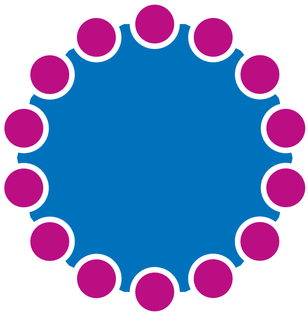


NHS

Quick Guide:

allied health professionals enhancing health for people in care homes

Transforming health, care and wellbeing with allied health professionals

#AHPsintoAction

Introduction

One in seven people aged 85 or over are living permanently in a care home, however evidence indicates many of these people are not having their needs properly assessed and addressed. (The framework for enhanced health in care homes (2016)).

The framework for enhanced health in care homes (EHCH) is based on a suite of evidence-based interventions, which are designed to be delivered within and around a care home in a coordinated manner to make the biggest difference to its residents. The framework identifies seven core elements of the model and how they can be commissioned to deliver joined-up services.

The EHCH framework applies equally to people who self-fund their care and to people whose care is funded by the NHS or their local authority: everyone has the right to high quality NHS services. The NHS Long Term Plan includes a commitment to upgrade NHS support to all care home residents, with roll out of the ECHC model by 2023/24.

About this quick guide

This quick guide aims to support local health and social care systems in improving the health of people living in care homes, with practical examples of how the allied health professions (AHPs) can support implementation and roll-out of the framework for enhanced health in care homes. It also serves to illustrate how AHPs can support further development of the skills and expertise held by care home staff, in managing their residents.

AHP services can support the following elements of the framework:

- Enhanced primary care support.
- Nutrition and hydration.
- Rehabilitation and reablement.
- End of life and dementia care.
- Workforce.
- Digital and technology.

The document includes a number of key themes for improvement that have been identified in its development, including:

1. Review ease of access to AHP services
2. Understand equity of access for people living in care homes
3. Understand ease of access to AHP services that cannot be delivered in the care home
4. Develop whole home approaches to commissioning
5. Support care homes to take structured approaches to common health issues to support demand management
6. Consider multi-professional approaches to support for care homes with high levels of demand on NHS services.

The case studies highlight how timely access to AHP services support personalised care, independence, and reduce avoidable admission to urgent care services.

This quick guide will support health and care staff who share an interest in making faster progress in improving care for people living in care homes. This includes primary care teams, provider organisations, care home staff, commissioner, third sector organisations, education and research institutions, alongside AHPs and the professional bodies that represent them. It will also help care home residents and their families to identify services that can support in quality of life and holistic care planning.

This quick guide also builds on the Quick guide to clinical input into care homes to provide further examples of services for care home residents.

More resources and case studies are available on the EHCH FutureNHS collaboration platform. To request access to these resources please contact: england.carehomes@nhs.net.

Key themes for improving AHP services for care home residents

1. **Consider multi-professional approaches to support for care homes with high levels of demand on NHS services:**
   As the case studies included within this quick guide demonstrate, AHPs can support a wide range of issues that can lead to hospitalisation and primary care referral including malnutrition, dysphagia, falls and palliative care leading to reductions in demand.
2. **Review ease of access to AHP services:**
   Support care homes to understand which AHP service they need, how to refer their residents and enable care homes to make referrals without intervention from primary care colleagues. This can help to free up limited primary care resources and is supported by Enhanced health in care homes: Learning from experiences so far (Kings Fund (2017)) which highlight the need for ready access to clinical expertise and a clear referral system.
3. **Understand equity of access for people living in care homes:**
   There is variation in access criteria for care home residents compared to people living in their own homes. This leads to people in care homes not always being able to access timely AHP services. Health and social care commissioners and providers are encouraged to review local commissioning arrangements and access to ensure clarity of responsibility and where referral thresholds exist, that these are appropriate.
4. **Understand ease of access to AHP services that cannot be delivered in the care home:**
   Attendance at hospital or outpatient settings can be unsettling for care home residents. It also creates pressure for care homes in providing an escort for their resident. AHP provider services are encouraged to review their processes for care home residents to ensure when attendance is necessary, disruption is minimised. For example, liaison between paramedics and medical imaging departments to ensure imaging is undertaken promptly enabling the care home resident to be taken straight home, or for therapeutic radiography preparatory medicines being delivered in the care home setting reducing the length of time the care home resident needed to be in the department.

