BHiRCH
Better Health in Residents
in Care Homes

Better Health in Residents in Care Homes (BHiRCH)

Project Handbook

for Practice Development Champions and
Practice Development Support Groups

This project is a collaboration between the University of Bradford; University College London; Queen Margaret University, Edinburgh; Lancaster University; Bradford Institute for Health Research; University of Newcastle and Research Network volunteers with the Alzheimer's Society.

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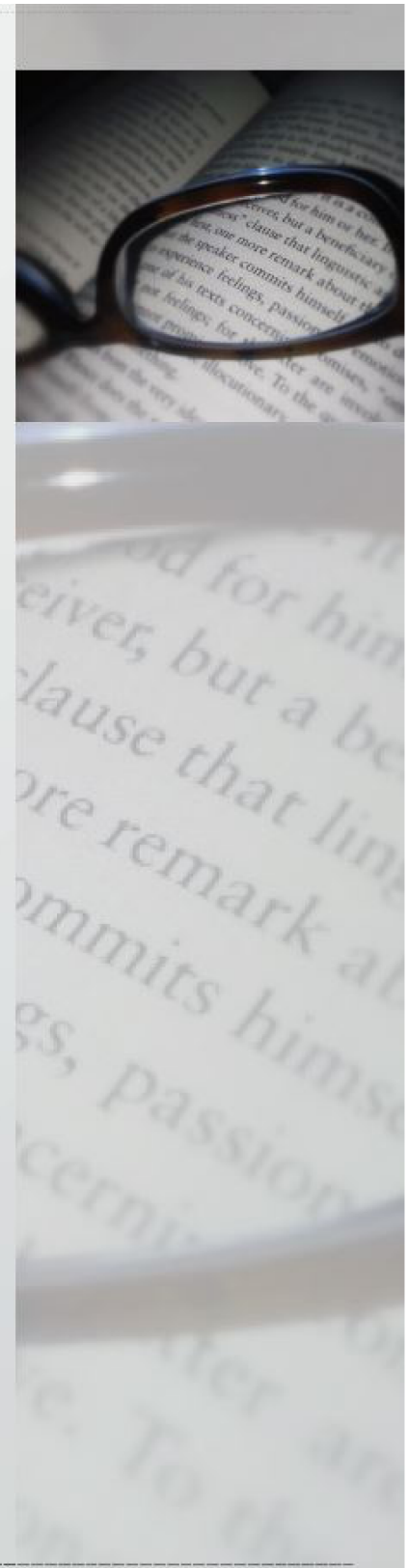

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1. Purpose of this BHiRCH handbook

This handbook is for Practice Development Champions and members of the Practice Development Support Group.

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2. Overview of the BHiRCH project

2.1 The problem being addressed

- Nursing home residents are among the frailest and most vulnerable members of society. They have significant impairments and complex health care needs. More than 75% of care home residents live with dementia.
- Early detection and intervention for ill health in care home residents is problematic. People living in care homes may be admitted to hospital for conditions which, if noticed and treated earlier, could have been managed in the care home.
- Admission to hospital can be distressing to the person, their family and nursing home staff and costly to the NHS. Being in hospital can lead to residents developing hospital-acquired conditions resulting in poor outcomes for residents. It can disrupt an older person's pattern of care and relationships.
- Avoidable hospital admissions are costly for the NHS. In economic terms, avoidable hospitalisation costs the NHS and taxpayers approximately £1.42 billion per year.
- Reducing rates of hospitalisation for treatable conditions is a government priority.
- Early detection of changes in residents' health is essential to ensure early intervention and active management of health conditions and prevent unplanned hospital admissions.

2.2 The aim of this project

The aim of this project is to reduce rates of hospital admission from care homes (with nursing) by ensuring early detection and early intervention for:

- **dehydration**
- **deterioration of congestive heart failure**
- **lower respiratory tract infection**
- **urinary tract infection**

These account for, on average, 33% of all hospitalisations.

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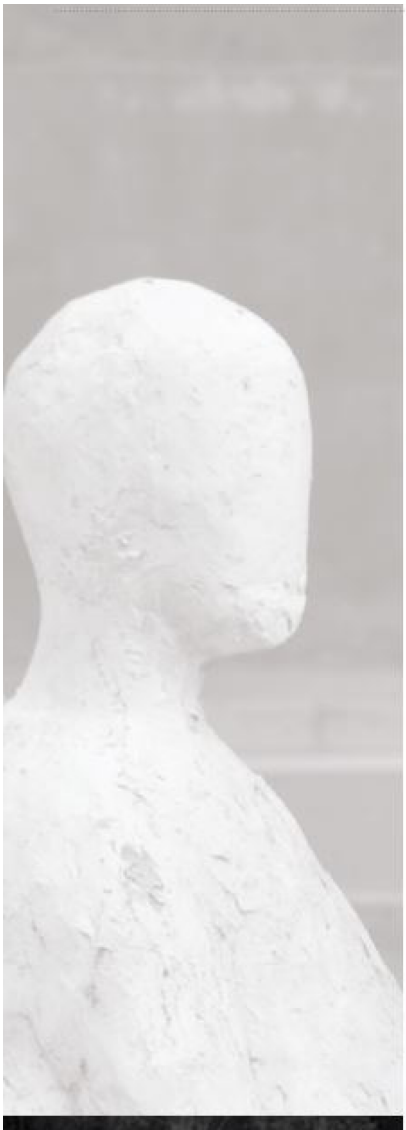

3.Key components of the BHiRCH project

The BHiRCH project has three key components supported by a structured process for introducing and embedding change:

- **The Stop and Watch Early Warning Tool**
- **The Care Pathway**
- **A structured approach for communicating with primary care – SBAR**

3.1 Stop and Watch Early Warning Tool

INTRODUCTION: The intervention will use an adapted version of Atlantic Florida University's ***Stop and Watch*** Early Warning Tool (version 4.0). This tool is widely used in the USA. It highlights simple signs and behaviours to identify common, but nonspecific, changes in a resident's condition that seem out of the ordinary for the resident. The tool is intended to be used as an alert to determine if further assessment of a resident by a registered nurse (with the ***Care Pathway***) is necessary.

