Department of Health
An Roinn Sláinte
Männystrie O Poustie
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THE ENHANCING CLINICAL CARE FRAMEWORK

For Adults Living in Care Homes

Wellness
at the heart of your home

Contents

It is best to read this Framework online at https://www.health-ni.gov.uk/publications/enhancing-clinical-care-framework due to the wealth of information and resources linked to within.

1. FOREWORD

I am pleased to present this ambitious and comprehensive Framework that recognises the challenges faced within care homes, some of which are longstanding. There has been a noticeable change in the characteristics of the care home population. People are living longer, which is to be celebrated, but many are doing so with more complex health and care needs than would previously have been the case. Whether living in their own home or in an adult residential or nursing home, individuals should receive the highest standards of care that holistically address those needs.

It is important that we recognise the significant impact the COVID-19 pandemic had on people who live in care homes, their friends, family and staff who cared for them. It is important that we learn from this to ensure we can provide the highest level of person centred care to people who live in care homes.

Clinical care must be equitable no matter where people call 'home'. There has been an increase in the nature of clinical care that can be provided in both residential and nursing care homes over recent years to meet the needs of someone living there. That is to be celebrated too, as it enables more people to stay in the place they call home for longer. Some people living in a residential home can receive care that would previously only have been available within a nursing home setting. Some people living in a nursing home can receive a level of care, including palliative and end of life care, that would previously have required a hospital admission.

I commend the already high standard of clinical care being provided by care homes in Northern Ireland. There is much excellent work being undertaken within care homes and the organisations providing support to them, focused on further enhancing the health and wellbeing of people living there. This is reflected in the Framework, and I would encourage everyone involved to enable the best practice it describes.

Peter May
Permanent Secretary
Department of Health

2. INTRODUCTION

This is a framework focused on people. It builds on the excellent work already being undertaken within care homes.

Its central aim is to ensure those living in care homes have access to the clinical and wellbeing support they want and need, to live healthy, fulfilling lives and to meet the daily challenges many will face.

Having engaged with residents, their families, staff and those providing support, we know that people living in adult care homes do not always have equitable access to the clinical care they need when they need it to maintain their health and wellbeing. This is in common with other jurisdictions. This Framework aims to address this.

The core objective is for the wider Health and Social Care system to move from a service model focus into care homes, to a focus on the individual needs of those living in a care home and what they want and need from specific services. The aim is for healthcare support within care homes to be increasingly proactive, equitable and planned.

The ultimate ambition is to ensure people living in care homes can equitably access the same range of responsive and preventative healthcare available to those living outside care homes, as part of an overarching, holistic approach to their health and wellbeing.

The Framework sets out four key ‘pillars’ for services within which this approach should be focused:

- Prevention
- An anticipatory approach, self-management and early intervention
- Urgent and emergency care
- Palliative and end of life care.

The Framework is an ambitious one. This is as it should be; people living in care homes deserve nothing less. The Framework also recognises the importance of the role of social care staff and nurses working in care homes.

People across sectors and professions, people living in care homes and those closest to them have partnered with us to develop this Framework, to articulate best practice and enhance outcomes and experiences of clinical care for those who call an adult care home their home.

It is not intended to intentionally, or inadvertently, lead to the over medicalisation of the personalised elements of care that are so critical to someone's wellbeing. The intent of the Framework is not to impact on the social model of care operating in residential homes or to turn nursing homes into mini hospitals.

Nor will it address other matters outside the remit of the Enhancing Clinical Care Framework (ECCF) work, such as funding for social care for someone in a care home.

I am particularly grateful to the care home managers who joined the Department's project team and to people living in care homes and their families who informed the development of the Framework.

I extend my sincere thanks to everyone within the project structures and beyond who partnered with us to progress the Framework.

Your knowledge, your experience, lies at its core.

Maria McIlgorm
Chief Nursing Officer
Department of Health

3. BACKGROUND AND AIMS

The definition of care homes, for the purpose of the Framework, are 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.

Health and Wellbeing: Delivering Together, is the ten year vision for health and social care and commits to the reform of adult social care and support with the aim of bringing long-term stability and sustainability to that sector.

The Health and Social Care (HSC) system's response to the challenges of the COVID -19 pandemic has helped to break down professional, sectoral and administrative boundaries and demonstrated that a better way of working across the wider HSC system is possible. One of the strategic recommendations from the Rapid Learning Initiative into the first surge of transmission of COVID-19 in care homes was to ensure this way of working continued and focused on the wellbeing of people living there. Building on that recommendation the then Minister of Health announced plans for the development of a new Framework to enhance existing nursing, medical and multidisciplinary in-reach into care homes. Northern Ireland is not alone in collaborating to look at the care home sector post pandemic. The ECCF project findings and recommendations are in line with other jurisdictions such as the Scottish Government Framework and the NHS England Framework NHS England Framework and also the recommendations of the British Geriatric Society.

Led by the Chief Nursing Officer (CNO), working in partnership with the Independent Care Home Sector, the Enhancing Clinical Care Framework (ECCF) aims to ensure that people who live in adult nursing and residential care homes are supported to lead their best life possible, underpinned by the right to equitable access to healthcare provision. This includes ensuring that they receive the right clinical care, at the right time, in the right place, delivered by the right clinician and with continuity of care a core element of that delivery wherever possible.

The term “we” when used in the Framework refers to something larger than the Department of Health project team. It incorporates all those involved in developing the Framework, whether formally as partners within the project structures or through informally providing views as work progressed.

The Framework incorporates what **we heard** from partners during development about the healthcare needs of people living in care homes. Clinical need is just one element of holistic care provision for people living in care homes. Care homes are social care environments, albeit some individuals will have nursing needs. The delivery of adult social care: the activities, services and relationships that contribute to living an independent, healthy and inclusive life, are fundamental to keeping people well.

4. ALIGNMENT WITH STRATEGIC PRIORITIES

Review and reform of health and social care provision across primary, secondary, acute and community care is a key priority in safely, effectively and compassionately meeting the needs of the Northern Ireland population, including the adult population living in care homes.

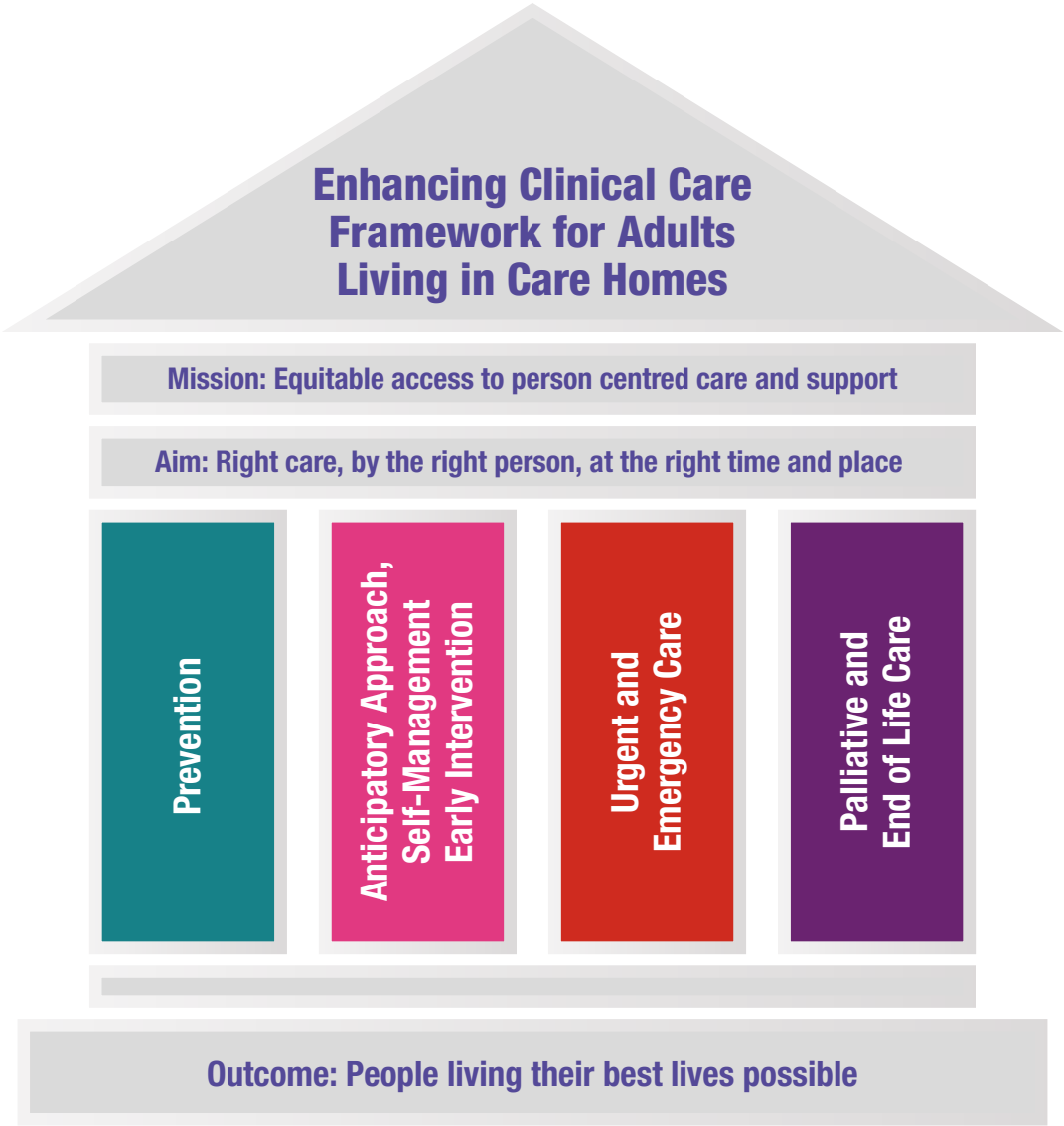
Development of the ECCF sits alongside and in support of a number of health and social care focussed strategic projects which include, but are not limited to, the following:

- Review of Urgent & Emergency Care NI
- No More Silos
- Review of Intermediate Care
- Reform of Adult Social Care
- Medicines Optimisation Quality Framework
- Mental Health Strategy
- Workforce Strategy and Action Plan
- Digital Strategy Health and Social Care Northern Ireland 2022-2030, including implementation of Encompass
- Nursing & Midwifery Task Group Report & Recommendations

5. THE FRAMEWORK

The Framework supports enhanced regional, equitable access and continuity of care for someone living in an adult residential or nursing home. The diagram below is an illustration of the Framework that seeks to enable people living in care homes to live their best life possible.

Diagram 1: The Framework



The Framework describes the principles and practices of what people living in care homes need to access for optimal clinical care and support to stay healthy and well. The diagram shows the Framework's four key pillars for services that someone living in a care home needs equitable access to. They are discussed further in section 10 and relate to:

- Prevention
- An anticipatory approach, self-management and early intervention
- Urgent and emergency care
- Palliative and end of life care.

A total of sixty six care homes volunteered to develop the Framework. Key elements were tested in a "live" care home environment by forty-seven care homes.

6. APPROACH AND KEY PRINCIPLES OF THE FRAMEWORK

A Co-Production approach was taken from the outset through embedding the wide range of representative voices within the project structures responsible for delivering the Framework.

We also engaged with the School of Nursing and Paramedic Science and Institute of Nursing and Health Research, Faculty of Life and Health Sciences, Ulster University responsible for overseeing the delivery of the “My Home Life” programme for care home managers as a critical friend.

An illustrative, not exhaustive, list of the main engagement activity can be found in the ECCF Co-production evidence log.

The **additional key approaches** to developing the Framework were:

Diagram 2: Key approaches

The Framework describes **key principles of best practice** that:

Diagram 3: Key principles

7. FOUNDATIONS OF THE FRAMEWORK

The Framework aims to enhance person-centred care for people living in care homes, aligning with the Person-Centred Framework (McCormack & McCance). Decisions are made in conversation with the person and, where they agree, with those important to them. CNO commissioned the My Home Life team at Ulster University to undertake a literature review on engagement, "The factors that influence care home residents' and families with decision making about their care and support."

The processes to achieving the optimal outcome for people living in care homes may differ across Trust areas. The Framework aims to enable consistency and equity of care through providing regional, standardised recommendations for access and resources to support assessment, monitoring and interventions. The Framework further includes the underpinning system enablers, for example, around workforce and digital technologies, that are required to skill and empower all those providing care to someone living in a care home.

During the development of the Framework, **we heard** about the importance of having foundations in the following four fundamental concepts. Doing so supports the human rights of people living in care homes being met and enables them to access equitable clinical care in line with their needs and wishes. They include **autonomy, advance care planning, informed choice and shared decision making and care at times of transition**.

AUTONOMY

We heard of the importance of not treating someone living in a care home as a passive recipient of their care.

The relationship between autonomy and capacity is not straight forward or easily assessed. The capacity to consent might not be constant and is decision, time and situation specific. All elements must be considered collectively in informed, shared decision making with people who live in care homes, to ensure their personal autonomy is being exercised as fully as possible.

The ethical right for someone to have their autonomy respected is a fundamental underpinning of the Framework. It is also enshrined in law.

Where someone living in a care home has capacity, their informed, voluntarily given consent to decisions about their care and support must be sought and respected, including continuation or cessation of that care.

Where someone is, or is considered to be, impacted by cognitive impairment, due attention must be paid to the Mental Capacity Act (NI) 2016.

ADVANCE CARE PLANNING

Advance Care Planning is a voluntary process of on-going conversations about profoundly personal matters around the clinical care and support people want to have in line with their values and beliefs. The regional policy is Advance Care Planning.

An adult should have their Advance Care Plan in place for healthcare well in advance of any medical crisis or diagnosis of a serious illness. Everyone living in a care home should have access to the most appropriate person to have those discussions with to ensure their wishes are being as fully and accurately identified as possible.

With their permission, those closest to the person must be fully informed of their wishes. Where someone, even with support, cannot articulate their choice, those closest to them must be fully involved to obtain their advice and insight to identify what that person would have wanted for themselves. They too may require support to articulate their views.

