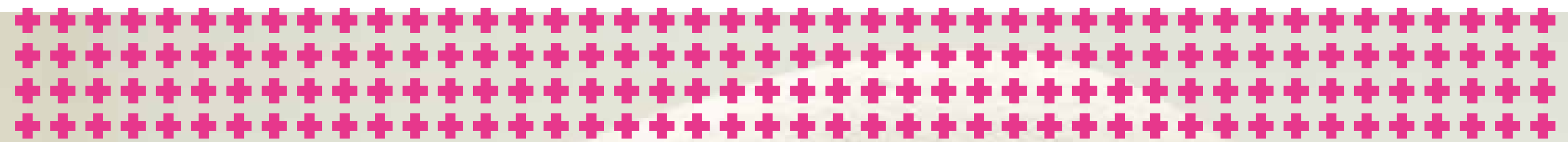
Transition to Care Home Nursing

The Queen's Nursing Institute

Section B - Working in the Care Home with Nursing Setting

Chapter 4 - Resident Focus: Fundamentals of Nursing Home Care

A resource in the QNI's 'Transition' series, designed for registered nurses with an interest in working in a care home with nursing and for those who are already in this area of practice, who would like an update on current practice and approaches.



Section B - Working in the Care Home Setting

Chapter 4 - Resident Focus - Fundamentals of Nursing Home Care

Completing this chapter will enable you to:

- Define Long Term Conditions and their impact on the older person
- Identify common health conditions associated with ageing
- Consider the clinical and nursing skills required
- Understand some of the additional complexity when working with co-morbidity
- Consider the role of the registered care home nurse when caring for residents at the end of life.

Introduction

As a nurse, working in a care home you will come into daily contact with many residents that are living with one or more Long Term Conditions (LTC). The issue (LTCs) has been at the top of the government's health agenda for many years and now takes up 70% of the health service budget. The NHS Five Year Forward View (2014) notes that managing long term conditions is now a central task for the NHS and makes the case for improved personalised care and support for people with LTCs and their carers. Within the NHS Five Year Forward View it has been acknowledged that there needs to be some major changes within health care systems and delivery of care in order to address the LTC agenda. LTCs are now a central task for the NHS; requiring a partnership with patients over the long term rather than providing single episodes of care. It is generally agreed that services need to be integrated combining NHS, GP and social care services as a way of improving care.

Across England, six identified vanguard sites are working to improve the quality of life of people living in care homes. The enhanced health in care homes (EHCH) model is based on a suite of evidence based intentions, which are designed within and around a care home in a coordinated manner in order to make a difference to residents.

Practicalities of Nursing People with LTCs

Many care home residents have multiple long-term conditions, which need monitoring and managing over a period. Multiple and sometimes complex symptoms require prompt nursing responses to minimise the impact on a person's quality of life. As a registered nurse, working in a care home it will be important for you to assess your own current knowledge and abilities regarding certain conditions, either as they appear on a daily basis or if you have a particular interest in an illness or condition. It would be useful for you to have some knowledge of local organisations that provide current and up to date information on treatments, initiatives relating to national guidelines and strategies.

As a registered nurse in a care home, you will have to establish your personal authority and assertiveness in order to influence other health and social care professionals, colleagues and patients to promote care. Being assertive means respecting yourself and other people, seeing people as equal to you, not better or less important than you. The goal of this assertive behaviour in this context is to stand up for residents' rights and act as an advocate. Being assertive does not always mean you get what you want, but it can help you achieve a compromise. You will need to develop a deeper degree of self-awareness, self-belief in your ability to convey information with confidence and conviction.

Person and Relationship-Centred Approaches to Care

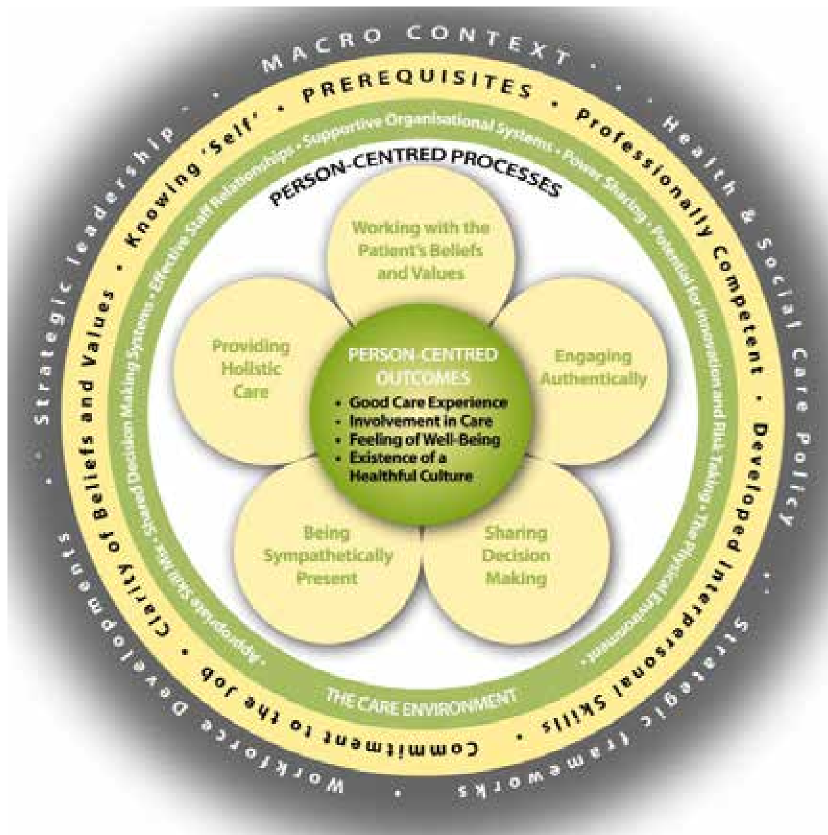
Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care.

