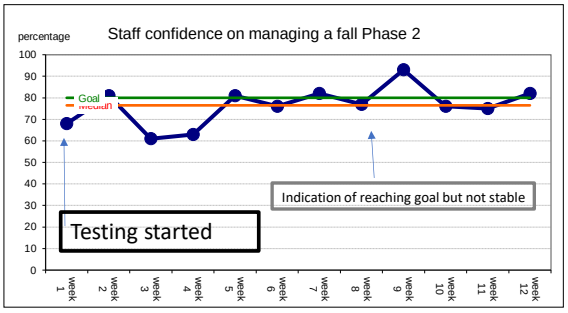
Resident Outcomes-continued

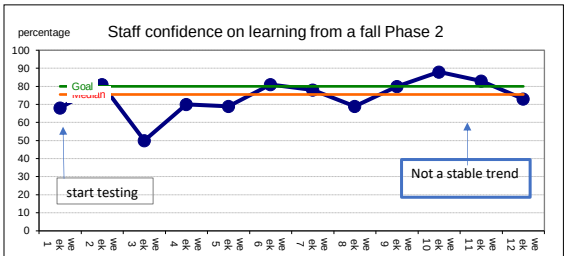


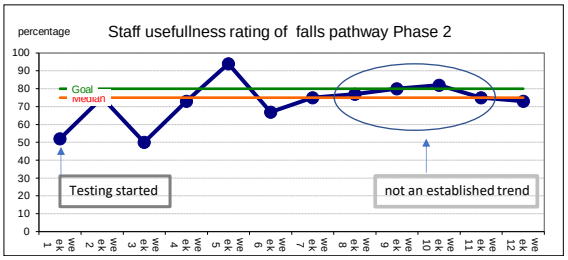
Residents are not fully aware of the range of HCPs that can help support them
-evident before entering a care home setting