INFORMED CHOICE AND SHARED DECISION MAKING

A key message from, "Care Homes & COVID-19: The Lived Experience of Care home Residents, their Relatives and Staff during the first wave of the COVID-19 Pandemic," is the importance of people receiving information in a timely and accessible manner and to support those with complex communication needs to access and understand the wider decisions being made regarding their home. For example:

> ***Staff were very good at looking out for me, keeping me safe… I now believe I cope better now that I understand things. Staff are always here to answer my questions and here to keep me safe.***

Informed choice and shared decision-making respects the rights of that person and enables them to make choices which align to their values and to what matters most to them. This is equally valid where a level of risk is identified in the decision being made. Risks, and any mitigations, should be discussed and agreed with the person in line with their level of tolerance. While ensuring their overall health and wellbeing is maintained, where the resident chooses to live with a level of risk, for example eating at risk due to issues with swallowing or mobilising with risk due to frailty, this is explored, respected, and recorded.

CARE AT TIMES OF TRANSITION

Research shows high levels of lack of autonomy in the decision to move to a care home for someone. Getting things right from the outset is critical. First impressions can be lasting ones that affect the health and wellbeing of people living there both positively and negatively when moving from their own home or a hospital into the care home, or from one care home to another.

> ***Well, I suppose people would need to want to come here. I didn't have a choice... it's just that it would have a been a smoother journey for me of getting here, if I had had a say in everything…***

The wider care home team must recognise the magnitude of a move to care home life for someone and those closest to them. This includes recognising the importance of preparatory visits and completing a pre-admission assessment. The ECCF Pre-Admission Assessment Document supports the identification of individual's clinical care needs and what matters most to them. For those providing care to someone living in a care home, research highlights the importance of understanding the needs of families to continue caregiving and its therapeutic effects on both the older person and their family. This is not solely about the sharing of roles and responsibilities for care but also about the sharing and understanding of each other's perspectives to foster collaborative relationships. ("It's the little things that count." Ulster University).

8. PEOPLE LIVING IN ADULT CARE HOMES

The proportion of the population aged 65 and over increased by 24% from 2011 to 2021 (NISRA Census 2021). While people living longer is a positive reflection of overall health, the number of people in care homes living with severe frailty has risen. Many people living in care homes now live longer with multiple conditions, including long-term physical and mental health problems.

Data exists about care home beds, but we were unable to obtain specific population health data for the purposes of this Framework about people living in care homes. For example, those presenting with dementia, frailty, brain injury, learning disability, degenerative neurological conditions. The number receiving palliative and end of life care and their average length of stay is unknown. Understanding the population needs of people living in care homes will be an important factor in ensuring we can continue to meet their needs now and in the future.

As of 30 June 2022, there were 15,888 registered beds in 244 nursing homes and 229 residential homes in NI (RQIA). The breakdown between statutory and independent care homes and registered beds is as follows:

Diagram 4: Breakdown of Care Homes (RQIA)

Service Type	Independent	Statutory	Total	Beds
Nursing Homes	241 (99%)	3 (1%)	244	10,626
Residential Care Homes	186 (81%)	43 (19%)	229	5,262
Grand Total	427 (90%)	46 (10%)	473	15,888

The table below shows the breakdown of Nursing and Residential care packages in effect at June 2022, for different client groups. Over three quarters (78%, 9,057) of care packages were in effect in the Elderly Care category. The breakdown of categories for the other Programmes of Care can be seen below. Please note, people living in residential and nursing homes by private arrangement with the homeowner, who have not had a comprehensive assessment/re-assessment of their care needs by the Trust are excluded.

Diagram 5: Care Packages (RQIA)

Client Group	Nursing	Residential	Total
Elderly	6.450	2,607	9,057 (78%)
Learning Disability	710	652	1,362 (12%)
Mental Health	477	232	709 (6%)
Physical/Sensory/Disability	390	55	445 (4%)
Total	8,027	3,546	11,573

9. HEALTH AND WELLBEING NEEDS OF PEOPLE LIVING IN ADULT CARE HOMES

People have a range of health and wellbeing needs that extend across relationships with family and friends. These include psychological and social needs, in addition to environmental needs and basic biological needs that, when fulfilled, contribute to wellbeing. However, there are fundamental needs that must be met for all of us to thrive, wherever we live, including in a care home environment. These include food, security, belonging and self-esteem.

The fundamentals of care are illustrated in the diagram on the following page on Maslow's Hierarchy of Needs.

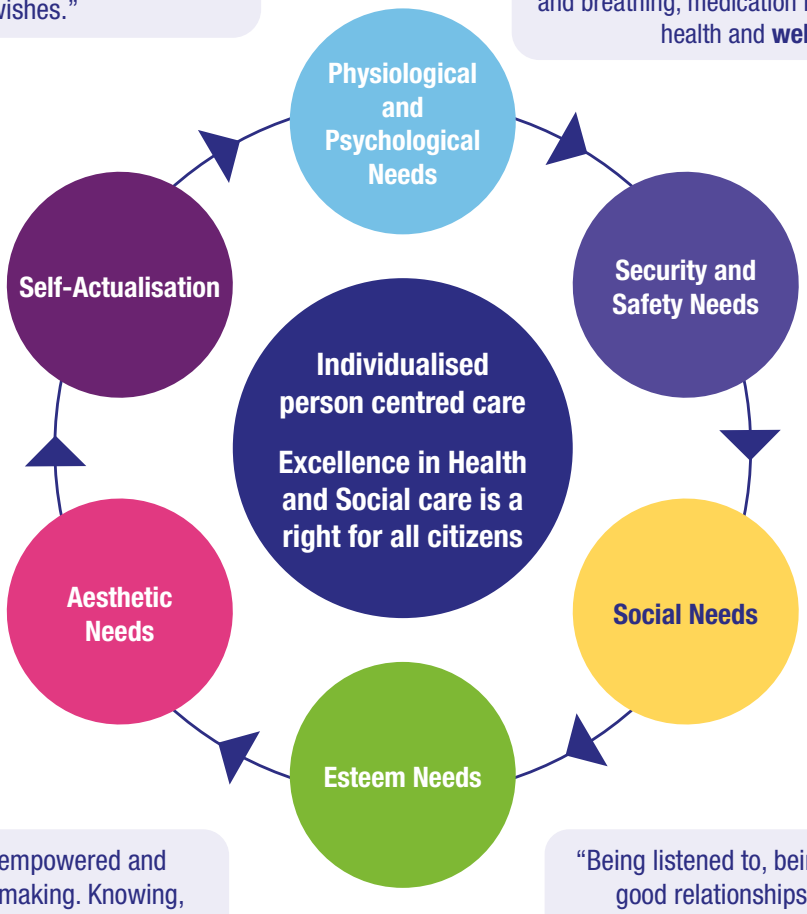
Diagram 6: Maslow diagram (Adapted from a Scottish Government diagram)

Developing an integrated Framework for Health and Social care support that meets all my needs and outcomes

"And when it's my time to leave this would help me to have a dignified, compassionate and peaceful death, respecting my choices and wishes."

"That all my needs are met in a person-centred and holistic way. Circulation, breathing, movement, elimination, FF&N, oral care, sight and breathing, medication management, mental health and **wellbeing**."

"When all my needs are met to help me live my best life."



"Right staff, right place, right time with the right knowledge and skill, evidence based, compassionate practice, prevention, early intervention and anticipation. Safe environment and reduction of harm. **Dignity and respect. Responsive, compassionate** care and support care as near to me as possible."

"Every moment counts. Tailored and personalised opportunities and creativity. Ability to express myself."

"Being involved, empowered and informed decision making. Knowing, included and maintaining control. Meaningful activity and autonomy."

"Being listened to, being heard. Promoting good relationships and meaningful experiences. Seeing family and friends. Involving families. Spiritual needs."

includes five principles of the Health and Care standards

Based on Maslow's Hierarchy of Need

10. MULTIDISCIPLINARY SUPPORT FOR PEOPLE LIVING IN ADULT CARE HOMES

The four key pillars of the Framework are colour coded throughout the document and relate to:

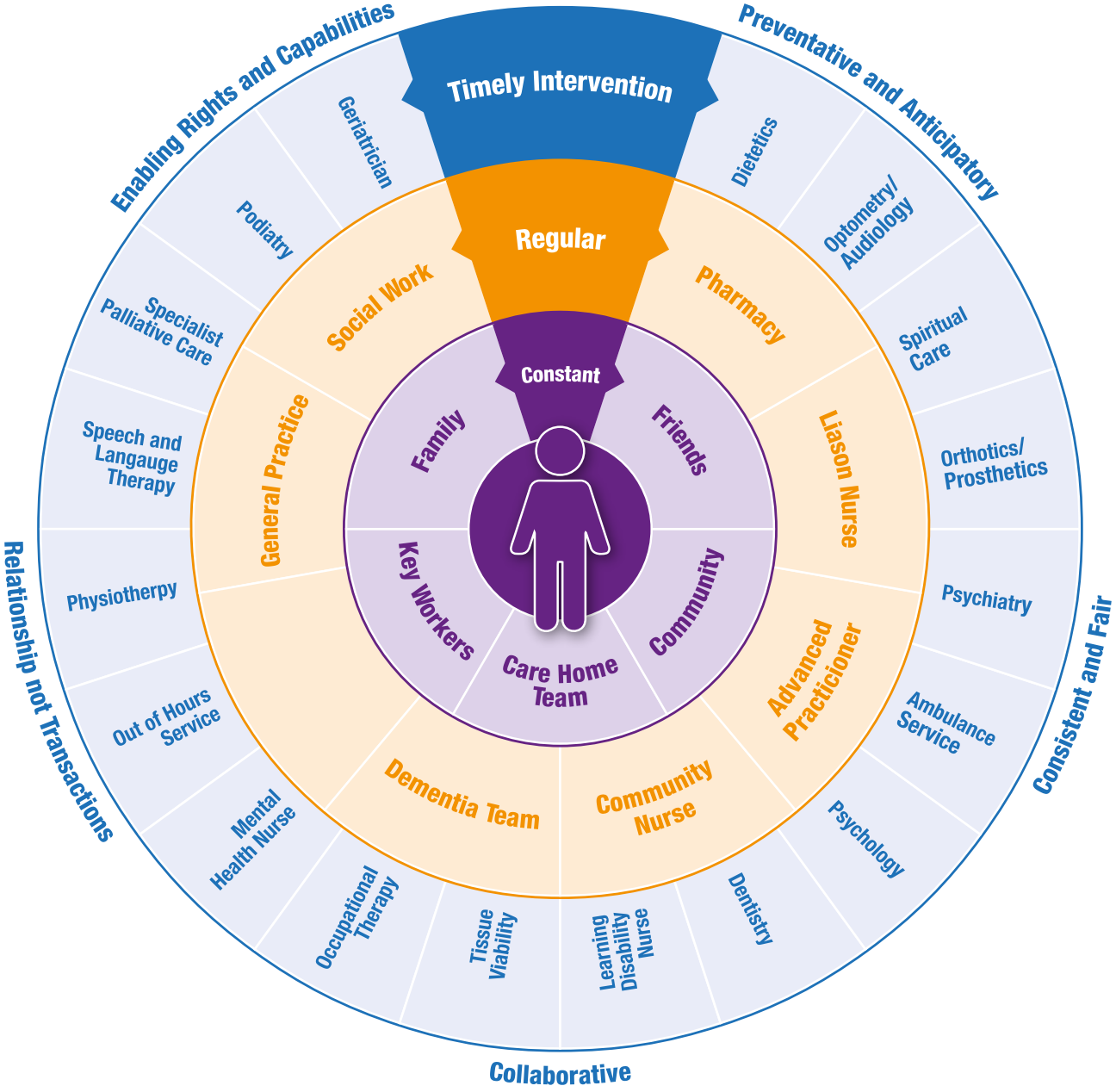
1. **Prevention**
2. **Anticipatory approach, self-management and early intervention**
3. **Urgent and emergency care**
4. **Palliative and end of life care**

Best practice is described for each specific pillar in the four sections below, followed by overarching recommendations (section 16).

Taking a multidisciplinary, collaborative approach within and across professions, sectors and organisations to ensure person-centred care for people living in care homes is critical to the four pillars, as is the fundamental importance of taking an anticipatory approach. **We heard** that the knowledge and relationships that the wider care home team and families have with the person are invaluable. These should be fully utilised in identifying and meeting someone's needs.

This ethos is illustrated in the following diagram. The Framework covers all people living in an adult care home, therefore the diagram cannot be considered an exhaustive list of those contributing to someone's care. People living in care homes will require access to different services according to their needs and this should be provided in a timely and co-ordinated way.

Diagram 7: The Multidisciplinary Team around the person living in a care home included in My Health - My Care - My Home and updated for Northern Ireland.



The focus of the diagram is not to illustrate the services that should reach into care homes. The focus is the person at the centre and the team providing healthcare and other support that they should have equitable access to. All those named in the concentric wheels should have clear, direct lines of access to each other, including out of hours, and know when to seek each other's input to meet that person's needs.

Surrounding the person in the inner wheel are the people who are likely to be a daily, or most constant presence for someone living in a care home. They usually have the largest impact on health and wellbeing, such as friends and family and the full team in the care home that interact with them. Clinical staff, care assistants, activity coordinators, catering and domestic staff all have their respective, key roles to play in ensuring the clinical and wider wellbeing needs of someone are being met as part of the "whole care home" approach to keeping people living healthily and well.

The people in the middle wheel work closely with the people identified in the inner wheel to provide regular healthcare advice and support, depending on someone's individual needs. Those named in the outer wheel do the same when a person living in a care home needs to access their services.

Depending on the individual, input from some of the people described in the wheels may be required intensively or not at all and involvement of the same professionals may vary over time for the same person depending on their needs.

11. PREVENTION

This section provides a description of best practice for key areas. **We heard** from people living in care homes, those providing their care and those closest to them that these are essential for prevention. Someone may not need access to everything described and the access they need may vary over time both in nature and intensity. The catalogue of services in this section is not exhaustive, nor should it be taken as representing a hierarchy of importance. The importance of these services lies in informing a person-centred plan of care so someone can access the timely clinical care and wellbeing support they need. This nurtures their health, mind and soul to live as healthily and well as possible.

The person and/or those closest to them are often experts regarding their illness. Working in partnership with them can help reverse, stop or delay the progression of pre-existing conditions.

Prevention is critical to maintaining health and wellbeing. The care home population have the same rights as everyone living in the community to access holistic care including wider preventative health care.