The Health Foundation has identified a framework that comprises four principles of person-centred care:

1. Affording people dignity, compassion and respect
2. Offering coordinated care, support or treatment
3. Offering personalised care, support or treatment
4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

Person-centeredness is an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons (personhood), individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development[1].

Figure 4.1 - Framework for Person-Centred Care (McCormack & McCance (2017, p42)



Mike Nolan and a team at Sheffield University identified six dimensions that underpin 'relationship-centred care' in the Six Senses Framework[2] (2006). These six 'senses' acknowledge the subjective and perceptual nature of the key determinants of care for the three groups of people in the care setting: older people, families and staff. Nolan and his colleagues argue that each of these three groups needs to feel:

- a sense of **security** (to feel safe);
- a sense of **continuity** (to experience links and connections);
- a sense of **belonging** (to feel part of things);
- a sense of **purpose** (to have a goal(s) to aspire to);
- a sense of **fulfilment** (to make progress towards these goals); and
- a sense of **significance** (to feel that you matter as a person).

“ You will have to establish a personal authority and assertiveness in order to influence other health and social care professionals to promote care.

Figure 4.2 – Health conditions you may see in a care home with nursing

Type of conditions	Minor conditions	Acute conditions	Long term condition	Intervention for prevention
Frailty	Lethargy Muscle weakness Deteriorating eyesight Deafness Memory problems Slow mobility	Falls Cataracts Deafness Delusion Collapse Exhaustion Delirium Malnutrition	Dementia Blindness Bed sores Malnutrition	Recognition of the deteriorating patient
Trauma & Orthopaedic	Strains & sprains Minor head injuries Limb malformation or spasms	Pain Hip Fracture Fractures Head trauma	Chronic Back Pain Osteoarthritis Osteoporosis Scoliosis	Falls Prevention Programme Exercise Awareness of posture
Skin	Infestations Infections Foot trauma & injuries Sunstroke Minor injuries, cuts, bruising	Abscesses & Cellulitis Skin cancers (BCC, SCC & Melanoma) Large open wounds	Leg Ulcers Pressure sores Psoriasis	Sun Awareness Hygiene education Clothes /personal washing facilities
Respiratory	Viral coughs, colds & sore throats Flu	Acute lower respiratory infection Pneumonia – lobar, viral and atypical Influenza Tuberculosis	COPD Asthma Lung Cancer	Influenza immunization Pneumonia immunisation TB screening, testing & immunisation Smoking cessation advice Advice on air pollution / breathing exercises
Gastrointestinal	Dental caries Loss of teeth IBS Gastric Reflux Constipation Diarrhoea Haemorrhoids	Oral cancers Dysphagia Acute Hepatitis A,B,C Peptic Ulceration Acute Pancreatitis Gastritis Hypoglycaemia Hyperglycaemia Constipation Diabetes	Cirrhosis Chronic pancreatitis Chronic Hepatitis B&C Hiatus Hernia Diabetes Faecal incontinence Oesophageal, gastric, pancreatic, liver, bowel cancers Stomas	Provision of Oral health information Referral to community dental services/ dietician/ SALT Provision of toothbrushes/paste Diabetes checks
Immunological/ Endocrine		Diabetes Hypothyroidism Hyperthyroidism	Chronic Viral Hepatitis Iron deficiency anaemia Rheumatoid Arthritis Multiple Sclerosis Coeliac disease Hypothyroidism Vasculitis Lupus	Immunisation against preventable infection: Tetanus & Polio Measles, Mumps & Rubella Meningitis Hepatitis A,B Influenza