5. **Develop whole home approaches to commissioning:**
   This document highlights a variety of examples of whole home approaches focussed on providing education and training in addition to one–to-one interventions. This is in line with findings by the Kings Fund 2017 who detailed quality improvement approaches, from individual care to a review of the care homes management systems, had significant impact on malnutrition, falls and dysphagia.
6. **Support care homes to take structured approaches to common health issues to support demand management:**
   Through the integration of activities and interventions into the daily routines of care home residents, care homes can reduce the need for professional intervention. For example, the implementation of drink rounds by East Berkshire Clinical Commissioning Group. Other examples include Pimp my Zimmer which led to improvements in the use of walking aids and a reduction in falls by up to 60%. It is important for those working in care homes to consider how best to maintain a residents physical function. Ensuring residents are enabled, where possible, to eat meals sat up in a chair whether in their room or in the dining room will have multiple benefits.

AHPs supporting the enhanced health in care homes framework

Whilst each case study is detailed under the appropriate element, many impact across more than one element. Table 1 highlights the crossover and relevance of each case study to the EHCH framework. It also highlights where whole home approaches have been taken to address the elements.

To share or discover more case study examples in this area please use the BetterCareExchange. Email Better Care Exchange to request an invite to join.

Local examples and the enhancing health in care homes (EHCH) framework

Case study examples of AHP services supporting the Enhancing Health in Care homes framework	Organisation	Whole home Approach	EHCH element					
			Enhanced Primary care support	Nutrition and Hydration	Rehabilitation and Reablement	End of Life and Dementia care	Workforce	Digital technology
Implementation of triage tools to support decision making	North West Ambulance Service	✓	✓				✓	
First response to care homes by emergency care practitioner paramedics	Yorkshire Ambulance Service		✓				✓	
Bounce Back Clinic: a multidisciplinary frailty clinic in primary care	Grange and Lakes Integrated Care Community		✓		✓		✓	
Thinking Food First:- The value of a unique, collaborative approach to managing malnutrition in care homes for older people	Cambridgeshire Community services NHS Trust	✓		✓			✓	
A team approach to improving the management of eating and drinking disorders in care homes	Derbyshire Community Health Services NHS Foundation Trust	✓		✓		✓	✓	
Bed-based intermediate care: Somerset Care and Yeovil District Hospital	Somerset Care and Yeovil District Hospital	✓			✓			
An Integrated whole home approach to falls prevention	Berkshire Healthcare NHS Foundation Trust	✓			✓		✓	
Active Residents in Care Home (ARCH)	St Georges NHS Foundation Trust-South London				✓	✓	✓	
Supporting advanced care planning within care homes	Kings College Hospital NHS Foundation Trust					✓		
Music therapy skill sharing	Central and North West London NHS Trust	✓				✓	✓	
Falls, frailty and sepsis awareness training	North West Ambulance Service	✓	✓	✓		✓	✓	
Pressure ulcer food first initiative (PUFFINs) and diabetic foot attack for care homes	East London NHS Foundation Trust	✓	✓	✓			✓	
Nutrition and hydration education in care homes	Gateshead Health NHS Foundation Trust	✓		✓			✓	
The rotational paramedic programme	Health Education England		✓				✓	
The Airedale telehealth model	Based at Airedale NHS Foundation Trust delivered across England	✓	✓					✓
Virtual dysphagia assessment	Blackpool Teaching Hospitals NHS Foundation Trust	✓					✓	✓

Case studies: AHPs supporting people living in care homes

Each organisation is responsible for the accuracy of the information shared. NHS England has not validated the published information.

Enhancing primary care support for care homes with AHPs

Case Study 1:
Implementation of triage tools to support decision making

Care home staff can feel quite isolated when making decisions about deteriorations in their residents' health. This can be due to a lack of understanding around assessment and management resulting in unplanned and unnecessary admissions to hospital. Frequently more appropriate care can be provided within the patient's normal surroundings and by health professionals known to them.

The Nursing and Residential Triage Tool (NaRT), was developed by two paramedics in collaboration with Manchester Triage Group and Advanced Life Support Group.

NaRT aims to:

- Reduce the number of admissions to in-patient care.
- Support nursing and residential care home staff with appropriate decision making for clinical assistance.
- Enhance the quality of care for patients with non-time critical presentations, such as falls.
- Reduce the amount of inappropriate 999 calls thereby supporting the appropriate use of emergency services.