11.1 Reducing variation in process and practice during a pre-admission assessment

We heard of the importance for someone's health and wellbeing of the preadmission assessment process to ensure they were in the right environment to have their needs met. Care homes having access to both the clinical data they need and being able to identify what matters most to someone is critical for their health and wellbeing when they transition to living in a care home. There is variation in process and practice around pre and post admission assessments and the use of informed shared decision making. This variation can directly impact on someone receiving optimal clinical care and wellbeing support. Regional, person-centred tools would reduce that variation and increase the potential for receipt of optimal care.

As a result of what **we heard**, a Pre-Admission Assessment Document for people pending admission to a care home was coproduced. The document enhances existing documentation being used through collating into one document the essential clinical data and other health and social care fundamentals of wellbeing, such as the identification of *'What Matters Most to Me'.*

Care home staff have commented:

> ***Having a meeting with the family is one of the first things you do, as they are a wealth of information on the person's characteristics, fears, hopes, anxieties. This document lets you document this, the "what matters most to me" section is fantastic.***

> ***When you are sitting with a person who has anxieties, by going through it, it reassures them, and they appreciate the humanity of that.***

The use of the Rockwood Clinical Frailty Scale was incorporated within the Pre-Admission Assessment Document. Where appropriate, it is recommended for completion for people living in care homes to inform person-centred care planning. It enables conversations between the entire team providing care and support to the person, using common language.

Recommendations

People living in care homes should have:

- the Pre-Admission Assessment Document available to ensure person-centred care planning based on what matters most to them.
- an assessment using the Rockwood Clinical Frailty Scale where appropriate.
- these assessments commenced as early as possible to help identify needs when planning a move to a care home.

11.2 Nutrition and hydration

Nutrition and hydration can have a huge impact on a person's physical and social aspect of care. For example, they could have an increased risk of infections, falls, issues with tissue viability, anxiety and depression. People living in care homes are more likely to have chronic conditions that place them at risk of malnutrition and dehydration. This can include significant cognitive impairment such as dementia and research has found that the rate of prevalence and incidence of dysphagia is between 50-75% for people living in care homes.

People with eating, drinking and swallowing difficulties are at higher risk of malnutrition & dehydration. They are on occasion at risk of significant harm from choking and people supporting them must do so in line with best practice and should understand their roles and responsibilities in providing that.

A New Models of Prescribing Pilot ran from October 2020 to March 2022, focused on dietetic ordering of Oral Nutritional Supplements (ONS), as well as enhanced dietetic input, for a small number of care homes across NI. The pilot demonstrated improved outcomes for people living there along with significant prescribing efficiencies both in terms of reduced workload for GPs and community pharmacies and a net average reduction in cost per month across the six participating homes.

Respecting personal autonomy is also critical. While they are more at risk, the emphasis should be on identifying the person's individual tolerance of risk and on working with them, and those closest to them, to mitigate those risks within the context of quality of life, personal choice and the least restrictive approaches to management of swallowing difficulties.

Recommendations

People living in care homes should have:

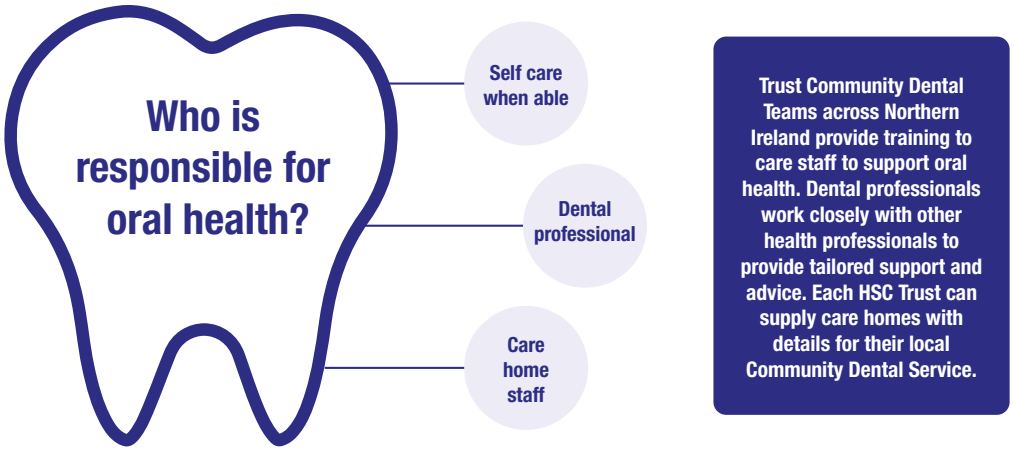
- the ECCF Pre-Admission Assessment Document completed prior to moving to live there. This will ascertain the person's dietary requirements, aligned to the beliefs they hold, when they transition to live in their care home.
- their hydration and nutrition requirements assessed based on need. These are completed by the appropriate clinician, using the appropriate assessment tool to meet them. The individual's tolerance of risk is included and any mitigating actions in place.
- appropriate nutritional supplements and any dietary requirements met to help prevent physical deterioration such as osteoporosis.
- support by the most appropriate person to self-manage through access to information and advice for example, someone living with diabetes.
- support to be part of communal activities, including meals with others, to maximise the benefits of positive social interaction.
- a modernised approach taken to the supply of nutritional products to care homes across NI, using the learning from the New Models of Prescribing pilot.

11.3 Oral health

The Northern Ireland Service Framework for Older People (DoH, 2014) states that poor oral health, including higher levels of untreated dental decay and gum disease, is a greater problem for adults residing in care homes than for adults in the general population. This has been linked to malnutrition, weight loss and poor recovery from illness. As many people are now keeping their natural teeth for much longer than before, it is essential that they receive excellent oral care. People in care homes can have less ability to care for their own mouths and teeth and access to support from carers, care home staff and dental professionals is essential.

People living in care homes may often be unable to communicate that they are experiencing oral pain, and this can manifest in other behaviours, for example, distress, inability to have adequate nutrition and hydration. People providing their care should be aware of this possibility and assess accordingly in order that the individual can access the required services.

Diagram 8: Oral Health (DoH)



Although essential, access to a dentist can be difficult to obtain for someone living in a care home who cannot attend a dental surgery and there are limited numbers of General Dental Practitioners who provide in reach services to care homes, for a variety of reasons. Combined with the characteristics of many people living in care homes, including complex medical conditions, frailty and cognitive impairment, these have significantly impacted the dental care that can be provided by General Dental Practitioners in a care home setting. An educational resource can be found at oral health training resource developed in 2022 following pilot work with care homes with input from some dental students. Best practice can be found in the NICE Guidelines.

Recommendations

People living in care homes should have:

- an oral health risk assessment on admission by someone appropriately trained and suitably skilled who knows how and when to refer to other required services. This should be used to inform a preventative oral health plan developed with them as part of their overarching care plan which considers how deteriorating oral health may manifest in them as an individual.
- their oral health inspected and monitored. Care Standards for nursing homes should ensure that oral health risk assessment is included in all aspects of the care people receive in a care home.
- standards of oral care assessed by RQIA during their inspection of care homes.

11.4 Eye Care

Many people living in care homes will have vision problems and eyecare needs. They should have access to both routine and urgent symptom led eyecare they need for early detection and intervention. This will help correct the poor eyesight that can significantly affect the person's ability to engage with those around them, to maximise their safer mobility and ensure their holistic needs are met. This includes maximising their independence and ability to participate as fully as possible in life in their care home, including the daily activities of living.

People who move to live in a care home who have been visually impaired from birth may be particularly vulnerable and should have access to any additional specialist support they need as part of their care plan.

Best practice guidelines (GAIN_eyecare_guidance.pdf (hscni.net)) recognises the importance of eyecare in the care home setting.

We heard that, whilst people living in care homes are able to access the eye care they need, conditions, such as significant cognitive impairment, can mask the identification of eye care needs or make it difficult to complete an assessment for someone.

Recommendations

People living in care homes should have:

- their sight assessed on admission by someone appropriately trained and suitably skilled who knows how and when to refer to other required services. The outcome should inform their person-centred care plan which considers how deteriorating visual health may manifest in them as an individual.
- their sight monitored and reviewed based on need. The outcome should inform their care plan.
- visual aids provided based on individual need which are then monitored and maintained.

11.5 Hearing care

The Royal National Institute for the Deaf (RNID) estimate that 80% of people in a care home will have some degree of hearing loss by 2032. Their research has shown that if the hearing loss of someone living in a care home is identified as early as possible and managed effectively, it can enhance their health and wellbeing by reducing the physical, psychological and emotional impact of their hearing loss in line with the biopsychosocial model of health. Hearing loss is recognised as a modifiable risk factor for dementia. Early identification enables someone to fully participate in life in the home by, for example reducing loneliness and social isolation, anger and frustration, especially in social settings.

People who move to live in a care home who have had hearing impairment from birth may be particularly vulnerable and should have access to any additional specialist support they need as part of their care plan. **We heard** that hearing loss can sometimes be misinterpreted as the early signs of dementia, which are similar or even make the symptoms of dementia worse for someone due to confusion about what is happening around them. However, there is currently no specific regional service for someone to access hearing care in their care home. That makes that care challenging to access for someone who cannot attend an appointment outside their home. It can also be challenging to complete an assessment of hearing need for many people living in care homes given the particular characteristics of that population.

Recommendations

People living in a care home should have:

- a hearing assessment, on moving to live there, by a suitably qualified and skilled person who knows how and when to refer to other services where appropriate. The outcome should inform their care plan.
- their hearing monitored and reviewed based on need. The outcome should inform their care plan.
- their communication needs met based on need, including equipment like hearing aids.

People with hearing loss living in a care home should be supported to:

- fully participate in decision making about their care. They should have access to the appropriate communication support to enable them to participate fully in decisions about the health, clinical care and other support they need.
- participate in care home life. All those providing care for someone should know how and when to make a referral to the appropriate audiology services.

11.6 Promoting Continence

Loss of continence is not part of the normal aging process but statistically it is more prevalent in the aging population. Continence should be preserved wherever possible. Incontinence is not an illness but a result, for example, of an underlying bladder dysfunction, bowel dysfunction or mobility issue, which often negatively impact on an individual's physical, psychological and social health and wellbeing.

Promotion of continence is vitally important for these individuals to help prevent social isolation and maintain skin integrity. It will reduce the pain suffered and prevent potential falls associated with distress and disorientation from urinary infections. Robust care management may prevent these complications and reduce hospital admissions.

Findings from the ECCF testing exercise were that very often the rationale for the urinary catheter insertion at source was uncertain, with little information from acute settings on the future catheter care plan for some people at the point of discharge. We also heard of the need for more people with catheter issues to be treated in their care home to prevent the impact on their health and wellbeing of avoidable transfer to hospital.

As a result, the following resources were developed:

- a Catheter Passport to provide a summary of essential information of someone's needs relating to their catheter care needs and
- a Urinary Troubleshooting Guide to support the treatment of catheter issues within a care home and avoid unnecessary and/or unwanted hospital admission or attendance. Both have complete transferability to anyone with a urinary catheter across the region.

Recommendations

People living in care homes should have:

- continence care where everyone caring for them knows how they can contribute or help towards first line interventions and has access to and knows how to onward refer those who need more help. For example, to the services of a continence nurse advisor that may help many of them manage or overcome their problem.
- access to a regular and frequent toileting regime that supports them to manage and maximise their continence.

People living in care homes who have indwelling urinary catheters should have:

- information easily accessible to relevant clinical staff and used to identify any in reach support to meet their needs.
- a Urinary Catheter Passport completed on admission to care homes across the region. The outcome should inform their care plan.
- continence care provided by staff that make use of the Urinary Troubleshooting Guide.
- a urinary catheter pack upon discharge from hospital to accommodate the next urinary catheter change and a referral made to Trust support services where appropriate.
- support to consider trialling the removal of their catheter with relevant clinical practitioner/s in line with their wishes/needs.

The development by Trusts of a digital Urinary Catheter Database should be considered as an underpinning system enabler. This should have the potential to be regionalised given the number of people placed by Trusts in care homes outside their own area.

11.7 Tissue viability and wound care

Tissue Viability is a nurse-led speciality that provides expert knowledge and skills to support prevention, diagnosis and treatment of a wide range of wounds and skin integrity concerns.

This is an important service for people in a care home to access because of the particular characteristics of the care home population associated with a risk of tissue damage. For example, the high level of those with incontinence, those with mobility issues, including the bed based and those with contractures associated with immobility from illness such as stroke or dementia. Adequate hydration and nutrition in tandem with effective continence management and mobility are closely connected with tissue viability and wound care. Prevention and early intervention when required are vital as is support from a range of people in a person's care team.

We heard that while they provide welcome support to care homes, the specialist Trust Tissue Viability Teams are small. Care homes are also utilising Link Nurses to obtain advice and support.

Recommendations

People living in care homes should have:

- support to prevent or mitigate the risk of tissue damage and aid wound healing, including appropriate hydration and nutrition.
- early identification, assessment and management of any tissue damage by a suitably skilled person who should know how and when to seek advice, support or to refer to other appropriate services, for example plastic surgery.
- support to maximise safer mobility to promote their overall health and wellbeing.

11.8 Foot care

People living in care homes should have access to appropriate podiatry assessment, treatment, support and monitoring services to maintain their mobility, reduce the risk of falls and support foot health. This is particularly important for those with circulation problems and diabetes, where lack of foot care can lead to foot ulcerations, amputations and even premature death.

We heard that people in care homes could access podiatry services but there is variation. Those identified as high risk such as people with diabetes or peripheral vascular disease can access these services free of charge. There is potential for inequity when provision is subject to the individual's ability to pay and not based on their assessed clinical need.

Recommendation

People living in care homes should have:

- access to timely referrals for podiatry services. This will support them in safer mobility and early identification of any underlying conditions, such as diabetes associated vascular disease.

11.9 Mobility and meaningful activity

It is important that all people living in care homes are supported to maintain their independence for as long as possible. A restrictive falls risk reduction approach can lead to peoples' mobility being limited. **We heard** of the deconditioning and loss of muscle that occurs quite rapidly when people reduce mobility, thus increasing their fragility and risk of injury from falls. This has sometimes been referred to as pyjama paralysis.