Type of conditions	Minor conditions	Acute conditions	Long term conditions	Intervention for prevention
Cardiovascular		Thromboembolic events (DVT, PE) Sub-Acute Bacterial Endocarditis Septicemia Stroke Myocardial infarction	Venous / arterial leg ulcers Coronary Artery Disease Hypertension Cardiomyopathy	Diet Smoking cessation Exercise
Urinary Tract	Urinary Tract Infection	Nephrotic pain Intermittent catheterisation Nereogenic bladder Kidney & bladder stones Prostate Cancer	Long term catheterisation Urinary Incontinence	Fluid Balance
Neurological	Unsteady on feet Dizziness Minor head injury	Tinnitus Head trauma due to falls Alcohol-induced or withdrawal seizures Seizure	Alcohol related brain injury (ARBI) Peripheral neuropathy Multiple Sclerosis Parkinson's Alzheimer's Motor Neurone Disease Epilepsy	Falls Prevention Services
Gynaecological	Vaginal discharge Urine leakage Vaginal prolapse/ bleeds Constipation	Pelvic Inflammatory Disease Urinary Incontinence Abdominal pain	Pelvic Inflammatory Disease Urinary Incontinence	Surgical Procedure for prolapse Long Term indwelling catheter
Alcohol related	Intoxication Unsteadiness Risk of 'falls' Accidents Memory loss	FALLS Alcohol related seizures Pancreatitis Acute hepatitis Gastritis Peptic Ulceration	Peripheral neuropathy Cirrhosis Chronic Liver Disease Alcohol Dependency Cancer	Appropriate sensitive screening Working with resident to explore triggers of drinking Impact of consumption Reduction in consumption

> “ The impact of sensory loss in the older person cannot be underestimated.

Type of conditions	Minor conditions	Acute conditions	Long term conditions	Intervention for prevention
Mental Health	Low mood Loneliness Social Isolation	Depression Anxiety state Panic attack	Dementia Schizophrenia Psychosis Depression Bi-polar disorder Personality disorder Post-Traumatic Stress Disorder	Befriending Service Motivational Interviewing Referral to day centre Befriending service Mindfulness

Below are links to voluntary organisation representing people with Long Term Conditions:

- www.alzheimers.org.uk
- www.diabetes.org.uk
- www.bhf.org.uk
- www.blf.org.uk
- www.mndassociation.org
- www.macmillan.org.uk
- www.mind.org.uk
- www.ageuk.org
- www.mssociety.org.uk

Working with Older Drinkers

- http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0085
- Website: Drink Wise Age Well: https://drinkwiseagewell.org.uk/message-bottle-opening-older-minds-alcohol-related-harm-dr-tony-rao/

Clinical and Nursing Skills

Personal Care

Caring for resident in a care home will allow you as the registered nurse to participate in and oversee the fundamentals of nursing care; this will include developing a holistic approach to personal hygiene, washing and dressing, nutritional needs and toileting. Whilst on the surface you may consider this the domain of the unregistered workforce, it will be crucial for you to develop a knowledge base and expertise in these aspects of care in order to teach the workforce about anticipatory and pre-emptive caring strategies of this frail and vulnerable group. Whilst delivering basic nursing care it allows an opportunity to develop a relationship with the resident where you will be able to encourage and offer emotional support as well as psychological support.

Sight and Hearing loss

Vision and hearing loss particularly effects older people and can affect quality of life. Often hearing and sight loss comes on gradually and can be viewed as a natural consequence of ageing; however, the impact of sensory loss in the older person cannot be underestimated. Older people with sensory loss may find it harder to eat a healthy diet, take exercise and socially interact. This can also lead to loneliness and even depression. As a registered nurse, it will be about having a clear understanding and ability to assess the impact of any impairment to help preserve and maintain good quality of life.

Guidance in residential care homes:
https://www.actiononhearingloss.org.uk/live-well/accessibility-guidance/older-people-in-residential-care-homes/guidance-for-residential-care-homes/

Oral Health

Another aspect of resident care is the maintenance of good oral health and mouth care. Care staff are required to assist residents with daily oral hygiene and to be able to complete an oral assessment in order to prevent dental decay, gum disease and dental pain.

In Wales there is an All Wales MCRA form for Mouth Care and a team in BCUHB that is training all the care homes in oral health and mouth care by developing champions in the homes and providing support to them.
For more information, go to www.1000livesplus.wales.nhs.uk/home

Dysphagia

Dysphagia impacts the person with the condition as well as their family members and care providers. Swallowing difficulties can lead to aspiration and reduced oral intake. Aspiration refers to the process when food, drink or medications pass into the trachea (instead of the oesophagus). It is important to highlight that aspiration can be silent and, in some cases it is not obvious when observing a resident during the process of eating or drinking, that the material is going into the trachea rather than the oesophagus. This can lead to more serious complications like pneumonia, malnutrition and dehydration. From a holistic point of view, dysphagia can cause patients to feel socially excluded, particularly at mealtimes when they may see others are eating normal meals. Given the prevalence of dysphagia in residents in care homes, it is important that nurses continually assess to determine if dysphagia is occurring. It is important that dysphagia is recognised and treated early so as to ensure measures are put in place to reduce its effects. [3]

Pressure Ulcers and Skin Integrity

Pressure ulcers affect around twenty per cent of people living in care homes NHSI (2016). Pressure ulcers can develop when a large amount of pressure is applied to an area of skin over a short period of time. They can also occur when less pressure is applied over a longer period of time. The extra pressure disrupts the flow of blood through the skin. Without this blood supply, the affected skin becomes starved of oxygen and nutrients and begins to break down, leading to an ulcer forming. Pressure ulcers tend to affect people with health conditions that make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods.