Training on the use of the tool is currently provided to care home staff and delivered by paramedics. The use of NaRT has seen reductions of up to 50% in 999 calls where its use is supported by alternative clinical response.

For more information please visit: Nursing and Residential Home Triage Tool.

Case Study 2:
First response to care homes by emergency care practitioner paramedics

Yorkshire Ambulance Service has operated a care homes' referral line since 2004 and its focus is responding to residents who have sustained minor injuries within care homes.

Care homes can make direct referrals to the Emergency Care Practitioner (ECP) service via a direct line for patients that meet the specified criteria. In addition, calls into the 999 emergency ambulance service are screened to identify potential cases that could be managed via the ECP route.

The service responds on average to 600 calls per month and achieves a non-conveyance rate of 75%. Further analysis shows that the ECP scheme is able to achieve a 50% non-conveyance rate when dispatched to all types of 999 calls, compared to 27% for all other ambulance crews.

For further information please contact: Andrew Hodge, Consultant Paramedic Urgent Care, Yorkshire Ambulance Service NHS Trust, email andrew.hodge1@nhs.net.

Case Study 3:

Bounce Back Clinic a multidisciplinary frailty clinic in primary care - Grange and Lakes Integrated Care Community

AHPs have a strong role to play in primary care working in First Contact Practitioner (FCP) roles, they can broaden the GP team and provide more services outside of hospital. The value of using AHPs with advanced practice skills means that patients can access appropriate expertise without the need to see a GP: assessment, diagnosis and management advice is all AHP-led.

Pilots show this can reduce both the burden on GPs and inappropriate referrals into secondary care, as well as improve population health and patient care.

A multi-disciplinary team of NHS and third sector professionals piloted a Bounce Back falls prevention clinic based in primary care. The clinic was led by a Physiotherapist working in a FCP role and included pharmacy, nursing and third sector assessment.

The aims of the Bounce Back service were:

- To reduce the risk of falls.
- Prevent admission to secondary care.
- Reduce the need for unplanned GP visits.
- Improve mobility and self-care.
- Improve understanding and concordance with medication.
- Enable closer links between acute and community providers and third sector and wider cross organisational teams.

The clinics were attended by a range of patients which included patients from residential homes. The results for those who had attended from residential home showed a 100% confidence improvement using the CONFbal score as a measure and 50% improvement on the Edmonton frail scale with 100% no further falls in the review period and no acute admissions.

Due to the success of the pilot a revised service model has been agreed for a further 12 months which considers the learning from the pilot. The model is also being set up in Gloucestershire and Cornwall.

For further information please contact: Amanda Hensman-Crook, consultant Physiotherapist, One Medical Group, Amanda.Hensman-Crook@GP-A82046.nhs.uk.

AHPs supporting hydration and nutrition

Case Study 4:

Thinking Food First: The value of a unique, collaborative approach to managing malnutrition in care homes for older people

The Food First Team in Luton and Bedfordshire led by the dietetic service work in collaboration with care homes to improve the nutritional care for all residents, as part of a 'whole home approach'.

The team offers a unique training, audit and accreditation program delivered to all care home staff, focusing on appropriate identification and management of malnutrition. Through the Food First approach the rising spend on oral nutritional supplements (ONS) is addressed preventing inappropriate prescribing. Some of the results of this approach have been a 60% reduction of ONS usage in care homes, £4 saving for every £1 invested, over 80% of service users' malnutrition risk remained stable or improved.

"Following the [Food First Team's] training our staff are more aware and involved in the changes we make in our home. We have fun and have made activities using the milkshakes, which our resident's love. We can see the positive change it has had by looking at their MUST (Malnutrition Universal Screening Tool) scores. Training and support from the [Food First] Team has helped make this happen and our residents look and feel so much better. This is a team effort!"

- Head of care and carer

For more information: Food First.

Further information is available at: Using Nutrition Support NICE Quality Standards as a basis to improve management of malnourished care home residents with a Food First approach.

Case Study 5:

A team approach to improving the management of eating and drinking disorders in care homes

Year on year increases in referrals to the Derbyshire Community Health Services NHS Foundation Trust's speech and language therapy service prompted a review of the support the speech and language therapy team was providing to care homes.

The pilot aimed to increase the knowledge of care home staff in the identification and care for residents with eating and drinking disorders to ensure patients at highest risk received timely intervention from speech and language therapy.