Being supported to self-manage and being active both mentally and physically is a key component in preventing the development of frailty. It also has a positive impact on a person's self-esteem, sense of belonging, quality of life, joint pain, tissue viability and sensory stimulation.

Falls are a significant issue. Maximising mobility and meaningful activity safely for people living in care homes is crucial whether they are mobilising independently, with an aid, chair based or bed based. A standardised medication review based on someone's care plan should be conducted to mitigate or prevent the potential for polypharmacy or under/over prescription of medicines to impact their risk of falling and their ability to participate in meaningful activity.

Those closest to them, Allied Health Professionals (AHPs), other health care professionals and the wider care home team all have their role to play in supporting someone to achieve their full potential to mobilise safely, maintain independence and engage in meaningful activity. The care home team should have direct access to the clinical support they need, for example, an Occupational Therapist. They should also have an Activity Coordinator who will develop a personalised activity plan. Meaningful activity does not have to be through a formal exercise or programme and should be accessible for those people with a cognitive or communication impairment, such as dementia, tailored to their needs.

We also heard of the benefits of the use of technology such as RITA**.** This tool supports personalised mental stimulation, including for those with cognitive impairment, for example, through relaxing music, creating their life story, playing jigsaws and karaoke. It can help calm anxiety and distress thereby enabling someone to participate in wider activity more fully within their home.

Recommendations

People living in care homes should have:

- care that accords with the Regional Falls in Care Homes Pathway and Bundle and overseen in their care home by a Falls Champion.
- an Activity Coordinator.
- a standardised medication review based on a person-centred care plan. This will mitigate or prevent the potential for polypharmacy or under/over prescription of medicines to impact someone's risk of falling and ability to participate in meaningful activity.
- equitable access to equipment and technology such as RITA and virtual wards.

11.10 Communication support and equipment

People living in care homes who have communication difficulties should be supported to express themselves and understand what is being said to them. Speech and Language Therapists can assess and advise on strategies to support communication, such as through therapeutic intervention, programmes and equipment. This can make a real difference to people's lives and ensures that they have an equal voice to be heard. Communication is central to well-being, shared decision making and social connectedness.

Art, Drama and Music Therapy can support people to communicate and express themselves. For example, Art Therapy uses the visual arts as a form of psychotherapy to encourage clients to explore issues, communicate and express themselves, discovering a personal visual language as a bridge to communication when verbal approaches are insufficient. Occupational Therapists work to reduce the barriers that impact a person's ability to engage in everyday occupations and activities, by presenting the activity in a more manageable way, through environmental redesign, provision of adaptive equipment and/or assistive technologies.

Recommendations

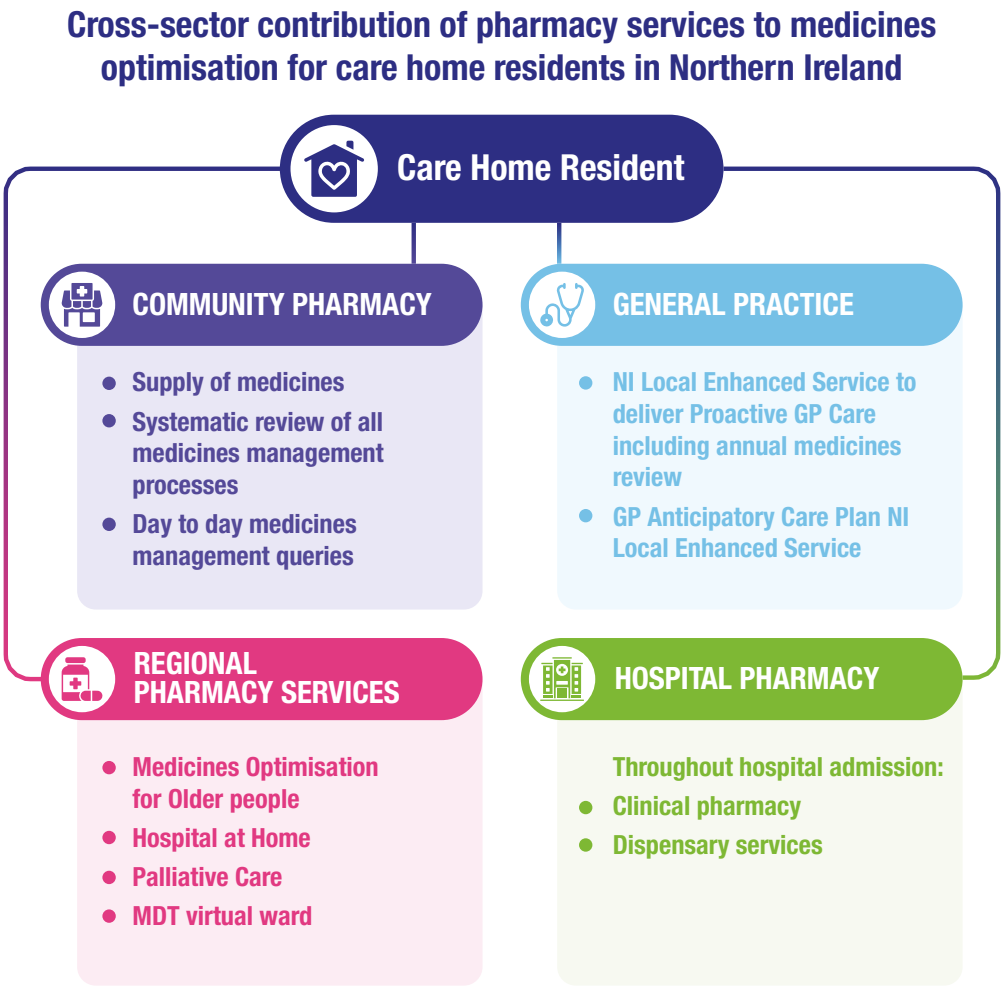
People living in care homes should have:

- the support they need to communicate and be understood from the appropriate person that can meet their assessed needs, including for those whose first language is not English.
- support to understand and to be understood verbally and in written material, for example using technology to maintain connections to those closest to them.

11.11 Medicines management and optimisation

In Northern Ireland, pharmacy services across the HSC contribute to individual person-centred care for people living in care homes to help them gain the best possible outcome from their medicines.

Diagram 9: Medicines management and optimisation



These services are provided by pharmacists and pharmacy staff in different sectors who are integral members of multidisciplinary teams, with expertise and responsibilities for reviewing medication, monitoring high-risk drugs, and considering the impact of polypharmacy for everyone throughout their journey. Pharmacy interventions take place at multiple stages in the pathway for people living in care homes. They are critical from the point of admission in terms of prevention and are relevant to all four pillars of the Framework.

People living in care homes often have a high degree of multi-morbidity and the resulting polypharmacy (taking multiple medicines) can present many positive benefits for the individual by alleviating pain, improving functional capacity, quality of life and extending life. However, **we heard** there is a clear link between polypharmacy and drug related hospital admissions. Polypharmacy increases the possibility of adverse drug events which can be misinterpreted as a new medical condition and additional drug therapy is then prescribed to treat this medical condition.

The importance of medicines management and optimisation across all four pillars is acknowledged through the involvement of the Medicines Optimisation Services for Older People (MOOP) Care home Specialist Pharmacists carrying out medication reviews in the development of the ECCF Falls pathway for care homes. The importance of being able to access medicines, including out of hours, for someone's care is discussed later in the Framework. Community Pharmacy Care Home Support Service (CPCHSS) works with care home staff on the development of protocols and procedures to facilitate the safe ordering, supply, storage, administration and disposal of medicines and appliances and reduce avoidable waste. This includes the day-to-day medicines management queries from the care homes to the community pharmacy.

We heard that a significant volume of the registered nurses' time in care homes is spent on medicines management and associated administration. We learned of pilot projects in the Western and Southern Trusts to explore '*Technician-led Medicines Management within Care Homes.'* Preliminary findings suggest that deploying a Pharmacy Technician resource to a patient facing role in a care home (whose role encompasses the full system), will improve overall quality of medicines management and safety; and reduce waste, medication errors and workloads. This will ultimately increase capacity to care and improve the lives of older people living within care homes.

Recommendations

People living in care homes should have:

- the Local Enhanced Schemes that are in place within GP practices (GPLES) to incorporate a person-centred medication review on admission to a care home and regularly thereafter.
- pharmacists embedded within GP surgeries. As the professional expert in medicines, they are well placed to provide a standardised medication review for residents on an annual basis. Certain high-risk drugs, such as antipsychotics, will require more frequent monitoring and review.
- evidence-based standardised medication reviews, incorporating "what matters" for the person and their family in line with NHS Scotland Polypharmacy Guidance Realistic Prescribing as evidenced by the iSIMPATHY project.
- technology utilised to improve medication safety, for example by use of virtual clinics or by enabling someone's prescribing data to be accessible across GP, community and hospital.
- clinical care in a care home that is registered to the Community Pharmacy Care Home Support Services (CPCHSS). This allows them to receive pharmaceutical care founded in safe and efficient supply and supported by an appropriate level of medicines optimisation.
- improved and enhanced safe and effective medication through optimisation of the skill mix of the pharmacy workforce providing services to care homes, to include roles for pharmacy technicians and pharmacy support staff.

The following underpinning system enablers should be developed:

- The establishment of a medicines referral pathway between pharmacy services in all sectors. This regional mechanism for pharmacists to refer will enable, for example GP, Advanced Practitioners or Community Pharmacists to refer for advice to a hospital-based specialist clinical pharmacy service, such as the Consultant Pharmacist led Medication Optimisation for Older People (MOOP) team with dedicated Specialist Case Management Pharmacists for care homes.
- Data to help support the safe and appropriate use of medicines for all residents of care homes, for example the development and utilisation of a set of prescribing indicators focused on improving outcomes and experiences of people living in care homes.
- The introduction of a Regional Medicines Code for care homes to improve safe medicines management processes within the care home setting.
- The introduction of phase two of the CPCHSS to include the review of a range of medicines safety indicators and support to manage conditions identified as at risk of deterioration.

11.12 Infection, Prevention and Control

Older people, people with a weakened immunity system and those living with long term conditions are all more vulnerable to severe illness from infections so whilst maintaining human rights people also have a right to be safe. Effective universal infection prevention and control (IPC) measures help support that.

Whilst having to strike a balance between creating clinically safe environments and one which is homely and personalised, people living in care homes should have their care provided by a care home team that is actively preventing and controlling infection. Staff adhere to IPC standards that are essential for safe, high quality care in all settings.

The Northern Ireland Regional Infection Prevention and Control Manual which is available here: PHA Infection Control | (niinfectioncontrolmanual.net) is intended to complement existing infection prevention and control (IPC) policies in individual Health & Social Care Trusts and other organisations and achieve standardisation in IPC across all Health-Care facilities.

Recommendations

People living in care homes should:

- be supported to maintain the relationships that enrich their lives, with their Human Right to a private and family life acknowledged.
- be able to access positive stimulation and relationships from engagement with community links that can nurture them spiritually and culturally. For example, local churches, libraries, museums, galleries and local facilities such as shops, bars and restaurants. This includes the voluntary and community sector, the work of local councils in supporting the health and wellbeing of older people and the mutual benefits from intergenerational connections with schools, nurseries and youth groups.
- live in a care home environment that is conducive to them carrying out their daily living activities. The environment supports them to engage fully in stimulating activities within the home and their community and maximises their independence, safety and quality of life. The physical environment embodies the twelve underpinning principles of Inclusive Design.
- be cared for by staff who are trained in and comply with the PHA Infection Control Manual.

11.13 Low mood, anxiety and depression

Transition to life in a care home is a major life event for people and those closest to them. This can result in low mood, for example from the loneliness of missing friends and family as they adjust to their new environment. However, while many people may wish to remain in their own domestic home, a care home that can offer the right sort of personalised support for their more complex needs and provide companionship, mental stimulation and a sense of security can be the most positive solution in someone's circumstances.

> ***It took me a while to accept that I was no longer living at home and no longer as independent as I previously was. My mobility is not so good, and I am very dependent now on people looking after me. That causes me frustration as I feel I should be able to do the things I used to be able to do.***

(From The Primacy of 'Home': An exploration of how older adults' transition to life in a care home towards the end of the first year)

We heard that talking to someone about how they feel, to understand what and who matters to them most is critical to their health and wellbeing throughout their life in the care home. Family, friends and everyone involved in providing care and support to that person, all have a part to play in working collaboratively to help them live life as they want it to be, as fully as it can be.

We heard of the importance of distinguishing between low mood and sadness that may be related to adjustment, compared with a more enduring depressive disorder. Low mood and depressive disorders often precede development of dementia and symptoms can be difficult to tell apart. Management begins with a careful assessment to determine cause, followed by a range of therapies which may include activity based interventions, psychological or pharmacological interventions.

11.14 Living with cognitive impairment

It is important to remember that someone living with cognitive impairment can live healthy and well with access to the right person-centred support to meet their needs. Their autonomy should be respected and their right to engage in shared decision making about their care when they have the underpinning capacity to make the specific decision. Where they do not have capacity, all decisions should be made in their best interest. It is evidenced in the 2019 report commissioned by the Alzheimer's Society from the London School of Economics and Political Sciences that 70% of people in care homes in England have dementia or severe memory problems.

Sometimes people living with cognitive impairment present with behaviours that can be difficult to understand and support. These behaviours can include a raised voice, resisting support with care or wanting to leave the care home environment. This usually happens when the person is trying to meet their needs and make sense of their world, which can be a confusing and frightening place for them. This can lead to significant stress for both the person and those who offer care and support to them.

We heard of the increase in recent years of people living in care homes with significant cognitive impairment. They are living longer and often with more complex co-morbidities that need clinical care. **We heard** that the identification and management of sudden onset confusion/delirium can be challenging for care home staff and can lead to the unnecessary distress of a hospital admission which, with the appropriate support, may have been avoided. **We heard** of people having to move from one care home to another to have their needs met, with an often traumatic impact on their health and wellbeing. With appropriate in-reach support they could have remained in the place they called home or remained there for longer. **We heard** of the importance of a suitably skilled workforce in care homes and the wider HSC system for enhancing the outcomes and experiences of people with cognitive impairment accessing clinical care.