According to the Merck Manual, pressure ulcers begin to form in as little as two hours. The sores rapidly advance and cause severe, deep infectious wounds if left untreated. Many nursing interventions and precautions can prevent pressure ulcers from occurring. A person's position should change every two hours to stop ulcers from forming. Changing positions is encouraged when a person is awake and asleep. If a person is bed bound, move the person from lying on his back to the left side, then the right side, and then back to his back.

In Wales they promote the Simple, Safe, Effective technique: www.invacare.co.uk/sites/uk/files/The%2030%20Degree%20tilt.pdf

Wound Management

Elderly wound care is a significant and important part of the duties often assigned to nursing home staff. Diabetes and other illnesses can compromise the strength of elderly individual's skin. This can result in a greater susceptibility to sustaining a wound. As a result of older skin's slower rate of healing, elderly wound care is often considered in a context of treating chronic wounds and making sure that they do not get any worse. Instead of aiming for complete eradication of a chronic wound, the approach focuses on managing a chronic wound and keeping overall damage to a minimum.

Figure 4.3 - Wound care difficulties may be caused by:

Infection: An open wound can develop a bacterial infection. If a wound becomes infected, the body will focus on fighting the infection instead of healing the wound.
Dead Skin: Also known as necrosis, dead skin around a wound may interfere with the body's ability to heal itself and close the wound.
Bleeding: If a wound bleeds on a regular basis, the bleeding may obstruct the body's ability to close the edges of the wound.
Poor Diet: If an elderly individual is not receiving essential nutrients like protein, vitamin C and zinc, then the wound may heal slower.
Immobility: Elderly wound care is complicated when a patient is unable to move. Constant friction and pressure can worsen a wound's severity and also cause issues such as ulcers and bedsores.
Excessive Dryness/Wetness: In order to maximize the results of elderly wound care, it is important that wounds are neither too dry nor too wet
Bedsores, ulcers and other types of wounds require frequent treatment and attention.

Some care homes operate a first dressing or first choice initiative where a list of tried and tested products are used on a wound in the first instance. The aim of this approach is to provide a clinically effective appropriate and cost-effective use of products to manage the vast majority of wounds. The list should be evaluated and updated on an ongoing basis, to reflect innovations in practice and new, evaluated products.

> “ Dysfunctional bladder and bowels are seen as part and of the ageing, process and can sometimes be wrongly assessed as a result.

Hydration and Nutrition

Making sure that older people have nutritious food and drinks is essential to good care and vital to the contribution for people recovering from illness and for those at risk of malnutrition. The British Association for Parenteral and Enteral Nutrition (BAPEN) advocates that:

- Malnutrition must be actively identified through screening and assessment;
- Malnourished individuals and those at risk of malnutrition must have appropriate care pathways;
- Frontline staff in all care settings must receive appropriate training on the importance of good nutritional care; and
- Organisations must have management structures in place to ensure best nutritional practice.

Bladder and Bowel Management / Incontinence

Dysfunctional bladder and bowels are seen as part and of the ageing, process and can sometimes be wrongly assessed as a result. This can lead to some conditions being mis-diagnosed and left untreated, as the routine of using incontinence products becomes normal practice. (Tannenbaum et al, 2013). Nurses can utilise in depth assessment skills to ensure that the causes of incontinence are fully investigated and in the first instance good management and prevention. Even when a cure is not achievable, optimum methods of incontinence management can produce ‘social continence’; alleviate embarrassment of preserve resident dignity.

Management of Acute Ill Health

As a registered nurse working in a care home, you will need to develop skills of assessing residents with chronic illnesses as well as acute exacerbations of ill health of individuals or an outbreak of infectious illness, such as acute respiratory or gastrointestinal infection such as norovirus.

Individual acute illness assessment skills will be vital to ensure that you react and refer the patient to the appropriate assistance promptly to avoid unnecessary hospital admission. These skills will require development over time and come with experience of the sudden decline in a chronically ill resident, and would not be something you would be expected to be an expert in whist making the transition into your new role.

People living in care homes are especially vulnerable to infections and severe disease because:

- Residents are often elderly and frail with other underlying diseases;
- Infections can spread rapidly in care homes due to the close contact between residents and, without adequate infection control, carers can unintentionally facilitate the spread of infection between residents;
- An outbreak of infection in a care home can therefore rapidly cause significant morbidity and mortality and requires prompt investigation and management.

The guidance below provides advice to staff working in care homes on the management of respiratory-related outbreaks in Nursing and Residential Care Homes and Norovirus (also known as the winter vomiting virus).