Staff Process results-80% confidence levels

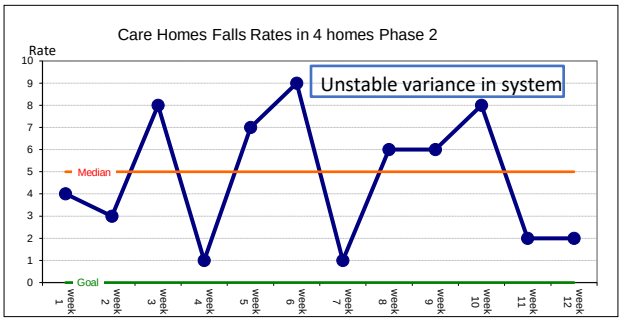


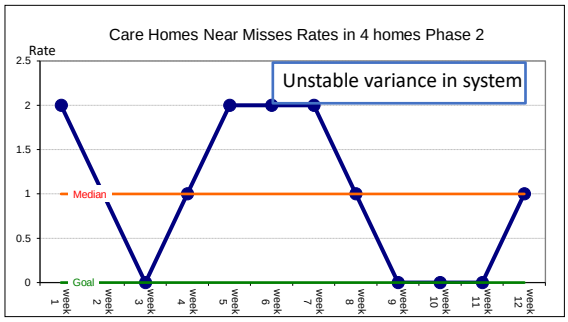


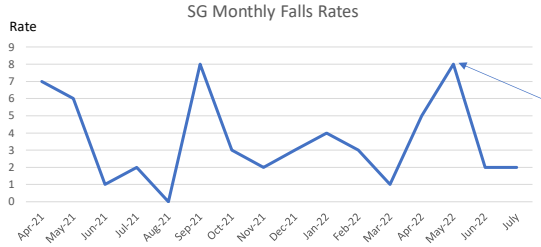




Falls rate run charts-30% reduction-not achieved







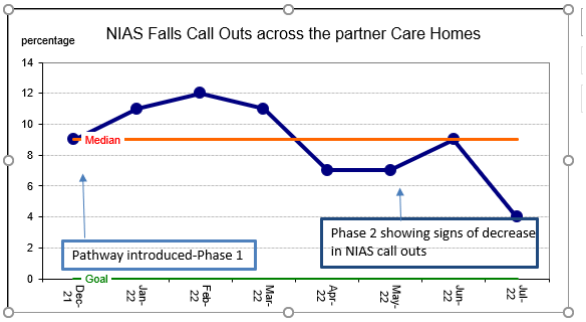
Astronomical peak

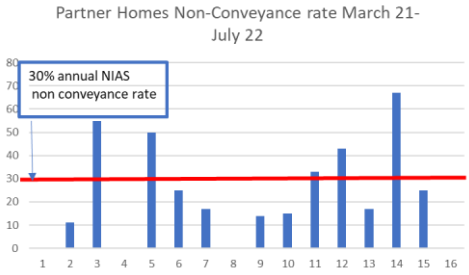
Home had several falls related to temporary respite placements

NIAS Results

37% reduction in NIAS Call Outs across the Partner Homes from Phase 1 to Phase 2 of project

non conveyance rate with **68%** of partner homes having appropriate conveyance- the Annual average of 30%





Annex O - ACUITY/DEPENDENCY TOOLS REPORT

Enhanced Clinical Care Framework for Care Homes
Acuity/Dependency Tools – Pilot Testing in NI Care Homes
Briefing Paper for Workforce Subgroup Meeting 4 August 2022

1.0 Introduction

A core area within the objectives for the Workforce Subgroup was to identify an acuity/dependency assessment tool that would enable the calculation of safe staffing within the care home sector.

The subgroup chairs source two acuity dependency tools from the literature and from personal, professional experience.

1. The CHESS Tool designed and developed by Four Seasons Health Care for use within their portfolio of care homes
2. The Care Home Staffing Tool developed by NHS Scotland (2008)

At the discussion with colleagues representing both of the named acuity/dependency assessment tools, it was agreed that the two tools would be pilot tested in a small number of care homes in Northern Ireland.
The CHESS Tool is being pilot tested in two care homes and the Care Home Staffing Tool (NHS Scotland, 2008) is being pilot tested in four care homes.
The expected outcome of the pilot testing will be feedback on whether the tool is 'fit for purpose' within the participating care homes and to highlight any gaps in the structure of the acuity/dependency assessment tool in the context of complex care required by some residents in the care home sector.
The initial feedback from the Care Home staff participating in the pilot testing will be summarised in the sections below.

2.0 CHESS Model

The pilot testing of the CHESS Tool (Four Seasons) commenced in two care homes in Northern Ireland on 7 March and continued until 7 June 2022.

One home is a large facilities offering both nursing and residential care.
The other home provides care for residents with a learning disability. These home were selected as they are not reflected within the portfolio of care homes operated by Four Seasons Health Care

Prior knowledge of the Care Home Staffing Tool

The participants had no knowledge of the CHESS Tool prior to the pilot testing exercises.

Understanding of the purpose of the tool

Participants were asked to reflect on their understanding of the purpose of the tool.

Participants reported that they had a good understanding of the purpose of the tool. Their level of understanding is reflected in the following comments.

'*Resident dependency versus staffing levels'*
'More accurate dependency level of residents and required staffing levels'

User Friendliness of the Care Home Staffing Tool
Participants indicated that they found the tool easy to use (2/3)

Fit for Purpose
Participants were asked to comment on how well they found the CHESS Tool helped them the care needs of their residents.

Participants reported that they found that the CHESS Tool helped them to assess the care needs of their residents very well.

Physical Care – Very good/Good
Technical Care – Very good/Good
Emotional Care – Very good/Good

Areas of care not included in the assessment tool.

'All needs covered but residential needs not reflective of staffing model required at present'
'All ADLs and emotional/psychological needs'

Training required to use tool.