Recommendations

People living in care homes should have:

- care that respects their autonomy and ability to make decisions where they possess the capacity to do.
- person-centred care provided by people with the right skills and experience to meet their needs.
- support to be understood verbally and in written material.
- support tailored to their needs to maintain connections with those most important to them. This should include access to technology and the support to use it.

11.15 Cognitive stimulation and nurturing the soul

People living in care homes should be able to benefit from remaining to be part of the surrounding community, with the richness to health and wellbeing that can bring. Health and wellbeing can also be influenced by their immediate environment. That could extend to the physical nature of the environment such as access, space, layout, fixtures/fittings, décor.

Diagram 10: Twelve underpinning principles of Inclusive Design

For people living in care homes, being able to see the people that matter most to them is critical to promote their sense of personal identity and is integral to their overall wellbeing. They must be facilitated to have visitors and where possible, to leave the home for visits to maintain family connections, their social networks and connections with their community.

We heard that communication between staff, the individual and the family during admission is highly valued by relatives. Particularly during this often difficult time of transition, finding out what matters most to someone and supporting them to maintain the personal connections that nurture them is key to their health and wellbeing as they adapt to living in a care home environment.

People living in care homes reflected upon the importance of connection with family and friends and receiving visitors.

> ***When I miss my friends, the staff let them know and arrange visits for me, this means the world to me.***

(From care homes in NI – Summary of feedback On care opinion platform Aug 2020 – May 2022)

11.16 Psychological wellbeing and spiritual support

Based on their core beliefs and values, spirituality can provide comfort, support and strength throughout someone's life. Supporting people to maintain their spiritual beliefs is an integral aspect of holistic, person-centred care. Spirituality can be expressed in many ways. For some people, spirituality may be expressed through faith and within a formal religion. For others, it may be expressed through music, arts, or nature.

Fear, anxiety, loss and sadness are all part of the normal range of experiences and emotions. Recognising these experiences and emotions and supporting the person to talk about them can help them to make sense of what is happening and feel cared for. It also enables people living in care homes to experience a greater sense of enablement, personal wellbeing and resilience in the context of illness, disease and life-changing or other social issues.

We heard about the importance of Advance Care Planning conversations including the person speaking about the psychological and spiritual aspects of their lives and what they need and want to happen.

We heard that spirituality and support for psychological wellbeing can become more important to a person as they grow older, are faced with chronic illness or enter palliative or end of life care. Some people want the person providing their spiritual support to be part of the overarching team support for them and their family, for example, when Advance Care Plans are being completed or when difficult clinical decisions are being made.

Someone may have been living in their care home for some time and have close relationships with others living there. **We heard** how important it was for them to access psychological and spiritual support at times when they observed the death, or serious illness of others living in the home whom they have come to care for. The same support needs of care home staff at these times should also be recognised.

Recommendations

People living in care homes should have:

- access to outdoors green spaces such as woods, meadows and parks, or blue space such as rivers, lakes and sea, where possible.
- spiritual support at the level of their choosing where they have identified that as important to them. Where possible, they should be enabled to have continuity of access, supported to attend their usual place of worship and to whoever provided spiritual support to them before they came to live in the home.
- acknowledgement of their potential need for psychological and spiritual support during times of bereavement. The potential needs of care home staff should also be recognised.

12. AN ANTICIPATORY APPROACH, SELF-MANAGEMENT AND EARLY INTERVENTION

The anticipatory model

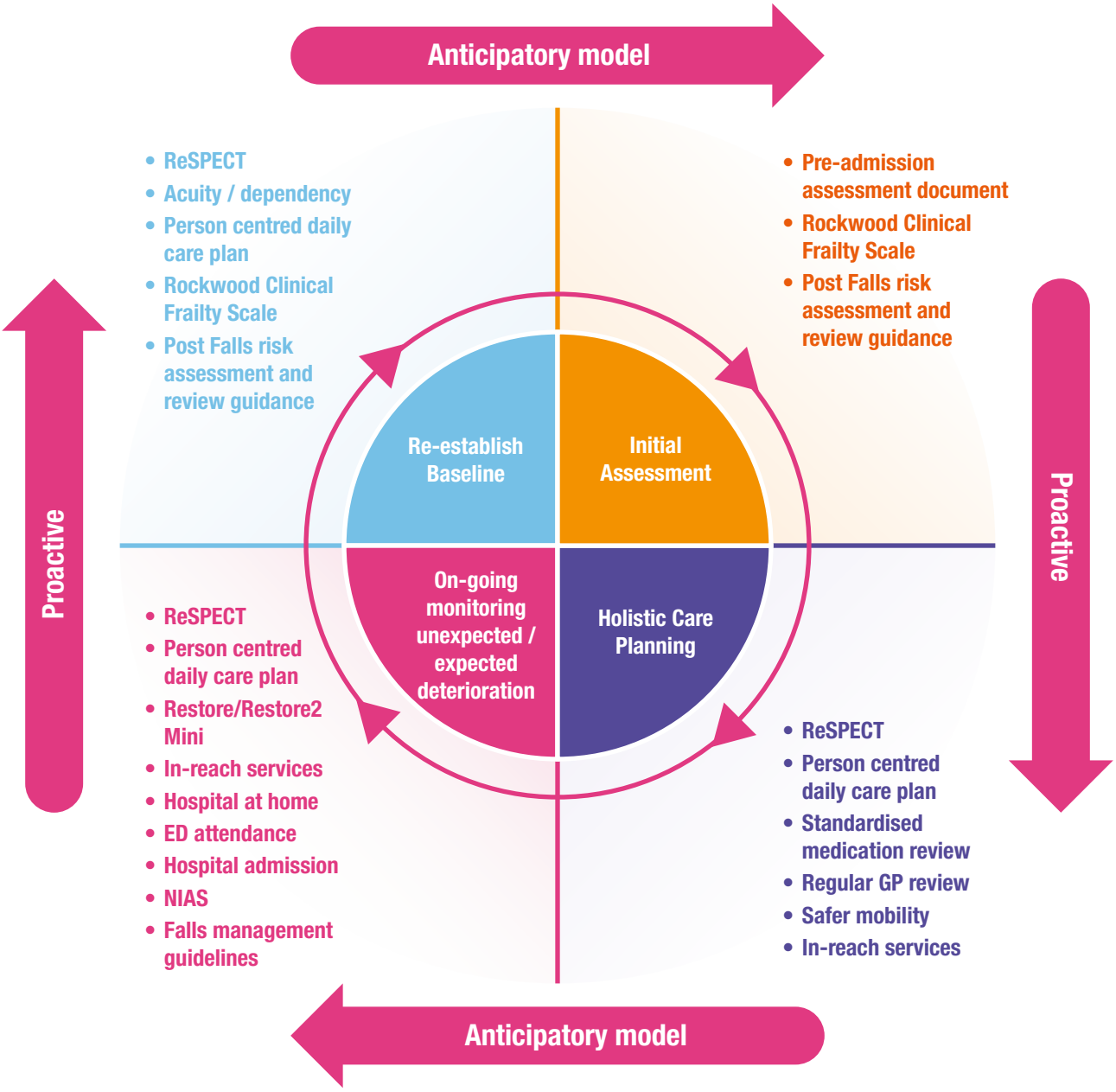
An anticipatory approach is the existing model used by care homes when working with someone to consider their day to day care needs and wants. The focus of the anticipatory model is on identifying potential clinical issues in advance of them developing and including them as part of someone's person-centred care plan for monitoring and any early intervention required. The anticipatory approach is further supported by the ECCF resources: the Pre-Admission Assessment incorporating the Rockwood Clinical Frailty Scale, the deterioration assessment tools Restore2 and Restore2 mini, the Falls Pathway and the Catheter Care Passport.

An Anticipatory Model for day-to-day care for someone living in a care home has been developed. The approach can be described as follows:

> ***The process of co designing a dynamic personalised care plan with the resident, family and care staff. The purpose… is to anticipate, avert or delay future decline through early identification of the resident need/s… This incorporates the resident's biopsychosocial needs. This is a living document reflecting the residents' care home living experiences…***
>
> Definition provided by Professor Kevin Brazil for the Framework

The model below illustrates how an anticipatory approach is incorporated into key elements of the Framework that links health care together for someone living in a care home.

Diagram 11: Anticipatory model



As can be seen in the model, multidisciplinary team working is critical to the success of taking an anticipatory approach.

Recommendations

People living in care homes should have:

- mobile, dynamic, proactive, person-centred care planning using an informed shared decision-making approach which is communicated to all those providing care and regularly reviewed and updated.
- care needs met through the recommended use of the regional, standardised ECCF resources and tools.
- the ability to have primary care from GP practice(s) or advanced practitioners aligned with their care home to promote continuity of care for the person and staff within the care home. People should be informed of the benefits of registering with these practices and be encouraged to do so. Their equitable right to have the GP of their choice, where they can, should also be respected.

People living in care homes require consistent connection with their General Practice team, which may include Advanced Practitioners, District Nurses and other multidisciplinary team members. This is essential for the ECCF innovative model of anticipatory care and early intervention. **We heard** directly from GPs and care home staff that the optional GP Local Enhanced Service (LES) supported enhanced engagement with GPs. Feedback was unanimous about the outstanding benefits brought by adoption of the care home LES. **We heard** it directly resulted in positive outcomes for people living in care homes, through the regular two weekly GP visiting pattern and the reassurance that was provided to them and care home staff.

People living in residential care homes can require additional support to maintain optimal health and wellbeing over the winter. **We heard** of a Winter Wellness Programme of work being undertaken in the Northern Health and Social Care Trust within residential homes. The programme was focused on preventing further decline through clinical and medication review, thus averting the need for acute hospital care intervention where it was appropriate and safe to do so. People living in care homes, their families and care home staff reported a greater degree of person-centred care and increased confidence and assurance from the service provided under the programme.

> ***It was so nice having the nurse in for a chat. She gave me a full check-up. It was very reassuring.***
>
> Resident

Mum had a lovely experience with the nurse who reviewed her care. She came back a couple of times after to see how Mum was. Mum felt very well looked after. She made sure she had a medication review with the GP and District Nurse.

Family Member

12.1 Supporting self-management

Care should be taken that people living in care homes are not disempowered simply because they live in a care home. They are often the experts in their own illness. Whatever their individual characteristics or challenges, the focus must be on what someone can do. Enabling self-management and protecting and encouraging someone's self-esteem empowers them to stay active and mentally healthy, as well as physically. Self-management applies to both the activities of daily living and the medical conditions someone may be living with. The autonomy of the individual should be respected and their tolerance of any risks inherent in self-management identified with them and plans put in place to prevent or mitigate that risk whilst supporting independence.

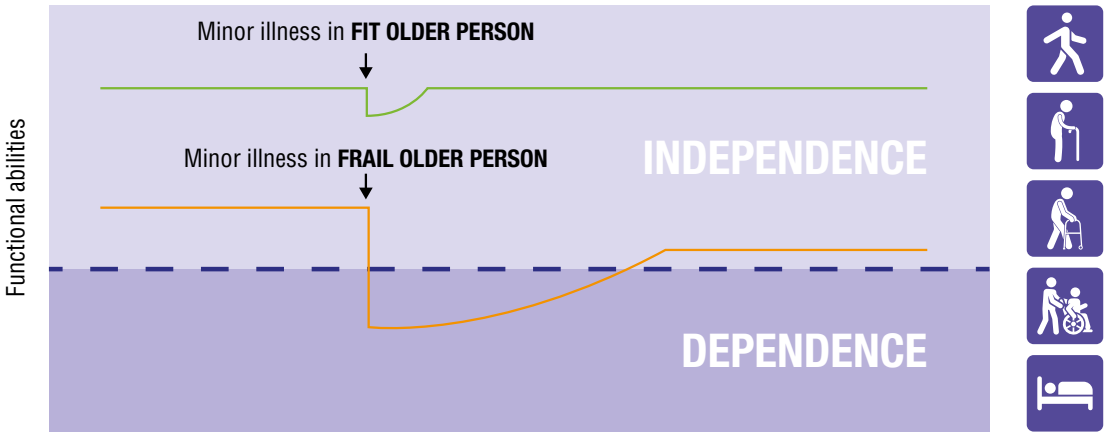
In supporting self-management it is important, especially at times of transition, to acknowledge the expertise that someone and/or those closest to them has about their health, well-being and disease management. As with the ECCF Pre-Admission Assessment Document, supporting people to talk about what matters most to them and the tailored support they need to self-manage will encourage self-esteem to empower and enable them to manage aspects of their health.

In addition to the MDT team described in Diagram 7 (page 22) supporting self-management is a role for the wider care home team. For example, the daily ongoing support from social care staff that optimises independence and well-being and the support from nursing staff to self-manage medications with appropriate supervision. **We heard** that for those whom self-management is not possible, or becoming less attainable, care home staff should optimise those aspects of self-management still attainable by emphasising capability.

Some people living with a range of conditions in adult care homes, for example cognitive impairment, visual or aural impairment, or a learning disability will need more support to be involved in decisions that influence self-management, for example, conversations around their abilities and tolerance of risk.

We heard that identifying frailty is key to supporting people to self-manage. Over the next 10 years, those aged 65+ in the population in NI are expected to increase by over 83,000 which is a growth of 23% (https://vimeo.com/757240574/7f8d0a8b62). There is a challenge in supporting people to self-manage as Frailty is not routinely identified. across the region, including in care homes. The ECCF Pre-Admission Assessment Document incorporates the Rockwood Clinical Frailty Scale. During every clinical change episode with someone aged 65 and over they should have a Rockwood Clinical Frailty Scale completed, where appropriate. This will help identify deterioration in frailty and support someone to receive the right services and interventions at the right time to achieve optimal outcomes for their health and wellbeing.

Diagram 12: Frailty



Recommendations

People living in care homes should have:

- the support they have said they need to self-manage. This is documented in their care plan, so all staff know about and respect those wishes.
- their families involved as partners in supporting self-management where appropriate and in line with someone's wishes.
- a care home team around them who know their role in supporting someone to self-manage as they wish.
- an assessment using the Rockwood Frailty Scale for those aged 65+ where appropriate.

Frailty should be routinely identified across the region. The data obtained should be used to identify the needs of the care home population and enable them to access the services they need to live as healthy and well as possible.