It is widely acknowledged that between 50-75% of care homes residents have a condition that affects residents' eating, drinking or swallowing. The care homes within the pilot were provided with basic dysphagia awareness training, which included the following learning outcomes:

- How to identify swallowing difficulties and how to help.
- How to prepare appetising food and drink.
- How to assist people to eat and drink as safely as possible.
- How helping people to eat well impacts on health and wellbeing.

Care homes taking part were recognised as dysphagia friendly settings, and nurses who attended additional training could become dysphagia nurse champions, promoting good practice in their setting.

"Now I understand why it's so important to get the texture of the food right. I never knew any of this before."

Care home staff member

"Staff have a greater understanding of thickening fluids and they are reporting problems as soon as they are noticed i.e. coughing when eating etc. but we aren't having to refer to the Speech & Language Therapy Team nearly as much as we are much more skilled now."

Care home manager

The outcomes of the pilot were:

- Increased knowledge and skills of the workforce and improved resident experience.
- Potential for a 50% reduction in hospital admissions.
- Promotion of appropriate referrals for specialist speech and language therapy support.
- Potential reduction in the number of primary care interventions for dysphagia related difficulties.

For further information please contact: Helen.witts@nhs.net.

AHPs providing reablement and rehabilitation

NHS England's Commissioning guidance for rehabilitation provides evidence and examples of good practice, along with practical advice to commission good quality rehabilitation.

Care home residents are sedentary for 79% of their day, leading to significant deconditioning (Giné-Garriger et al 2019).

There is good evidence to support the provision of quality, person-centred based exercise programmes, delivered at the right intensity, and for sufficient duration for care home residents. The impact of which is, improvements in activities of daily living, reduction in frailty and improvements in quality of life. This is supported within the Nice quality statement, Mental wellbeing of older people in care homes (QS50).

The opportunities for care home residents to engage in meaningful activity are often found to be limited, which has a negative impact on resident's mental and physical health, self-esteem and quality of life.

The Royal College of Occupational Therapists have developed guidance which enable residents, their relatives, care home staff and care home managers to have greater understanding of the impact of activity on wellbeing in care homes: Living well through Activity in care homes -The Toolkit.

Active aging is important for all older people.

Case Study 6:

Bed-based intermediate care: Somerset Care and Yeovil District Hospital

Yeovil District Hospital purchased 18 beds at Somerset Care's nursing home in Yeovil (Cookson's Court) to become intermediate care rehabilitation beds.

Members of the hospital's rehabilitation team work alongside Somerset care nurses as a single team. They identify and assess patients in hospital to provide a ten-day period of intensive reablement. At the end of the period they are assessed and discharged home, with or without home care and support, as required.

Headline impact to date includes: 402 admissions to Cookson's court by April 2017, with 98% of people being discharged home and 42% of patients required a reduction in their predicted home care packages upon discharge. This has resulted in estimated £1.6 million savings in ongoing care costs to the local authority, and an income protection of an estimated £1.9m in 2017/18.

For more information see: https://www.nice.org.uk/sharedlearning/bed-based-intermediate-care-somerset-care-and-yeovil-district-hospital.

Case Study 7:

An Integrated whole home approach to falls prevention - Berkshire Healthcare NHS Foundation Trust's Care home support team

The Integrated Care Homes Service supports 53 care homes, both nursing and residential in the West of Berkshire. An occupational therapist and a physiotherapist have worked with care homes to support falls prevention within the care homes. The approach has included an audit process which reviews falls incident forms for falls that have occurred within the previous 3 months, from which trends and themes are identified for inclusion in subsequent training for care home staff.

"Quite simply the benefits are invaluable…The support has heightened awareness, and increased prevention…we are looking at different seating solutions, innovative technology, and have developed our own Falls Prevention Strategy. The team are responsive and flexible, and help to holistically review the resident to maximise independence, promote positive risk taking, whilst at the same time helping keep our residents safer. For us the proof is in the numbers- with their support our falls have already reduced!"

Care home manager

The work of the team has led to 154 falls champions being trained within care homes, and training has included the use of telecare and falls incident analysis.

The team have also worked with ambulance trusts to review the falls policies for these care homes which in some cases were found to state that 999 was required for each fall. This work has enabled care home staff to undertake assessments of patients who have fallen, leading to reductions, where appropriate, in the time residents were on the floor and identification of when a 999 call is required.