- Use of Excel – participants indicated that training on excel was not required.
- Demonstration of the Tool – participants highlighted that they would have liked a demonstration of the use of the tool.
- Familiarity with criteria – participants indicated that training on the criteria for assessment would be required.
- Interpretation of results – participants indicated that training on interpretation of results would be required.

Confidence in using the tool
Participants were asked to evaluate their confident in using the tool initially and then after having used it to assess their residents
Participants reported a low level of confidence in using the tool initially. Some Participants reported that their level of confidence improved after having used the tool.

Time taken to complete assessments
Participants were asked to report on how long, on average, it took them to complete the assessment of each resident?
Participants reported that the time taken to complete the initial assessments ranged from 5 – 15mins.
Time required to enter the assessment for all residents in the Care Home?
Participants reported that the time taken to enter the assessments for all residents ranged between 5-10 hours.

Time taken to complete the 30 day review of assessments
Participants reported that on average it took 1-4 hours to complete the 30 day review of assessment.
Additional comments would you like to make about the CHESS tool.
Participants were invited to provide comments on the Care Home Staffing Tool.

- What worked well - More beneficial to use; Covers more aspects of care needs so gives a more accurate dependency level
- Even better if… quicker way to complete monthly review - should not drop people of if 30 days not updated

Experience of using other acuity/dependency tools
Participants were invited to share their experience of using other acuity/dependency tools.

- Rhys Herrn

Staffing Levels
Participants were asked to share their experience on how the use of the tool informed daily staffing levels.
Participants reported that the use of the tool identified the need for additional Care Assistant staff for the day and night shift.

Benefits of using the CHESS Tool
Participants were asked to reflect on the benefits of using the Care Home Staffing Tool from the perspective of residents, staff and the care home.

- Residents – improved outcomes; increased supervision and availability of staff
- Staff - increase moral help retention; reduce pressure and workload
- Care Home – better standards could be achieved; increase staffing and standard of care improve reputation

The difference using the CHESS Tool would make
Participants were asked to share their reflection on the difference that using the CHESS Tool may make.
'*more confident that complex needs were being met - this would also allow for staff to have more time with residents and this would benefit their mental health and well-being'*
'The tool gives a more accurate dependency for residents and shows the breakdown of what the residents needs are, where the greatest needs are. Evidence for staffing levels and evidence if requesting additional staff'.

3.0 Care Home Staffing Tool (NHS Scotland 2008)

The agreed pilot testing phase was between 7 May and 7 August 2022.
The pilot testing was completed by the Nurse Manager in all participating Care Homes.

Prior knowledge of the Care Home Staffing Tool
The participants had no knowledge of the Care Home Staffing Tool prior to the pilot testing exercises.

Understanding of the purpose of the tool
Two of the three returns from participants indicated that they did understand the purpose of the tool. The level of understanding is reflected in the following comments.

'I am hoping it will help me to evidence the safe effective staffing levels in the home using a recognised assessment tool'
'To determine staffing level'
'To obtain data of our residents dependency levels in order to work out how much staff required'

User Friendliness of the Care Home Staffing Tool
Participants indicated that they found the tool difficult to use (2/3)

Fit for Purpose
Participants were asked to comment on how well they found the Care Home Staffing Tool helped them the care needs of their residents.

- Some aspects of care areas not covered x 3
- Participants felt that the tool partially enabled them to assess the complex care needs of their residents.
- The responses were similar for Physical, Technical and Emotional care needs

Areas of care not included in the assessment tool.
Participants were asked to highlight areas of care not included in the Care Home Staffing Tool assessment structure.
The feedback has indicated that the tool enabled the assessment of physical care needs better than complex technical or emotional care needs.
Training required to use tool.
Participants were asked to highlight their training requirements to enable them use the Care Home Staffing Tool properly.