12.2 Remote monitoring

Early identification of risk and prompt clinical intervention reduces further decline and inappropriate admission to hospital. Remote monitoring could be used as an adjunct to soft clinical signs to enable care home staff to seek earlier advice and support for those at risk of deterioration.

Remote monitoring includes Virtual wards which allow people living in care homes to access the care they need at home safely and conveniently, rather than being in hospital. The NHS, particularly in England, is increasingly introducing virtual wards to support people at the place they call home, including care homes. Remote monitoring can also involve the use of equipment, such as wearable devices, that are used to monitor someone's health while they can remain in their care home and enable early intervention.

Recommendation

People should have access to:

- digital technology and equipment to enable remote monitoring to assist care and decision making when appropriate.

12.3 Early intervention

For people living in care homes, early proactive intervention is critical to support their overall wellbeing, to maintain health and to reduce potential deterioration. For example, through early detection of hearing loss, the person can be supported to remain engaged and involved in the life of the care home. This helps reduce the risk of withdrawal, isolation and depression. Early recognition of changes in someone's condition allows for earlier intervention for prevention by the right professional, at the right time and in the right place.

We heard of the importance of staff having the skill and experience to identify early cognitive changes. This is vital to ensuring that someone living in a care home has access to the same interventions and standard of dementia care as those living in their own home. This may include differential diagnosis of reversible or non-progressive causes of cognitive impairment, multidisciplinary dementia care including intervention for distress, or timely palliative care.

We heard that many of the care home population are living with complex medical conditions and require input and regular monitoring from specialist services so care interventions can be accessed as early as possible. People should be supported and have access to transport to enable them to attend hospital-based clinics where this is possible and will not cause distress. Where this is not possible, specialist input into the care of the person living in a care home should be adapted to the situation. This may be by telephone, a virtual ward, video consultation or by visiting the care home.

We heard that to prevent or mitigate the impact of medical appointments that consideration should be given to the introduction of multimorbidity specialist review clinics. Here, one attendance would cover all aspects of specialist care thus minimising numerous current overlaps at existing clinics such as diabetes, heart disease, dementia and COPD.

There is also a role for community healthcare teams, including advanced nurse practitioners, district nurses, pharmacists and AHPs in supporting care homes to manage conditions identified as a result of care home staff monitoring deterioration, with a view to reducing calls to General Practice. This includes ensuring appropriate management in the administration of 'time critical' or 'high risk' medicines.

Recommendations

People living in care homes should have:

- the same interventions and standard of dementia care as those living in the community.
- regular planned reviews from specialist services for complex medical conditions. These should make the best use of technology to prevent/mitigate the impact of hospital attendance without affecting the outcomes and experience of care provided to someone.
- access to multimorbidity specialist review clinics.
- access to community health care teams, including advanced nurse practitioners, district nurses, pharmacists and liaison nurses e.g. tissue viability to support care home staff.

13. URGENT AND EMERGENCY CARE

The following definitions are used in this section:

Urgent - An illness or injury that requires urgent attention but is not a life-threatening situation.

Emergency - Life threatening illnesses or accidents which require immediate intensive treatment.

The Northern Ireland Ambulance Service (NIAS) told us that of the 20,868 NIAS 999 calls made from care homes in 2022/23, the person was discharged at the scene in 3921 cases (18.7%). Some of these calls may not have required the services of NIAS. NIAS told us that the busiest day for calls from care homes was a Friday and the busiest time for calls was between 11:54 and 12:39. This means that both NIAS and the care homes are seeking access to the same services during the hours those services are available, for example GPs. This is reflected in the Framework's overarching recommendations for direct referrals to relevant services and a single point of contact where appropriate.

Not all urgent care needs require a hospital or other clinical setting. People living in care homes should have equitable access to the required services in their home environment based on what matters to them. This could be either through appropriate multidisciplinary services coming into their care home or by care home staff empowered by appropriate training and support and with access to the multidisciplinary clinical support they need to do so.

We heard that not all care homes have the facilities to provide urgent care and hospital can be the only avenue for exploratory investigations. However, people with severe frailty often do not wish to have hospital-based assessments and investigations. Many would rather be at home and choose not to go to hospital (The Geriatric Emergency Department Collaborative (@theGEDC)/Twitter).

We heard about the difficulties for people living in care homes accessing some urgent care services that are only available through someone attending in person, for example the GP, Optometrist, or dental practice. The role of GPs as expert generalists in providing urgent and emergency care and advice is critical. People living in care homes can unexpectedly become acutely unwell and should be able to access services provided by a

GP practice who are familiar with them. **We heard** from care homes and GPs of the significant enhancements to clinical care for people living in care homes when GP practices provided additional, aligned in reach to a specific care home as envisaged by the GPLES. **We heard** that the regular two weekly GP visiting pattern was key to success.

Urgent Pandemic Packs that were supplied to care homes for the care of people requiring clinically urgent treatment, for both COVID-19 and non-COVID-19 conditions helped them access medication out of hours. **We heard** that access to "just in case medicines" and "anticipatory medicines" were beneficial for care homes.

On those occasions where hospital attendance and/or admission is the correct approach based on an individual's wishes and/or clinical need, someone living in a care home must have equitable access to the hospital based healthcare they require, including an Emergency Department (ED).

Even when warranted, the impact of attending hospital can provoke upset and deterioration for many people living in a care home, depending on their individual characteristics. It can be a very distressing and confusing experience for older people attending EDs as evidenced by Care Opinion.

We heard that respect for the autonomy of people living in care homes with the mental capacity to make their own decisions is paramount. Decisions about what matters to them and what they want to happen in urgent and emergency care situations should be included and adhered to in the plans for their care. Out of hours and agency staff involved in decision making should be informed of any Advance Care Plan.

As appropriate, families should be included in decision making. **We heard** how important it was that families were supported to understand the implications of the decisions being made. This is especially important when the wishes of the family are not in accord with those identified in someone's Advance Care Plan, for example the circumstances when an ED attendance is not appropriate.

We heard that informed shared decision making in situations where urgent or emergency care is needed can be significantly challenging, for example around end of life. Effective, compassionate communication between everyone involved is fundamental. People living in care homes should be encouraged to have an Advance Care Plan in place and make use of the ReSPECT document when made available by the Department of Health.

Recommendations

People living in care homes should have:

- timely access to urgent care in and out of hours. This should include access to Intermediate Care such as Hospital at Home to allow individuals to access acute level care within the care home when appropriate and in keeping with their choices around place of care.
- access to care such as behavioural science, mental health, learning disability, hospice expertise and expert pharmaceutical advice.
- the urgent services they need, delivered within their care home, as much as possible. Care homes should not be over medicalised but people living in care homes should be able to access for example mobile X-rays, ultrasound scans and ECGs.
- access to staff who are suitably trained to administer intravenous prescribed medication to treat conditions such as dehydration, infection and heart failure where appropriate. Obtaining arterial blood gas or other investigations through point of care testing should be explored.
- support while attending a hospital for urgent and emergency care.
- the pharmaceutical support they need. At point of discharge from hospital or any other care setting, up to date information about medicines should be communicated and appropriate supply of medicine provided to facilitate safe and effective delivery of care. Further work should be progressed around access to “in” and “out of hours” medication for care homes.
- the ECCF recommended resources available to help inform clinical decision making in the identification of deterioration that may need urgent care (the Rockwood Clinical Frailty Scale, Restore2 for nursing homes and Restore2 mini for residential homes).

14. PALLIATIVE AND END OF LIFE CARE

Principles and Values

People living in care homes should be able to access palliative and end of life care, incorporating the WHO 2020 narrative for principles and values around this.

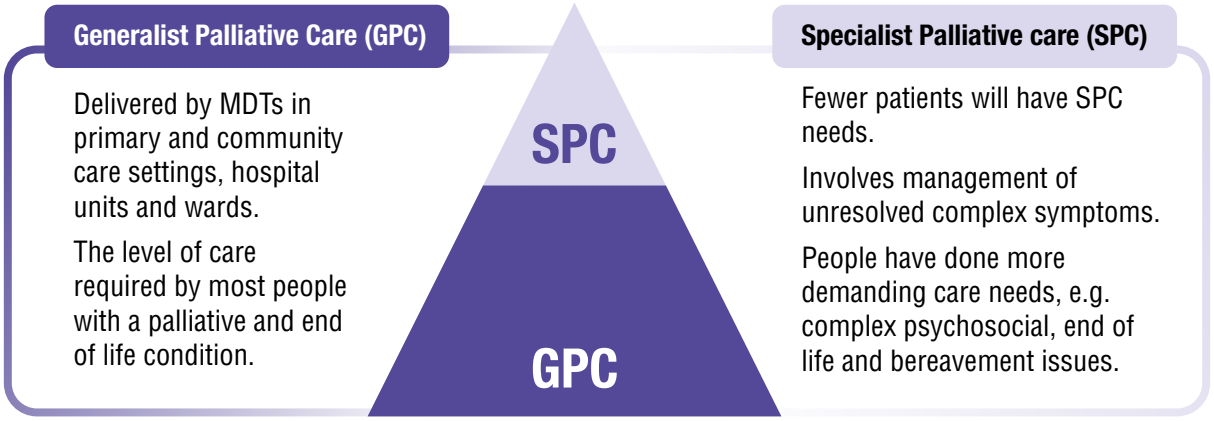
Definitions

Thanks to advancements in medicine and improvements in targeted treatments, more people are living longer with treatable but non curable conditions and with a good quality of life. As a result, more people in care homes are living with co-morbidities/long-term conditions, such as diabetes, cardiac disease and respiratory illnesses and using polypharmacy to manage them. Given these characteristics many are receiving palliative or end of life care. Commonality of language across organisations and professions is a key element of the Framework. To ensure a common understanding, the Framework uses the following definitions:

- **Palliative care:** the active care of a person with advanced progressive illness. Management of pain and other symptoms along with holistic support is paramount to achieve best quality of life. Many aspects of palliative care are applicable earlier in the course of the illness in conjunction with other treatments.
- **End of life:** a period of time during which a person's condition is actively deteriorating to the point where death is expected, usually estimated within the last twelve months of life. End of life care addresses the holistic needs of people who are approaching death.

Diagram 13: Generalist and specialist palliative care

The pyramid diagram explains **generalist** palliative care, and **specialist** palliative care provided by expert professionals.



People living in care homes must have access to tailored MDT support to mitigate the general effects of ageing, such as difficulties with eating, drinking and swallowing to live as well as possible. The general effects of ageing, combined with cognitive impairment such as dementia or delirium, can make it difficult to recognise pain and other symptoms when someone's condition deteriorates. Proactive, specialist support may prevent crisis admissions to hospital and the associated detrimental impact on health and wellbeing.

We heard that many staff working within a care home have significant experience and expertise in providing palliative and end of life care. They can provide most of the care for someone who is approaching end of life and enable them to die in the place of their choice. **We heard** of the importance that they have at least a foundation level of skills and knowledge in palliative care and understand the importance of ongoing, timely and sensitive communication.

Care home colleagues told us of challenges around Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) conversations, including the non-transferability to care homes of previous decisions made in a hospital setting. Revisiting discussions can cause distress to individuals and their families at an already difficult and emotive time.

Recommendations

People living in care homes should have:

- wherever possible, transferability of decisions and planning facilitated between different settings, for example hospital and care homes. The person and their family should be involved as partners.
- equitable and timely access, including out of hours to palliative and end of life care, including specialist palliative care based on their needs and wishes.

Health and social care bodies should ensure their palliative care strategies and service delivery plans recognise the important role played by care homes in providing palliative and end of life care.

Identifying palliative and end of life needs

People living in care homes should have their palliative and end of life needs identified early using appropriate tools so they can access timely, coordinated care that maximises their quality of life. Using the ECCF Pre-Admission Assessment Document and recommended deterioration assessment tools Restore2 and Restore2 mini covers clinical information and crucially information on "what matters most to me" for that person. This includes thinking about the future palliative and end of life care they want. Care homes involved in the testing told us:

> ***…It gives you a Framework to raise difficult topics, e.g., deprivation of liberty, do not resuscitate…***

All staff in a care home should know who is receiving palliative and end of life care, including agency staff. That information should be easily accessible to all those who are providing care and be adhered to. This is particularly important for any emergency care needs. **We heard** from NIAS that they have attended care homes in an urgent or emergency situation where an Advance Care Plan is either not in place or cannot be located. A register maintained by their care home would assist in easily identifying those people who are actively dying to ensure their wishes are known and met.

Recommendations

People living in care homes should have:

- their palliative and end of life care needs identified early and their needs and wishes regularly reviewed.
- their needs and wishes identified on a palliative care register maintained by their care home.
- the ECCF Pre-Admission Assessment available to ***identify*** care needs that may be palliative and/or end of life care and Restore2 and Restore2 mini available to ***identify*** deterioration that may need palliative and/or end of life care.

Assessing palliative and end of life care needs

We heard that regional best practice assessment tools would support someone receiving the optimal care they are entitled to. Any assessment of needs must take a holistic approach. Someone can be distressed about more than pain and other physical symptoms. All the domains of palliative care which may be contributing to their distress (physical, psychological, spiritual and social factors) should be carefully considered. Ongoing, proactive assessment of their palliative and end of life care needs necessitated by their symptoms and condition should take place. This ensures their care plan continues to reflect their values, beliefs, and preferences.

Examples of regional tools include the Advance Care Plan, the Pre-Admission Assessment Document which incorporates the Rockwood Clinical Frailty Scale and deterioration assessment tools Restore2 and Restore2 mini.

Recommendations

People living in care homes should have:

- holistic assessments of their needs that are proactively reviewed.
- an Advance Care Plan and the ECCF recommended tools Restore2 and Restore2 mini available as part of the suite of documents that ***assess*** palliative and end of life care needs.

Work should be undertaken to review and update existing regional assessment and monitoring best practice tools for palliative and end of life care.

Meeting palliative and end of life care needs

Where possible, people should be supported to die well in the place they call home. Care should be provided with continuity and compassion. Where appropriate, that should include information about the purpose of palliative care, potential disease trajectory and, where requested, the process of dying. This should be provided by the most appropriate person and in the best way to ensure understanding. Care should be integrated between the individual, those closest to them and all those providing their care. **We heard** of the difficulties for someone living in a care home accessing integrated palliative and end of life care, including out of hours. **We heard** that there could be variation across Trusts and GP practices in the palliative services people in care homes could access. This was especially true for those with complex and/or unresolved needs. A regional approach has been developed to support practitioners and organisations in implementing the model of care set out in (Living Matters Dying Matters, 2010).