Outcomes:

- A 55%reduction in falls over 6 months in one care home through a change in the way care is delivered to residents who fall regularly.
- A 90% reduction in 999 calls by a care home through a change in approach to the management of falls with an associated 41% reduction in falls.
- A 66% reduction in falls in a home that now has falls champions: staff have received falls prevention training and the care home are engaged in the audit process.

For more information please contact:
becky.thomas2@nhs.net.

Case Study 8:

Active Residents in Care Home (ARCH), St Georges NHS Foundation Trust, South London

Active Residents in Care Homes (ARCH) used a whole systems approach to increase meaningful activity and improve wellbeing of care home residents. It was led by an occupational therapist supported by physiotherapists and therapy assistants and involved three self-selected residential care homes in London. The care homes included cared for older people with or without dementia.

ARCH had four main aims:

1. To improve the health and quality of life of residents in care homes through increasing their level of participation in meaningful activity.
2. To increase the confidence and skills of care home staff to actively facilitate residents' engagement in meaningful activity.
3. To identify environmental (e.g. social, cultural or physical) barriers to activity and initiate actions to address these in partnership with the care home.
4. To create a culture of activity where residents are supported to engage in meaningful activity throughout the day and where activity is considered integral to care.

"I think some of the residents seem a bit happier really…when they have things to do I think they are much happier and more relaxed and you know, chatting. And then even after an activity they're then talking about the activity afterwards so it sort of has a longer lasting effect."

Residents daughter

The approach was delivered in 5 phases and included 3 months of implementation and 9 months consolidation, by which time the care homes were expected to be able continue ARCH as part of routine care.

Residents were assessed to establish individual resident's activity/wellbeing needs in a variety of areas such as mobility, falls risk, nutrition and hydration. Care home staff utilised a traffic light system to highlight the facilitators and barriers to activity. From these, individual priorities were determined for each resident. This process enabled care home staff to see activity as part of routine care and move away from a task orientated approach to care provision.

An example of the success of the ARCH intervention was with Annice, who had been a keen gardener before moving into residential care. Providing residents access to the garden was however deemed unsafe by care homes managers and staff, due to easy access to the main road. The collaborative approach used with ARCH enabled action to improve the safety of the garden, this in turn led to a gardening group being set up. Annice's gardening knowledge was used to develop a sensory garden which had a positive impact on both her and other residents' quality of life and wellbeing.

For more information please contact: Michael Hurley, Professor of Rehabilitation Sciences: Michael.Hurley@sgul.Kingston.ac.uk.

Further information is available:
The protocol for the ARCH study.
A study exploring the experiences of the ARCH therapists.

Improving end of life care and dementia care with AHPs

Case Study 9:

Supporting Advanced Care Planning within Care Homes, Kings College Hospital NHS Foundation Trust

PEACE (pro-active elderly advanced care) plans are developed to plan future clinical care in the case of predictable events such as pneumonia or deteriorating swallowing in older people with deteriorating health conditions such as dementia and advanced frailty. They are also useful when individuals have specific requests around their care at end of life such as a strongly preferred place of death. The PEACE plan is drawn up with the individual, family and multi-disciplinary team (MDT) and provides detail on pre-planned escalation of medical care in response to specified predicted events.

Analysis of admissions to accident and emergency from local care homes over a 6-month period identified that in 75% of cases, presentation at hospital was due to an infection or deterioration in a condition which could have been predicted. Nearly 10% of the small sample reviewed died in hospital, for some very soon after admission.

This project aimed to implement advance clinical care planning in the form of PEACE documents, drawn up in the care home setting without necessitating the need for a hospital admission to prompt this.

The project identified that nurses within care homes had difficulty completing PEACE documents for a number of reasons, including a lack of detailed knowledge of disease processes.

An advanced physiotherapy practitioner worked with care home staff, care home residents and their families to develop PEACE plans. At the 6 month follow-up this initiative resulted in:

- 84% of care home residents with PEACE documents died in the nursing home
- 82% of PEACE plans were followed in terms of care provided
- 22% were admitted to hospital during follow-up
- A 50% reduction in risk of hospital admission was found through introduction of the PEACE plan

For more information contact: Julie.whitney@nhs.net.

Case Study 10:
Music therapy skill sharing

Singing groups for people with dementia and their carers are gaining increasing popularity and support. They are often facilitated by community-musicians and volunteers; however, those delivering these sessions may have limited background knowledge of how to optimise the therapeutic aspects of group singing to support this client group.