Public Health Agency (2015) Care Home Guidance for managing outbreaks of Acute Respiratory Illness:
http://www.fluawareni.info/sites/default/files/Care%20Home%20Guidance%20October%202015%20%281%29.pdf

Public Health Agency (2013) Norovirus Incidents & Outbreaks in Nursing and Residential Homes: http://www.publichealth.hscni.net/sites/default/files/Norovirus%20Incident%20Outbreak%20Pack%20from%20Duty%20Room%20Oct%202013.pdf

It is also important that you are aware of your local authority/ CCG guidance on managing outbreaks in care homes: NICE (2016) Sepsis Guidance in the older people: http://www.bmj.com/content/bmj/suppl/2016/08/11/bmj.i4030.DC1/sepsis_nice_v70_web.pdf

Delirium

Delirium is a common disorder in older people and one of the main causes of hospital admission that can be life threatening NICE (2010). Raising awareness of this sometimes fluctuating and acute syndrome is vital in the care home setting, as is can sometimes go undiagnosed.

What is delirium?

Delirium is a state of mental confusion that can happen if you become medically unwell. It is also known as an ‘acute confusional state’. Medical problems, surgery and medications can all cause delirium. It often starts suddenly and usually lifts when the condition causing it gets better.

Delirium is more common in people who:

- are older
- have memory problems
- have poor hearing or eyesight
- have recently had surgery
- have a terminal illness
- have an illness of the brain, such as infection, strike or a head injury.

The most common causes of delirium are:

- a urine or chest infection
- having a high temperature
- side-effects of medicine like pain killers and steroids
- dehydration, low salt levels, low haemoglobin (anaemia)
- liver or kidney problems
- suddenly stopping drugs or alcohol
- major surgery

- epilepsy
- brain injury or infection
- terminal illness
- constipation
- being in an unfamiliar place.

Frailty as a Long Term Condition

Frailty affects older people in many ways and hinders their ability to live independently and to maintain social interactions, and is often related to a decline in mental health. Frailty is closely linked to an increased risk of falls and consequent fractures. It can also lead to social isolation, a need for social care and ultimately transition from home into a residential or nursing care setting.

Frailty can be difficult to define and older people can present with a combination of:

- Accumulated impairments in physical, mental or environmental wellbeing
- A diagnosis of dementia can indicate frailty even when the resident's physical state does not
- Weak muscles and conditions like arthritis, poor eyesight, deafness and memory problems.
- They typically walk slowly, get exhausted quickly and struggle to get out of a chair or climb stairs. Slow walking speed is a simple test that could help; taking more than five seconds to walk four metres is highly indicative of frailty.
- People with frailty have a substantially increased risk of falls, disability, long-term care and death.

There are several recognised assessment tools used to identify and manage frailty:

- Edmonton Frailty Scale
- The Age UK website has more information: http://www.ageuk.org.uk/

The language and management of frailty can act as barriers to engaging with older people who may not perceive themselves, or wish to be defined by a term that is often associated with increased vulnerability and dependency. Older persons may not recognise themselves as living with frailty and there is evidence that older people do not want to be considered as 'frail', although happy to accept that they are an older person.

Moving and Handling

Work within care homes will require various types of moving and handling tasks as you assist residents with their activities of daily living. Assessing moving and handling risks are key to ensuring that both residents and staff remain safe and injury free. You may need to seek specialist advice on how to assist some residents with specific moving and handling needs. Sources of advice include occupational therapists and physiotherapists; manual handling advisers and ergonomists with experience in health and social care; professional bodies and organisations.

Things you will need to consider when looking at your overall moving and handling requirements within the care home include:

- the type and frequency of moving and handling tasks

- the range and amount of equipment needed, equipment storage and maintenance

- staff required for moving and handling, and their competence and training

- the environment, e.g. flooring, ramps, lighting, space restrictions etc;

> “ Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes.

moving and handling in the event of emergencies, such as fire evacuations.

Falls
Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. being a major precipitant of people moving from their own home to long-term nursing or residential care, (King's Fund 2014). Falls are increasingly common with age and frailty and must form part of a prevention care plan for patients living in care homes[4].

In North Wales, they have developed a Prevention and Management for Falls in Care Homes Pathway. This comprehensive resource pack addresses all aspects of falls assessment and collaborative approaches to care in the care home setting.

Loneliness and Social Isolation
Loneliness and social isolation are often discussed in the same sentence. However, they mean different things. Loneliness can be understood as an individual's personal state of mind, where they feel and perceive themselves to be lonely. Social isolation refers to separation from social or familial contact, community involvement, or access to services. It is therefore possible to be isolated without being lonely, and to be lonely without being isolated. Older people are particularly vulnerable to loneliness and social isolation and the impact on their health can be detrimental to their quality of life. Social isolation is associated with raised blood pressure, poor physical health, increased mortality and poorer mental health including depression, suicide and dementia.

Depression
Depression in older people may sometimes be more difficult to detect as symptoms can be non - specific e.g. tiredness, forgetfulness, malaise or insomnia which may well be identified as part of the ageing process. As many as one in four older people have symptoms of depression Age UK (2016). Treatment with antidepressants may not be appropriate because of potential drug interactions and toxicity, which can lead, for example, to an increased risk of falls.