Everyone involved in someone's palliative care should be clear about their respective roles and responsibilities for delivering what that individual wants. **We heard** that GPs have a critical role in providing palliative and end of life symptom management and that someone living in a care home must have appropriate, timely access to support from a GP practice.

Where required, people living in care homes should have access to emotional and intellectual support to make informed choices about their palliative and end of life wishes. Where someone, even with support, cannot articulate their choice, families should be fully involved to obtain their insight about what that person would have wanted. It should be recognised that where families are involved, they too may require support to articulate their views on behalf of their loved one and to understand the implications of decisions being made.

We heard that in reality, there are many instances where those conversations have not taken place, either prior to someone's admission or during their time in the home. **We heard** that Advance Care Plans could either not be known about or not be easily accessible to all those providing someone's palliative and end of life care, for example when agency staff were on duty or at times of crisis. There are also occasions where care home staff have had no time to get to know someone's wishes, for example, they came to live in the care home for the first time to receive their palliative or end of life care and died soon after admission.

We heard that care home managers did not always have timely access to the medicines and equipment they needed to provide the care someone required, for example syringe drivers. **We heard** that an HSC Trust specialist clinical pharmacy team for palliative care is in development as part of the MDT support for someone with complex palliative care needs.

We also heard that some Specialist Palliative Care Pharmacists have already provided training on palliative care medication to nursing home staff. **We heard** of legislative and contractual barriers to requisitioning and holding a stock supply of medication for an individual living in a care home.

Recommendations

People living in care homes should have:

- timely access to integrated, palliative care that is regularly reviewed based on need.
- access to holistic support to make choices about their palliative and end of life care.
- their, or their families, decisions about palliative and end of life care easily accessible and adhered to.
- access to sufficient equipment within their home, including out of hours.
- a review of medication at the end of life for symptom control that reflects their values and preferences, including discontinuation or refusal of treatments.
- access to a pharmacist or GP trained in the use of palliative care medicine in order to optimise the delivery of safe and timely medicines, for example via the Community Pharmacy Palliative Care Network.
- anticipatory medicines available when assessed to be in their last weeks of life. Effective management processes including governance and safeguards should be established.

Agency care home staff should have a single point of contact to obtain clarity from a suitably informed, permanent member of care home staff.

A Consultant Pharmacist led specialist clinical pharmacy network for palliative care across all Trusts should be established as an underpinning system enabler.

Someone may have been receiving palliative care for some time but their approaching death can still have a significant impact on their family. The care home team and those living there will often have come to know that person well and find the situation deeply upsetting. **We heard** that identifying and meeting any emotional and spiritual needs is particularly important.

The overarching ECCF Framework is an enabler for that to happen. As a family member told us, when best practice is not followed, “dignity, comfortable and familiar are being contrasted with the inhumane, needless and unfamiliar.” **We heard** of instances where someone nearing their end of life had been unnecessarily exposed to the associated trauma of an ED when that was not their wish when the care home could have met their needs with appropriate in-reach support.

While there can be many variables around decisions being made at this most challenging of times, NIAS shared the following compliment received from a family member describing their experience of end of life care:

> ***I want to give a very sincere thank you for the most professional, caring and compassionate 'First Responder' service on the 17th/18th Jan, when I got a call from the xxxxxxxx care home in xxxxxxxx. My mother in law was very unwell and I was unsure if she was 'fit' for a trip in an ambulance to hospital.***
>
> ***She had recurrent kidney infections and had been weakened by failing kidneys. Her breathing had become laboured, and our main concern was about ensuring the 'right' decisions would be made, and she would have dignity, comfort and family beside her.***
>
> ***The First responder xxxxxxxx was a 'God send', he really took a speedy assessment of her situation and helped us steadily come to the 'right' decision. The on call doctor had recommended she go to hospital, but I felt it was inhumane to needlessly drag her out of her bed and familiar surroundings and possibly hasten her fatality.***
>
> ***So, when we were assisted to make the right decision, she remained comfortable with assistance of oxygen and family around her and 2 hrs later she peacefully passed away.***
>
> ***So, the family wish to thank this invaluable service and specifically xxxxxxxx for his compassionate, careful and knowledgeable decision making in our desperate hour of need.***

We heard that support tailored to those grieving for someone is often not available and the impact on the health and wellbeing of others living in the care home can be profound. A Bereavement Charter sets out pledges to those who have been bereaved about the standards of service and care they should expect to receive following the death of a loved one. The Patient Client Council are working on the co-development of a Bereavement Charter for Northern Ireland.

Recommendations

People living in care homes should have:

- support tailored to their needs when grieving.
- spiritual and bereavement support made available. When required, this support should be extended to families, friends and staff providing care.

When available, the NI bereavement charter should be adopted by all those working in and with care homes and used to guide the support that is offered to those who are bereaved.

15. UNDERPINNING ENABLERS FOR THE FRAMEWORK

We heard of enablers that the wider HSCNI system needs to have in place, or needs to develop, as underpinning support for the best practice described in the Framework. They enable the enhancement of clinical care in care homes through focusing on improving the outcomes and experiences of that care for people living there. They relate to making best use of digital technology in the care home sector and what is required to support that, the collection of data against an agreed common data set and matters around the care home workforce.

DIGITAL TECHNOLOGY

Virtual Wards

Following learning from COVID-19, the NHS in England is introducing more virtual wards to support people to receive their clinical care in the place they call home, including care homes. This includes care that may otherwise require hospital admission. Support from a virtual ward can include remote meetings and monitoring by the multidisciplinary team supporting the care home team to provide health care to someone living there.

We heard of the positive experience here in Northern Ireland during COVID-19 of the use of digital technology by care homes and those supporting them to enhance clinical care for someone, including in enabling “virtual wards”. The potential of virtual wards should be explored so people living in care homes and the staff who care for them, could be supported to manage health conditions within the home and thereby reduce the potential impact of a hospital admission.

The use of virtual wards to provide care for people living in care homes should be subject to appropriate governance and monitoring arrangements, to ensure it is delivering optimal, person-centred care in line with the individual’s wishes and needs.

Digital Care Home Plan

The role of digital technology in health and social care has never been more important. As society becomes more digitally advanced, the care system will need to keep pace to ensure equitable access for the people who live there. For example, access to virtual appointments and personal health data.

We heard of the need to develop the use of digital systems and the skills of care home staff to best utilise them. The Digital Care Home Plan (DCHP) is a foundation enabler of the Framework. It responds to the current and emerging need of individuals living in a care home, care home providers, staff and families, to realise the benefits of digital technologies. It outlines the vision, mission and objectives for a regional, standardised approach for the digital enablement of care homes, focused on the needs of people living there. It also considers what capabilities will be required across the wider HSC system to successfully deliver these needs and deliver the best equitable clinical care.

The DCHP supports delivery of the NI Digital Health & Care Strategy and is aligned and informed by a wide range of regional strategies, plans and programmes, including the Framework.

We heard of advantages for people living in care homes of relevant care home staff gaining the appropriate level of access to information about clinical care available to their equivalents working in HSCNI through the NI Electronic Care Record (NIECR). For example, care home staff being able to access accurate, timely details of someone's medication or upcoming medical appointments would help ensure that individuals are fully and correctly accessing the medication they need and attending the required clinical appointments to keep themselves as healthy and well as possible.

On behalf of the care home sector, the project team engaged with colleagues involved with access to the NIECR and also the strategic Encompass programme for the digitalisation of the HSCNI system.

Work is in the initial scoping stages for a strategic project that will include consideration of all independent and voluntary sector access to NIECR, including Nursing & Residential care homes. The Digital Strategy Health and Social Care Northern Ireland 2022-2030 Portfolio Board has approved the recommendation to give Nursing and Residential homes appropriate access to EPIC as part of the Encompass programme.

DATA

We found that information about the care home population is limited and does not include detail on population health needs of the people living there. This information is essential for planning to meet the current and future clinical and support needs of that population. We found that there are no agreed common data sets for the care home sector that are focused on monitoring and improving the safety and quality of outcomes and experiences of care delivery for people living there. **We heard** repeatedly of the need to develop the data currently available on the care home population, realising the benefits of the use of digital technologies when doing so. Data needs to be accurate, timely and easily accessible, preferably through it being held and maintained by a central source.

WORKFORCE

Workforce issues within care homes are longstanding, such as the need for stability and suitably skilled and experienced staff to deal with the increasing complexities of people living there. The situation has become even more challenging for the care home sector post COVID-19. Many of the workforce issues are being progressed by the Department and includes the Reform of Adult Social Care. Leadership is also supported in the care home sector through initiatives such as the 'My Home Life' programme at Ulster University.

Diagram 14: MyHomeLife

The My Home Life Leadership Support Programme funded by the Department of Health and delivered by Ulster University, is an international initiative that promotes quality of life and positive change in care homes for older people. The My Home Life Programme has been specifically designed to meet the unique needs of care home managers and staff in leadership roles by supporting them to include quality of life for people living there, relatives and staff. The project focuses on three work streams:

- Facilitating the care home sector to pilot and test new ways of working and sharing the evidence base for best practice.
- Delivering local packages of engagement and support to enhance leadership and encourage quality improvement.
- Engaging locally, regionally and nationally with policy makers, practitioners, care homes and the public to take forward a shared vision for quality of life.

The need to get these things right for the care home workforce to improve outcomes and experiences of those they care for, is a fundamental enabler for the enhancement of current care to the best practice described in the Framework.

The CNO is leading work to implement the findings of the Nursing and Midwifery Task Group which includes nursing in care homes. Workforce issues include stabilisation and education and development. Service delivery and reforms include a District Nursing Framework, designed to enable delivery of 24-hour district nursing wherever you live. Other lead clinical professionals within the Department, including the Chief Dental Officer and Chief Pharmaceutical Officer, are working to develop or review strategies. They take a regional, equitable approach to care provision whether provided to people living within the community or within a care home setting.

A “whole home approach” points towards improved outcomes for people living in care homes when a dedicated service is in place. **We heard** of the importance of leadership within the home to ensure the wider care home team are promoting quality of life through shared learning and evidence based practice.

Career pathways

It has long been recognised that making the sector attractive to work in is a key factor in staff recruitment and retention for care homes. Career pathways within the sector, including routes into the social work and nursing professions, are being developed by Northern Ireland Social Care Council (NISCC) and Northern Ireland Practice Education Council for Nursing and Midwifery (NIPEC) for those working in the sector.

Training and development for the care home team

Under their respective standards, it is the responsibility of residential and nursing homes to ensure that people living there have their needs met by staff suitably skilled and competent to do so. We looked at some things that would enhance staff training and development. For example, working with care homes to coproduce a Learning Needs Analysis tool to identify and record training and development needs of registered nurses working there. **We heard** of the need for care homes to have access to training courses based on what they need and in a way that meets the particular demands for the sector. For example, e-learning rather than classroom based can make training more accessible, given the demands of the independent sector.

The Framework recognises the critical, integral role of social care in promoting and safeguarding health and well-being. The social care workforce is the largest in both residential and nursing homes. It is critical that they have access to the training and development they need. It is their skills and knowledge that supports people when they move in and throughout their journey to retain their sense of self-esteem, personal identity, family connections, social networks and community connections. This, along with optimal clinical care, is a fundamental element in holistically enabling someone in a care home to live their life as contentedly and fully as they can.

> ***I love the staff here as they always do my hair and nails. I have made lots of friends in (name of care home) and enjoy the fun and games. The staff would do anything to make you happy and I enjoy having chats with them."***
> *(From Care Homes in NI - Summary of feedback on "Care Opinion" Platform Aug 2020-May 2022)*

Acuity tool

We heard that a care home Acuity tool is of key importance in enhancing access to clinical care for people living in care homes.

Assessment models developed for safe staffing in other areas, such as hospitals, are currently being used by care homes. Care homes told us that these models are out of date and, most importantly, do not reflect the complexities of the care home population. No one existing model meets the sector's needs. Discussions by the CNO with her counterparts in England, Scotland, Wales and ROI around shared learning and the potential co-development of a care home Acuity tool have commenced.

16. OVERARCHING RECOMMENDATIONS

Below are the overarching recommendations across all four pillars which should be read in conjunction with the individual recommendations of each pillar. A full table containing all the ECCF recommendations is available here.

Section	Recommendation
Overarching recommendations	The legislative framework around care homes should be reviewed to take account of the changing characteristics and increasing complexities and comorbidities of that population over the last five to ten years.
	Meaningful communication and conversation with the person accessing their clinical care and support in an environment that is sensitive to their needs is key. They should be fully involved in informed shared decision making about that care and about "what matters most" to them. Their tolerance of risk is identified and informs the care and support provided. They should have appropriate access to information held about them.
	The role of the family is a key contributor in supporting someone to stay healthy and well. Where the person themselves cannot express their wishes, those closest to them must be fully involved in informed shared decision making about that care, appropriately supported to do so if required. Families should have appropriate access to information held about their loved one.
	Everyone living in a care home should be encouraged and supported to have an Advance Care Plan in place that records their wishes about health treatment and care.

Section	Recommendation
	The support of GP practices is critical to the Framework. The individual's human right to retain a GP practice of their choice must be respected but evidence also shows enhanced outcomes and experience when people living in care homes have access to GP practices aligned with the home. The benefits of registration with the GP practice linked to the care home should be emphasised. It does not necessarily need to be the GP in the practice providing the support. For example, a pharmacist within the GP practice could conduct a standardised medication review as part of planned healthcare and provide expert medication advice.
	There should be single point of contact for care homes to access clinical support, including out of hours for someone who needs it, such as GPs, hospital based services, dentistry and pharmacy.
	Where appropriate, care homes should be able to make direct referrals, including out of hours services, to relevant services in the multidisciplinary team wrapped around someone to provide their care.
	People in care homes should access care provided with continuity by the right clinician at the right time and right place for them.
	There should be standard regional clinical pathways and assessment tools available for people living in care homes. This will increase optimal care by reducing variations in process and practice and by introducing common terminology and a minimum data set. Existing community and hospital documentation should be standardised across the region and common terminology used.