Music therapy is an intervention provided by qualified music therapists. However, there is an increasing international consensus on the vital role of wider music therapy skill-sharing as the number of people with dementia increases (McDermott et al., 2018).

To address this music therapists, have, through the CHORD study, developed a manual for singing group facilitators on how to incorporate music therapeutic skills into community groups. The use of the manual supports effective facilitation of singing groups.

For more information visit: Indirect Music Therapy Practice and skill sharing in Dementia Care.

AHP workforce development

Case Study 11:
The rotational paramedic programme, Health Education England

During 2018, a model of rotational working for paramedics, developed by Health Education England (HEE), has been piloted in collaboration with four ambulance services in England. The model was developed to use the unique skill set of specialist and advanced paramedics to increase capacity in primary, urgent and emergency care.

Specialist and advanced paramedics rotate between a number of clinical settings, including primary care, community multi-disciplinary teams and the ambulance control centre. They use advanced clinical assessment skills to help provide the right response the first time. This enables more patients, many with multiple and complex conditions, to receive the right care, first time - safely managed in their usual place of residence or in the community.

As a result, the pilots are seeing a reduction in the number of avoidable ambulance conveyances to hospital and attendances at A&E. The rotational programmes are also helping to build relationships across ambulance, primary care and community services, supporting more integrated care.

Often, the Primary Care rotation has included specialist and advanced paramedics providing wrap around support to care homes 5 days a week. The Rotating Paramedic Model demonstrates how paramedics can support primary care in the effective treatment of care home residents, and enable them to remain safely in their care home environment avoiding unnecessary ED attendance.

For more information, contact: Rhian Monteith, Clinical Lead, Rotating Paramedic Model, Health Education England Rhian.Monteith@hee.nhs.uk.

Case Study 12:
Falls, frailty and sepsis awareness training, North West Ambulance Service

Community Specialist Paramedics from the North West Ambulance Service are delivering training to care home teams covering a range of subjects including:

- The assessment of patients post fall to reduce the risks associated with an avoidable long lie on the floor.
- The identification of sepsis.
- The assessment of frailty.
- The management of nutrition including dental hygiene and its impact on nutrition.
- Observation and weight recording to improve consistency and reliability.
- End of life care planning.

These two-hour sessions are well attended and enable care home colleagues to access training on a range of subjects which are often covered through individual professionals. The service is enabling care homes to better identify when they need to contact the ambulance service for support with management of residents.

For more information please contact: Carol.Robertson@nwas.nhs.uk.

Case Study 13:

Pressure Ulcer Food First Initiative (PUFFINs) and diabetic foot attack for care homes across Luton and Bedfordshire

PUFFINs was first set up in North Bedfordshire in 2012 and expanded to the south of the county, including Luton in 2018. Locally, pressure ulcers were identified to contribute to increased hospital stays, admissions, and health care resource, including GP visits, as well as impacting on a person's quality of life, and pressures on care home workforce. On starting the programme none of the homes included had an awareness of how to undertake diabetic foot checks.

Podiatrists alongside dietitians and tissue viability nurses provided training to both nurses and support staff to improve knowledge and skills around pressure ulcer prevention, malnutrition screening/treatment/prevention, diabetic foot care to maintain good foot health and reduce the risk of diabetic foot attack, whilst educating and updating care home staff on the podiatry referral pathways. Following training the 'Champions' were expected to take their new knowledge back to their care home to drive improvements in care across their teams.

The training highlighted that the care homes included were not routinely undertaking foot check assessment for patients with diabetes. Less than half the homes included would previously have referred to the podiatrist to support the management of patients with diabetic foot wounds which could negatively impact outcomes.

For more information please contact:
emma.stoneman@nhs.net or victoria.thompson7@nhs.net.

Case Study 14:

Nutrition and hydration education in care homes, Gateshead Health NHS Foundation Trust

"We've already seen some improvements in residents' weights, especially with foods and drinks that I didn't know were good for this."

Care home carer

Malnutrition is a significant risk for care home residents with 37% of those who have recently moved into a care home being at risk of malnutrition or already malnourished Bapen (2011).

A Dietitian led project in Gateshead Health NHS foundation Trust, aimed to improve nutrition and hydration care for residents and develop the care home workforce through introduction of an enhanced dietetic service and delivery of nutrition and hydration training in care homes. Prior to the training it was identified that only 72% of Malnutrition Universal Screening Tool (MUST) assessments were completed correctly.