Enhancing Wellbeing and Maintaining Ability
There is a growing emphasis on enabling care home residents to live well and to maintain their current state of health, to ensure the best possible quality of life, and being proactive and preventative in their care. It is therefore a requirement for health care professionals to detect problems early, prevent avoidable health problems such as falls, and quickly treat any acute illness to avoid potentially serious consequences.

Cultural, Spiritual and Sexual Needs
Spiritual, cultural and religious needs play an important part in many older people's lives and should not be underestimated when considering a patient's health and wellbeing. Religion and spirituality can play an important role in guiding the lives of older people and can assist in establishing meaning to their lives. Cultural belief systems can also help with explanations of illness and causal factors. It is with this in mind when delivering resident care that these aspects are considered and discussed with residents to assist you further in building a meaningful relationship.

There is now more emphasis on sexuality and intimacy amongst care home residents, the impact on a person's self-esteem and mental health cannot be underestimated. This is particularly pertinent for lesbian, gay, bisexual or transgender people who might be less likely to disclose their sexuality.

End of Life Care
End of life care is central to the care provided by registered nurses within a care home. It requires an active compassionate approach that treats comforts and supports individuals who are dying from progressive or chronic life-threatening conditions.

The term 'end of life care' includes wider aspects of care of the dying e.g. supportive, palliative and terminal care that could go on for the last weeks, months or years of life. Macmillan nurses and palliative care nurses will be included in the wider multi-disciplinary primary care team and will work closely with GPs and other nurses in sharing expert knowledge and providing support when caring for those patients at the end of life.

Palliative Care
Palliative care is care of residents with serious illness from which recovery is not expected. Dealing with pain and other symptoms is important, but palliative care also looks at the person as a whole, including their overall sense of wellbeing as well as their physical condition. The goal of palliative care is to achieve the best quality of life for patients and their families, even if that life is likely to be short. The elements of palliative care should be introduced as soon as possible alongside other treatments and not just during the last few days or hours of somebody's life. Palliative care tackles four main types of need that may arise towards the end of life, both when death is the result of serious illness and when it is the natural 'closing down' that can happen to frail older people.

These needs are:

- **Physical** – managing symptoms such as pain, sickness, tiredness or loss of appetite; good 'tender loving care' such as preventing pressure sores;
- **Psychological** – giving emotional support to the

resident and those who care about them, giving time to listen to them and understand their concerns;

- **Social** – giving support and advice on practical matters such as getting their affairs in order;

- **Spiritual** – a need to explore thoughts about the meaning of life, or concerns about what happens after death.

End of life care for a resident in a care home should also ensure it meets national standards as laid out in Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020. This report by NHS England with the backing of 26 national health organisations agreed what good quality care at end of life looked like for residents and set key ambitions for palliative care in England.

Figure 4.4 – Six Principles of 'Ambitions for Palliative and End of Life Care: A national Framework for local action 2015-2020[5]'

The six key principles are:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help

The charity Marie Curie has launched a new online resource for health and social care professionals who do not have expertise in palliative and end of life care. It is the first time that a comprehensive and robust suite of end of life care material has been made available free, quickly and easily accessible all in one place.

Visit the Marie Curie Palliative Care Knowledge Zone to get the information and support you need when caring for someone with a terminal illness: www.mariecurie.org.uk/knowledgezone.

In Wales there is National End of Life Care Programme Guidance (2010) – The Route to Success in end of life care - achieving quality in care homes. Six Steps to Success – Programme for Care Homes.

Resuscitation Decisions in a Care Home

Whilst working in a care home there will be many discussions regarding resuscitation decisions and advanced decisions to refuse treatment, and as a nurse, working within this environment it will be important for you to have a clear understanding regarding your organisations policy if a resident is found in a position of collapse. As often the sole clinician on duty, you will need to be able to recognise clear directives regarding such decisions and interventions.

There are many different protocols for initiating or withholding resuscitation and here are some areas of resident care to consider when contributing to these decisions:

- Mental Capacity
- Consent
- Expectations
- Rights
- Quality of Life.

> “ Loneliness and social isolation are often discussed in the same sentence. However, they mean different things.

Decisions relating to cardiopulmonary resuscitation - Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (previously known as the 'Joint Statement') 3rd edition (1st revision) 2016.

Reflection trigger point – what would you do if?
These reflection triggers are for you to get together with your mentor and if appropriate other team members to debate possible solutions. They could be used as a basis for a discussion or even a teaching session. We are aware that the solutions to these triggers may vary from one Care Home to another according to local policy and procedure. We are also aware that there may be no 'right or wrong' answers to how certain situations might be tackled and therefore it will be for you as a qualified nurse to apply your thinking within the parameters of your own professional practice.

- You have been dressing a wound of a resident for the last two weeks. On this occasion, you notice that the wound looks inflamed around the peripheries and the resident complains of more pain. What would you do?