Section	Recommendation
	Equitable access to integrated multidisciplinary, collaborative working across boundaries of organisation, sector and profession, focused on meeting someone's needs is a fundamental right for people living in care homes accessing services. This includes GPs, NIAS, RQIA, community services and care home and Trust staff. Accessing this support is of critical importance to health and wellbeing at times of transition for someone. This includes moving to live in a care home, moving between care homes, moves between services, for example adult mental health services to Older People's Mental Health services and admission or discharge from hospital. This will require further changes in culture and practice across a range of organisations and professions.
	There should be shared IT platforms to support optimal, integrated care through improved data sharing between health and care professionals across sectors, and services. The person and their family should have appropriate access to the information held about them. Care homes and NIAS should have appropriate access to NIECR and Encompass, and their voice should be included in strategic work taken forward by government Departments and Trusts. Technology should be fully utilised to facilitate virtual consultations, remote monitoring and wearable devices. This has the potential to enhance proactive care and indicate the need for early intervention.

Section	Recommendation
	To enable optimal, safe care, everyone responsible for providing someone's care should have the appropriate underpinning training and education support to do so, including specialist palliative and end of life training and experience. Training must be based on what care homes say they need. Opportunities should be accessible to the wider care home team not just clinical staff and be provided in the way most suitable for the characteristics of the care home sector. Registrants Learning Needs Analysis tool developed by the project will support the identification of the registered nurse's needs. Technology should be fully utilised as an enabler for training and development in the care home sector, for example e-learning rather than classroom based.
	A bespoke acuity tool should be developed for the care home sector. This will enhance the confidence of care home managers in the identification of safe staffing against the assessed complex needs of people living in a care home. A suitable acuity tool is the solution to inform a staffing model that will meet the assessed needs of people living in a care home.
	To reduce variation in provision there should be standardisation of Trust in-reach teams taking account of local population need. Trust teams should take a "whole home approach" with partnership working between people living care homes, their loved ones, AHPs and care home staff.
	The Role of Advanced Nurse Practitioners and Advanced Allied Health Professional Practitioners as part of the team wrapped around someone living in a care home should be fully utilised to enhance outcomes and experiences of clinical care.
	Prevention, early identification and intervention is critical to maintaining health and wellbeing/preventing deterioration for someone living in a care home.

17. NEXT STEPS

Collaborative Forum. The intention is that ECCF Phase 2 (Implementation) stage will be taken forward by the DoH Social Services Policy Group under the auspices of Workstream 3 of the Social Care Collaborative Forum. This will provide the structures and linkages to other strategic and policy work within the Department required to progress ECCF. It will also provide the appropriate governance arrangements as the Collaborative Forum is accountable to the HSC Performance and Transformation Executive Board (PTEB) chaired by the Permanent Secretary of the Department.

The partnership approach taken by ECCF Phase 1 (Development) stage will continue. The voices of people living in care homes, those closest to them and staff working in care homes to provide clinical care and support will remain central to work being undertaken. Those members representing organisations will have the required level of decision making and operational influence within their organisation to ensure work is taken forward.

18. GLOSSARY

Term	Definition
Acuity tool	A tool used to accurately assess patient need and dependency and to inform staffing models.
Acute Care	Acute care is where a patient receives active, short-term specialist support and treatment for a condition. This can include treatment for a severe injury, period of illness, urgent medical condition, or to recover from surgery. In the NHS, it often includes services such as ED, inpatient and outpatient medicine and surgery.
AHP	Allied Health Professional – one of the thirteen professions in Northern Ireland, whose designated titles are protected by law and who are registered with the Health and Care Professions Council (HCPC).
Care Home	Registered with the Regulation and Quality Improvement Authority 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
CHST	Care Home Support Team - a clinical team based within each Trust providing support to care homes.
Catheter Care Passport and Troubleshooting Guide	Resources developed by the ECCF Project relating to catheter care management.
Chief Nursing Officer (CNO)	Department of Health NI Chief Nursing Officer provides professional advice on issues relating to Nursing, Midwifery and the Allied Health Professions.

Term	Definition
Clinical Care Pathway	Tools used to guide multidisciplinary evidence-based health care. Their aim is to translate clinical practice guideline recommendations into standardised clinical processes of care to reduce the variability in clinical practice. This promotes organised and efficient multidisciplinary care and improved outcomes for a specific group of patients with a predictable clinical course, in which the different interventions by the professionals involved in the care are defined, optimised and sequenced.
Combine9	An assessment tool provided for residential homes to assess deterioration during the COVID-19 pandemic.
Community Care	Care people receive in their own community. It plays an important role in supporting people to live in their own homes (domestic or residential setting) and reduces the need for medical interventions either in a primary or secondary care setting. It also plays a fundamental role in the way the system operates by providing a way out of hospitals and a route back to the community or to the place they call home. It can be provided by GPS, nurses, AHPs and social workers. https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report
Co-production/ Partnership Approach	An approach that aims to connect people together in representative networks, so that they can meaningfully influence, shape and participate as real partners. It is predicated on valuing and utilising the contribution of all involved. It seeks to combine people's strengths, knowledge, expertise, and resources to collaboratively improve health and wellbeing outcomes.
DOH	Department of Health

Term	Definition
DNACPR	DNACPR stands for do not attempt cardiopulmonary resuscitation. DNACPR is sometimes called DNAR (do not attempt resuscitation) or DNR (do not resuscitate) but they all refer to the same thing.
Northern Ireland Electronic Care Record (NIECR)	NIECR is a record system for all Northern Ireland. It is a digital portal which allows authorised clinicians in different settings to see and record key information about a patient they are providing care for– which improves safety and supports better care. Progress Report - eHealth | Department of Health (health-ni.gov.uk)
ENCOMPASS	Encompass will create a single digital care record for every citizen in Northern Ireland. It will be in use across all HSCTs. It will give patients and service users the ability to view and update their health information. It will also make it easier for HSC staff to access information. https://dhcni.hscni.net/digital-portfolio/encompass
ED	Hospital Emergency Department
Frailty	Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.
GP	General Practitioner. GPs treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment. General practitioner | Health Careers
Health care	The maintenance or improvement of health via services provided by a range of professions to prevent, diagnose and treat disease, illness, injury and other physical and mental impairments.

Term	Definition
Holistic	A philosophy of caring for people that takes into consideration the whole person in terms of all the needs they may encounter as an individual. For example, cancer can affect many areas of life. A holistic approach is essential to reflect cultural awareness and to ensure that the needs, priorities, expertise and preferences of people are always valued and taken into account.
HSCT	Health and Social Care Trust. These are the statutory bodies responsible for the management and delivery of health and social care services to a particular defined population. There are five geographical Trusts: • Belfast Health and Social Care Trust • Northern Health and Social Care Trust • Southeastern Health and Social Care Trust • Southern Health and Social Care Trust • Western Health and Social Care Trust and one regional Trust: • Northern Ireland Ambulance Service Health and Social Care Trust
HSCB	Health and Social Care Board. Migrated to DoH from 1st April 2022 as the Strategic Planning and Performance Group.
HSCNI	The Health and Social Care system and service provision in Northern Ireland. Primary Care, Health and Social Trusts, the independent sector and voluntary and community sector

Term	Definition
Intermediate Care	Intermediate care services are provided to people, usually older people, after leaving hospital or where they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system – community services, hospitals, GPs and social care. There are three main aims of intermediate care and they are to: • Help people avoid going into hospital unnecessarily. • Help people be as independent as possible after a stay in hospital. • Prevent people from having to move into a residential home until they really need to. Intermediate care can be provided to people in different places, for example, in a community hospital, residential or nursing homes or in people's own homes. This type of specialised care can be delivered by a variety of different professionals, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.
Maslow Hierarchy of Needs	A theory of psychological health predicated on fulfilling innate human needs. Abraham Harold Maslow was an American psychologist who created a hierarchy of fundamental needs for the linear growth of an individual. Maslow believed that in order to achieve a state of personal fulfilment where they reach their full potential, someone must first satisfy preceding needs in priority - food, security, belonging, self-esteem and morality, culminating in self-actualisation.
MOOP	Medicines Optimisation Services for Older People in NI

Term	Definition
Multi-disciplinary Team (MDT)	An extended care team of different clinicians who work together to serve the needs of a local population, such as people living in care homes, including Nurses, Doctors, Allied Health Professionals, Health Care Assistants, Pharmacists, Mental Health Professionals and Social Care workers with a focus on prevention and early intervention and the active management of complex patients to support them to better manage their conditions.
No More Silos	'No More Silos' (NMS) has been developed by officials and clinicians from both primary and secondary care who form a regional NMS Network. Their action plan builds upon the learning from the review of urgent and emergency care and focusses on ten key actions that will be implemented to ensure that urgent and emergency care services across primary and secondary care can be maintained and improved in an environment that is safe for patients and staff. The ECCF project is one of the ten key actions.
NIECR	Northern Ireland Electronic Care Record is a record system for health and social care for all of Northern Ireland. It is a digital portal which allows authorised clinicians in different settings to see and record key information about a patient they are providing care for– which improves safety and supports better care. Progress Report - eHealth | Department of Health (health-ni.gov.uk)
NIAS	Northern Ireland Ambulance Service HSC Trust. NIAS | NIAS (hscni.net)
NIPEC	Northern Ireland Practice and Education Council for Nursing and Midwifery About Us | NIPEC (hscni.net)
NISCC	Northern Ireland Social Care Council Home Page - NISCC

Term	Definition
Nursing Home	Subject to the exceptions given in the legislation, any premises used, or intended to be used, for the reception of, and the provision of nursing for, persons suffering from any illness or infirmity. The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (legislation.gov.uk)
Out of Hours (OOHs)	Healthcare services provided to people requiring medical advice or assistance outside the normal opening hours of GP practices.
Partnership Approach	See Co-production
PHA	Public Health Agency Welcome | HSC Public Health Agency (hscni.net)
Pharmacy Technician	Pharmacy Technicians work under supervision of a pharmacist to manage and prepare the supply of medicines. This can involve giving medicines to patients, either on prescription or over the counter and providing information on potential side-effects. Pharmacy Technicians work with patients to reach the best possible care for them, advising them on their health, how to take their medicines and their lifestyle choice. This can be face-to-face or over the phone. Sometimes Pharmacy Technicians need to refer patients on to another healthcare professional such as a pharmacist, doctor, nurse or allied health professional.
Polypharmacy	Polypharmacy means taking more than one medicine, can be complex to manage, and can sometimes become a problem. When a person takes many medicines, there is a larger risk for side-effects and interactions. The practicalities – taking all medicines at the right time, and in the right way – becomes harder too. Patients with long term conditions are especially vulnerable. Usually, they are prescribed more medications, and it is important these are reviewed as appropriate.

Term	Definition
Population Health	In broad terms, this approach aims to improve the health of a population of people, such as the health and wellbeing of people living in care homes, via reduction of inequalities of 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 want.
Pre-Admission Assessment Document	This document enhances existing documentation being used through collating into one document the essential clinical data and other health and social care fundamentals of wellbeing, such as the identification of *'What Matters Most to Me'* to help inform person-centred care planning. This will help to prevent deterioration through early positive intervention and promoting maintenance of independence. The document also provides structure around challenging conversations, such as palliative care or capacity.
Primary Care	Primary Care is the entry point for the majority of people to the Health and Social Care system through a range of community based services. Examples include services provided by General Practitioners, dental practices, pharmacists, optometry (eye health) services and community based nurses, midwives, physiotherapists and occupational therapists.
Quality Improvement (QI) methodology	The ECCF Project used established Quality Improvement (QI) methodology to test elements of the Framework in a live care home environment. This provided a structured basis for the testing exercise, measuring success and evaluating outcomes.
Rapid Learning Initiative (RLI)	An initiative Department of Health led into the learning from the first surge of COVID-19 into and within care homes to identify the learning to prevent/mitigate the impact of future surges.

Term	Definition
Residential Home	Subject to the exceptions given in the legislation, an establishment is a residential care home if it provides or is intended to provide, whether for reward or not, residential accommodation with both board and personal care for persons in need of personal care by reason of— (a) old age and infirmity (b) disablement (c) past or present dependence on alcohol or drugs; or (d) past or present mental disorder The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (legislation.gov.uk)
ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)	Advance planning tool recommended for use by adults in Northern Ireland.
Restore2/Restore2 Mini	The standardised evidence-based tool for assessing a deteriorating resident recommended by the Project for use across the care home sector.
Rockwood Clinical Frailty Scale	A tool to screen for and help identify degree of frailty and to support someone to receive the right services and interventions to achieve optimal outcomes for their health and wellbeing. Rockwood Clinical Frailty Scale
Regulation and Quality Improvement Authority **(RQIA)**	RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services. Regulation and Quality Improvement Authority - Regulation and Quality Improvement Authority – Health & Social Care Services Northern Ireland (rqia.org.uk)

Term	Definition
Secondary Care	Healthcare services provided mainly within a hospital setting by health professionals who generally do not have the first contact with a patient. People who require more specialist care are referred by their GP to the acute hospital sector. In addition to this, Emergency Departments provide a 'front door' to people who either self-refer or who are assessed by primary care clinicians as needing urgent care.
Social Care	Social care is about supporting social wellbeing. Key areas of social wellbeing are relationships and belonging, independence and responsibility, purpose and meaning and safety and wellbeing. Social care staff support these key aspects of wellbeing by encouraging participation in family, social and community life, promoting choice and decision making, supporting people to live their lives in a way which has meaning and value to them and by helping people to keep safe and well.
Virtual Ward	Virtual wards support people to receive their clinical care in the place they call home, including care homes. This includes care that would otherwise require hospital admission. Support from a virtual ward can include remote meetings and remote monitoring by the multidisciplinary team and care home team providing health care to someone living in a care home.
Whole Home Approach	An approach used that develops learning across the wider care home team for the benefit of the entire population within that home.
Well-being	The state of feeling healthy and happy.
Wellness Pathway	A visual description at HSC system level of the environments the ECCF project wishes to build for the clinical care framework i.e., regional standardised gateways, tools, and resources to support the assessment, monitoring and interventions for people living in care homes and the underpinning system and workforce enablers required.