- Use of Excel – 2/3 Participants highlighted a need for training on Excel
- Demonstration of the Tool – 2/3 Participants highlighted that they would have liked a demonstration of the use of the tool.
- Familiarity with criteria – Participants indicated that they were able to understand the criteria for assessment.
- Interpretation of results – Participant indicated that they would benefit from help with interpreting the results.

Confidence in using the tool
Participants were asked to evaluate their confident in using the tool initially and then after having used it to assess their residents
Participants reported a low level of confidence in using the tool initially. Some Participants (2/3) reported that their level of confidence improved after having used the tool.
Time taken to complete assessments
Participants were asked to report on how long, on average, it took them to complete the assessment of each resident?
Participants reported that the time taken to complete the initial assessments ranged from 11 – 30mins.

Time required to enter the assessment for all residents in the Care Home?
Participants reported that the time taken to enter the assessments for all residents ranged between 11 – 14hours for two Care Homes and 1-4 hours for the one Care Home. This is more likely to be informed by the number of residents in the Care Home.

Time taken to complete the 30 day review of assessments
Participants reported that on average it took 1-4 hours to complete the 30 day review of assessment.

Recording of admissions and discharges during the month
None of the participants reported using the tool to record admissions or discharges during the month. This result is more reflective of the low level of turnover in the Care Homes.

Additional comments would you like to make about the Scottish tool.
Participants were invited to provide comments on the Care Home Staffing Tool.

- What worked well - the grid demonstrating the staffing levels
- Even better if… reports could be downloaded more easily

Experience of using other acuity/dependency tools
Participants were invited to share their experience of using other acuity/dependency tools.

- CHESS
- Rhys Herrn

Staffing Levels
Participants were asked to share their experience on how the use of the tool informed daily staffing levels.
Two participants reported no change in staffing levels after using the assessment tool
One participant reported that additional staff were required for each shift morning, evening and night time for both registered nurses and care assistants. The number of staff required per shift ranged from 0.5 – 2 per shift resulting in up to 7 additional shifts for a week.

Benefits of using the Care Home Staffing Tool
Participants were asked to reflect on the benefits of using the Care Home Staffing Tool from the perspective of residents, staff and the care home.

- Residents – ability to assess dependency
- Staff - may lead to a higher level of staffing
- Care Home – improved nursing

The difference using the Care Home Staffing Tool would make
Participants were asked to share their reflection on the difference that using the Care Home Staffing Tool may make.
'If it led to the development of increasing staffing levels and the trusts being able to fund the care at a more realistic rate this would make a big difference'
'*if I had more of an explanation of how this works then possibly it could make a difference'*
Participants were asked if they would recommend the use of this tool for care homes.
'not until I had better/more information about it'

The AHP Models of Input to Care Homes task and finish group, Draft Summary of Findings and Recommendations - 02/09/22

(These are draft and may change/develop as the work is agreed by all of the task and finish group and stakeholders engaged with)

Introduction

The AHP Models of Input to Care Homes task and finish group was set up as part of the ECCF Workforce subgroup as it was recognised that AHPs are an essential element of the workforce required to meet the needs of care home residents.

The purpose of the task and finish group was to evaluate the current models across Northern Ireland for AHP input to care homes and to make recommendations to the ECCF Workforce subgroup on the preferred model of AHP input. Throughout this paper the term “care home residents” is referring to those for whom care homes is their long term residence, rather than those in intermediate or rehabilitation beds.

The models are categorised into 2 main groups-models of AHP input from core AHP services and models of AHP input from resource dedicated to care homes. Some temporary funding was secured through the No More Siloes Initiative (NMS), which enabled some dedicated AHP support to specific care homes. These 2 main models of AHP input have been evaluated to identify findings and themes.