- You have been caring for a resident that has dysphagia and you notice that at meal times, it is becoming increasingly more difficult to feed the resident and they appear to be losing weight. How might you address this?

- You discover that a patient has been given the wrong medication over a period of time, and that each nurse has followed on from the original error. How would you go about alerting this?

- A sudden death where resuscitation status is not in place.

Building your resilience to maintain patient focus

As a registered nurse in a care home, you will have to establish a personal authority and assertiveness in order to influence other health and social care professionals, colleagues and patients to promote care. Being assertive means respecting yourself and other people, seeing people as equal to you, not better or less important than you. The goal of this assertive behaviour in this context is to stand up for residents rights and act as an advocate. Being assertive does not always mean you get what you want, but it can help you achieve a compromise. You will need to develop a deeper degree of self-awareness, self-belief in your ability to convey information with confidence and conviction.

In this work, it is very important to access support on a regular basis, even if you don't feel you need it. Caring for older people who have multiple complex needs can be mentally and physically demanding at times and you need to be aware that this may impact on your own emotional wellbeing. Remember that your colleagues are experienced in this kind of caring and can be a 'listening ear' if you begin to feel overwhelmed. Supervision or case meetings are essential forums to air your thoughts and feelings about a patient. It gives a chance to share with colleagues any challenges you are facing when providing care and brainstorm solutions.

Summary

This chapter has focused upon the fundamentals of nursing in a care home with nursing and the responsibilities of the registered nurse to ensure that quality care is being delivered at all times. It has highlighted the complexities of caring for people with multiple long-term conditions and the approaches and nursing skills and knowledge needed.

The chapter gives you an understanding about the value of being a strong health advocate, and the importance of continuing to develop your learning to provide the best possible patient-centered care for older people

Further resources

- The Health Foundation Inspiring Improvement website for more information www.health.org.uk

- Quality Statement 1 – NICE Guidance on Person Centred Care Planning – Home Care for Older People – June 2016.

- Framework for Person Centred Care (McCormack & McCance 2017, pg42)

- McCormack, B. & McCance, T (2017) Person Centred Practice in Nursing and Healthcare: Theory and Practice. 2nd Edition. Chichester: Wiley Blackwell.

- NHS (2016) New Care Model - The framework for enhanced health in care homes https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf

- NHS (2014) Five Year View www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

- Ambitions for Palliative and End of Life Care The National Palliative and End of Life Care Partnership is a national network of organisations who together created this strategy for better end of life care.

- Mortimer, J., & Green, M. (2015) Briefing: The Health and Care of Older People in England 2015 . http://www.cpa.org.uk/cpa/docs/AgeUK-Briefing-TheHealthandCareofOlderPeopleinEngland-2015.pdf

- NICE (2017) Care of dying adults in the last days of life

https://www.nice.org.uk/guidance/qs144/resources/care-of-dying-adults-in- the-last-days-of-life-pdf-75545479508677

- NHSE Quick Guide: Clinical Input into Care Homes – Transforming urgent and emergency care services in England http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-clinical-input-to-care-homes.pdf

- King's Fund (2014) Making our health and care systems fit for an ageing population https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.p

- British Geriatric Society (2012) Quality care for older people with urgent and emergency care needs: 'The silver book'

- Leadership Alliance for the Care of Dying People (2014) One Chance to Get it Right https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf

- NHSI (2016) - Stop the pressure – helping to prevent pressure ulcers: http://nhs.stopthepressure.co.uk/care-homes.html

- NICE Guidelines - Quality statement 1: Pressure ulcer risk assessment in hospitals and care homes with nursing: https://www.nice.org.uk/guidance/qs89/chapter/quality-statement-1-pressure-ulcer-risk-assessment-in-hospitals-and-care-homes-with-nursing

- Malnutrition Matters – Meeting Quality Standards in Nutritional Care (2010)

http://www.bapen.org.uk/pdfs/bapen_pubs/mm-toolkit-exec-summary.pdf

- Burns, J. (2016) Patient safety and hydration in the care of older people, Nursing Older People, 28, (4), pp. 21-24. 7.

- Chaudhury H, Hung L, Rust T, Wu S. (2016) Do physical environmental changes make a difference? Supporting person-centered care at mealtimes in nursing homes. Dementia (London). 2016 Jan 12.

- Lee, A. (2016) Identifying and managing constipation in older people, Nursing and Residential Care, 16, (8), pp. 366-369.