Following the training

- Correctly completed Malnutrition Universal Screening Tool (MUST) screening increased from 72% to 94% after intervention
- 19% of 3 residents under the care of a dietitian had their oral nutritional supplements discontinued due to improvements in their MUST score
- One third of residents under the care of a Dietitian completed their dietetic treatment and were discharged from the service
- The level of malnutrition, measured as BMI <20kg/m2, reduced from 36% to 22% over the 4-month pilot intervention

Following on from the success of the initial pilot intervention, all Gateshead care home staff now benefit from a rolling Nutrition & Hydration training programme and equitably receive an enhanced dietetic service providing regular face to face in-house reviews of all residents under the care of the Dietetics Department replacing the telephone service that was in place prior to this intervention. For more information please contact: robyn.collery@nhs.net.

"We have noticed a huge improvement in certain resident's daily intake on the fluid charts and I think this has mainly come from staff just offering more. Our resident's families and friends have also asked about the water drops and think it's a fab idea…The staff have made a real conscious effort to maximise calorie intake for those residents that need it. Diets are now consistently fortified. Drinks are thickened correctly…I have been able to share some good ideas with our chef manager, particularly on ways to fortify food. I have noticed a huge improvement in residents overall 'MUST' scores and, we have been able to stop supplements for a number of our residents."

Care home manager

AHPs making better use of technology

Case Study 15:
The Airedale telehealth model

The Airedale Digital Care hub has been established since September 2011. It uses a remote secure video link to connect nursing and residential care homes with health care professionals which include occupational therapists and paramedics, who can monitor people on screen and provide advice and support in terms of clinical management.

The hub currently supports in excess of 500 care homes across the country. In addition to the support for individual patient management the service provides a virtual training room, which enables colleagues working in care homes across the country to join training sessions using the video link equipment. This enables a wide range of professions including AHPs to provide training to these care homes.

Virtual clinics are being introduced by dietitians in Airedale for care home residents who have access to this model, reducing the need for domiciliary visits.

The implementation of this model has enabled care homes to receive advice and support to manage residents within the care home setting and reduce ambulance conveyance rates to hospital from 80% to 20%.

For more information please visit: http://www.airedaledigitalcare.nhs.uk/.

Case Study 16:
Virtual dysphagia assessment - Blackpool Teaching Hospitals Foundation NHS Trust

The use of a virtual approach to the assessment of patients exhibiting swallowing difficulties has been successfully piloted by Blackpool Teaching Hospitals NHS Foundation Trust within nursing homes. This innovative approach enables prompt assessment of patients with problems eating and drinking by a Speech and Language Therapist.

Using an encrypted portal, clinical specialists are linked to patients, reducing home visits (thereby saving clinical time). The pilot evidenced improved response times without the need for additional staffing costs. The pilot demonstrated a clinically acceptable inter-rater reliability for diet (100%) and fluid (75%).

This approach also supported by the provision of training to care home staff, certified against the inter-professional dysphagia framework

"…the nurses here have got an extra skill and so if we have residents coming in…from community, with crisis admissions who've got swallowing issues, we've all got some basic swallow training and so we all feel more competent in recognising the complications of swallowing and we know…where to start off from so that the residents are safe while waiting for the swallowing assessment."

Care home staff member

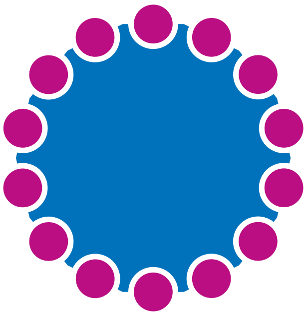
to ensure competence and confidence which increased knowledge and awareness of swallowing difficulties by care sector staff.

The key benefits of the model:

- Upskilled care home staff, enabling improved confidence of the management of residents with dysphagia
- Quicker patient assessments / reduced waiting times
- Avoidance of serious problems relating to dysphagia and hospital admission
- Benefits to patients and care homes through not needing to travel to outpatient appointments
- Efficiencies for the work force with reduced time for assessment and eliminated travel costs

Teleswallowing® is currently used within the NHS trusts in Blackpool, West Hampshire and the Isle of Wight.

For further information: veronica.southern@nhs.net.



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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.

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Feedback

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