The task and finish group have focused investigation on five of the AHP professions which typically receive referrals for care home residents, namely Occupational Therapy, Physiotherapy, Speech and Language Therapy, Dietetics and Podiatry. Health and Social Care (HSC) Trust staff from these professions have contributed to quantitative and qualitative data collection for this report. This includes activity data and case studies

In order to gather views from care homes on the different models of AHP input a comparative study was carried out. It was agreed that the comparative study would focus on one Trust area, Northern Trust (NHSCT), which had piloted AHP input to their Enhanced Care Response Team (ECRT) for care homes over a 15-month period until March 2022. It was acknowledged that the pilot had facilitated more substantial AHP input to specific care homes than in other Trust areas. This allowed these care homes to have very direct experience of dedicated AHP input. Evaluation reports have been developed by NHSCT on ECRT and this information was shared with the task and finish group.

Summary of engagement findings from comparative study

There was greater satisfaction in all areas discussed in all of the engagement sessions when the AHP model of input was from a dedicated AHP service for care homes

The referral process is easier and more streamlined when into a dedicated AHP service for care homes. It is also of note that having a dedicated AHP service allows

the use of a whole home approach where all residents benefit from a prevention approach with a strong emphasis on education, training and advice, rather than only receiving individual referrals. This is likely to reduce deterioration and the requirement for individual referrals.

Waiting time from referral to assessment is reduced when the referral is into a dedicated AHP service for care homes

The partnership approach between AHPs and care home staff is much stronger when the model of AHP input is from a dedicated AHP service for care homes.

The impact of AHP services for residents was reported as high with both models of AHP input. Although it was noted that the more timely intervention from an AHP service dedicated to care homes had a more positive impact on quality of life.

Training and advice was provided by AHP staff when the model of AHP input is from a dedicated AHP service for care homes. There wasn't capacity for this, other than advice regarding individual referrals or general written guidance such as leaflets, when the model of AHP input is from core services

Satisfaction with service was highest when the model of AHP input is from a dedicated AHP service for care homes.

Themes identified from overall findings

- The model is quite reactive when referrals are made into core AHP services. Issues are dealt with as they appear, without the capacity to carry out a root cause analysis or provide training to staff within homes.

- When the AHP input model is from core AHP services, individual referrals are triaged as urgent or routine and then added to the appropriate waiting list. Urgent referrals are prioritised and responded to urgently, e.g. 48 hours acute exacerbation of respiratory condition. Routine referrals should be seen within the ministerial and IEAP AHP access target of 13 weeks. The data would suggest that this is not the case as some referrals are waiting significantly longer than this

- A whole home approach is mainly used in a dedicated AHP model of input within care home support teams which focuses on prevention and collaborative working with care home staff to support and improve the wellbeing of all residents using AHP strategies.

- When there was dedicated AHP clinical input to care homes waiting times were significantly reduced. It's recognised that examples of dedicated AHP input are not widespread and there would be a current resource issue to make this service available across all care homes.

- Care Home staff valued the strong partnership approach when they had dedicated AHP input to their care homes. In particular they valued being able to easily seek advice.

- Care Home staff valued tailored education and training but thought it would be better if this was more frequent in order to facilitate all staff receiving this.

There is benefit to residents and staff when AHPs work as part of a dedicated AHP team for care homes due to the close team working and co-delivery model. This allows greater understanding of each other's role and how to best work together for improved resident outcomes.

Recommendations

The recommendation from the evaluation of current models of AHP input to care homes in Northern Ireland is that there is evidence of the need for a dedicated responsive AHP service for care home residents in each Trust area in addition to core AHP services. This should include AHP input from across the five AHP professions of Occupational Therapy, Physiotherapy, Speech and Language Therapy, Dietetics and Podiatry.

- A model of AHP input dedicated to care homes would enable:
    - A right time right place whole home AHP approach which focuses on prevention and supporting care homes with targeted approaches from AHPs to reduce residents' deterioration and clinical decline
    - Collaborative working with care home staff and AHPs working closely together in partnership for all residents
    - Early identification of need with prompt referral and timely specialist AHP intervention when required