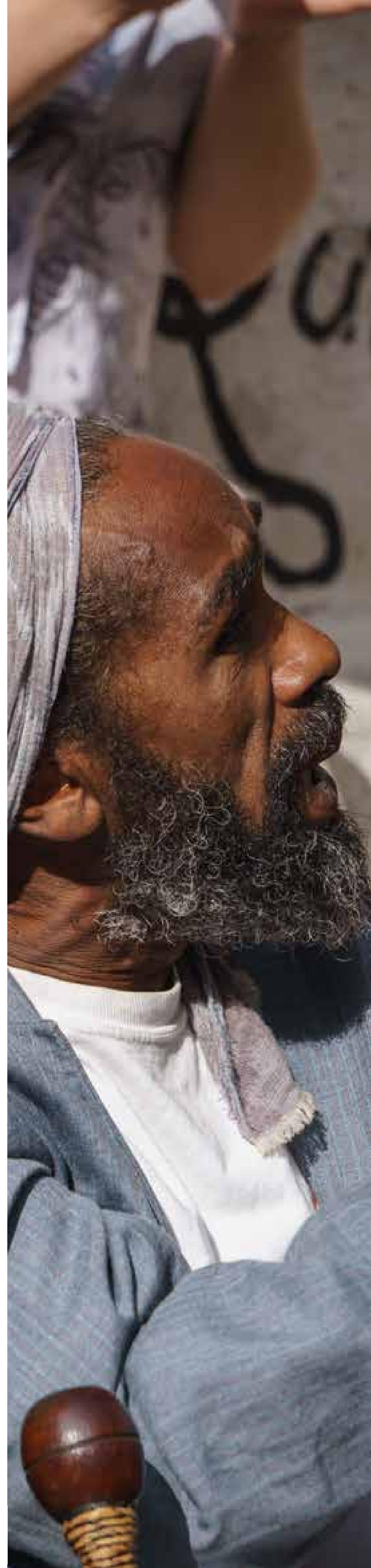
- NHSE (2015) Excellence in Continence Care - Practical guidance for commissioners, providers, health and social care staff and information for the public

- British Geriatrics Society (2010) Continence Care in Residential and Nursing Homes http://www.bgs.org.uk/bladdersnbowels/subjectreference/bladderbowel/continencenursinghomes

- Tannenbaum C, Agnew R, Benedetti A, Thomas D, Van Den Heuvel E (2013) Effectiveness of continence promotion for older women via community organisations BMJ Publishing .

- RCGP and BGS (2017) Integrated Care for People with Frailty – Innovative approaches in practice.
- British Geriatrics Society (2017) Fit for Frailty Part 1http://www.bgs.org.uk/fit-for-frailty/resources/campaigns/fit-for-frailty/fff-headlines

- NHS England (2014) Safe compassionate care for frail older people using an integrated care pathway – practical guidance for commissioners, providers



“ Being assertive does not always mean you get what you want, but it can help you achieve a compromise.

and nursing, medical and allied health professional leaders.

- Mental wellbeing of older people in care homes https://www.nice.org.uk/guidance/qs50
- Depression in older adults http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/depressioninolderadults.aspx
- Age UK (2016) Your mind matters – ideas and tips for emotional wellbeing http://www.ageuk.org.uk/Documents/EN-GB/Information-guides/AgeUKIG56_Your_mind_matters_inf.pdf?epslanguage=en-GB?dtrk=true
- Queenscourt.org.uk http://queenscourt.org.uk/spirit/- A resource to explore religious beliefs.
- Older People's Understanding of Sexuality (OPUS) Research Initiative: http://www.micra.manchester.ac.uk/research/projects-and-groups/opus/
- NICE Guidelines CG103 (2010). Delirium: diagnosis, prevention and management.
- Recognising and Preventing Delirium – A Quick Guide for Care Home Managers: https://www.scie.org.uk/publications/ataglance/recognising-and-preventing-delirium.asp
- https://www.nscphealth.co.uk/edmontonscale-pdf
- Perna et al. (2017) Performance of Edmonton Frail Scale on frailty assessment: its association with multi-dimensional geriatric conditions assessed with specific screening tools. (BMC Geriatrics)
- https://bmcgeriatr.biomedcentral.com/track/pdf/10.1186/s12877-016-0382-3?site=bmcgeriatr.biomedcentral.com
- Kenneth Rockwood – Professor of Geriatric Medicine developed, early screening, and frailty diagnostic tool.
- Rockwood Clinical Frailty Scale https://www.cgakit.com/fr-1-rockwood-clinical-frailty-scale
- SCIE and NICE (2017) Improving oral health for adults in care homes – A quick guide for care home managers.

References

1. McCormack & McCance 2017, p.20

2. The Senses Framework: improving care for older people through a relationship-centred approach. Getting Research into Practice (GRiP) Report No 2. NOLAN, M. R., BROWN, J., DAVIES, S., NOLAN, J. and KEADY, J (2006) http://shura.shu.ac.uk/280/1/PDF_Senses_Framework_Report.pdf

3. Waterhouse, C. (2016) A basic understanding of dysphagia in neuroscience nursing, British Journal of Neuroscience Nursing, 12, (2), pp S10 – S1

4. NICE Guidance (2015) Falls in older people: https://pathways.nice.org.uk/pathways/preventing-falls-in-older-people

5. National Palliative and End of Life Care Partnership, 2015, Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020, [pdf] Available at: <http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf> [Accessed 19 December 2016].

Notes on the chapter