WHO: Care assistants and Nurses complete the ***Stop and Watch*** Early Warning Tool when:

1. they notice a change;

or

2. anyone else in the care home (including residents, other staff and care partners) notices a change.

WHEN: As soon as is practical after a change has been noticed or reported to care staff by residents, other care home staff or care partners; at the latest by the end of the shift.

WHAT WILL THEY DO:

1. Residents, care home staff and care partners notice a change and inform care assistants and nurses.
2. Care assistants or the nurse complete the ***Stop and Watch*** Early Warning Tool, circling the changes they observe.
3. Care assistants notify the nurse of this change, giving the nurse the completed ***Stop and Watch*** Early Warning Tool.

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Name:

I.D. No:

Stop and Watch
Early Warning Tool

INTERACT
Version 4.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S Seems different than usual
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities

a Ate less
n No bowel movement in 3 days; or diarrhoea
d Drank less

W Weight change
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin colour or condition
H Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

Initial change noticed by — *Date and Time (am/pm)*
Family ☐ *Care Assistant* ☐ *Nurse* ☐ *Other* ☐

Stop and Watch completed by — *Date and Time (am/pm)*
Care Assistant ☐ *Nurse* ☐

Reported to (Nurse's name) — *Date and Time (am/pm)*

Course of action — *Date and Time (am/pm)*

Time to complete — *Date and Time (am/pm)*

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3.2 Care Pathway

INTRODUCTION: The ***Care Pathway*** is a clinical guidance and decision support system that includes Primary and Secondary assessment of:

- dehydration
- deterioration of congestive heart failure
- lower respiratory tract infection
- urinary tract infection

Primary assessment is the first level or initial assessment which comprises screening type questions and secondary assessment is the more detailed level of assessment of the person. The ***Care Pathway*** has been designed to facilitate early assessment and diagnosis of acute changes in health in order to prompt early intervention.

WHO: Nurses use the ***Care Pathway***, having been alerted to a change in a resident's health by the ***Stop and Watch*** Early Warning Tool, completed by care assistants or themselves.

WHEN: As soon as is practical after being alerted. If the Primary or Secondary Assessment result in an ambiguous outcome, the ***Care Pathway*** should be administered repeatedly at 6-hour intervals, until such time as the nurse is satisfied, from the evidence collected, that the issues of concern have resolved and/or appropriate intervention has been instigated.

HOW:

1. The nurse will conduct the Primary and Secondary assessment following the steps of the ***Care Pathway***.
2. The nurse will record primary and secondary outcomes of the care pathway on the form.
3. Following use of the ***Care Pathway***, the nurse will make a clinical decision about the next course of action which will include one or more of the following actions:
   a. If the assessment is inconclusive, but the nurse judges that the resident's condition is not an immediate concern they can:
      i. direct further general monitoring using the ***Stop and Watch*** Early Warning Tool (as often as deemed necessary), or
      ii. direct monitoring for specific symptoms of the resident's condition.
   b. If the nurse determines that the resident's condition can be treated in the care home, they can initiate treatment.
   c. If the assessment indicates a potential diagnosis, or there is immediate concern about a resident's condition, they can communicate with primary care using the SBAR tool (Situation, Background, Assessment, Recommendation – see page 12).
4. The nurse will feed back information about the course of action to the relevant staff on each shift, and to domestic staff and care partners, as appropriate.

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Name:

I.D. No:

Care Pathway: Primary Assessment

STEP 1

STOP AND WATCH

(See attached Stop and Watch tool)

By: Care Assistant or Nurse
When: By the end of the shift
Why: Emphasises non-specific behavioural changes as indicators of illness and readily observed by care staff and families during routine care and visiting
Next step: Report to Nurse

STEP 2

PRIMARY ASSESSMENT

By: Nurse
When: Triggered by Step 1
Why: Continue to Step 3 if any test is positive. If all tests are negative, repeat Step 1 at 6-hour intervals

- Check **respiratory rate** ▶▶ More than 22 per min = Test for **lower respiratory tract infection**

  Rate:

- Check for **lower urinary tract symptoms**
  - Increased frequency or urgency
  - discomfort on passing urine
  - lower abdominal discomfort/pain

  ▶▶ Positive = Test for **urinary tract infection**

  Notes:

- Check **temperature** ▶▶ More than 37.5°C = Test for **urinary tract or lower respiratory tract infection**

  Temperature:

- Check **blood pressure** ▶▶ MorSystolic BP (top figure) is lower than 110 = test for **dehydration**

  BP:

- Check **weight** ▶▶ 2kg decrease = Test for **dehydration**
  2kg increase = Test for **deterioration of congestive heart failure**

  Change in Weight:

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Name:

I.D. No:

Care Pathway: Secondary Assessment

STEP 3

SECONDARY ASSESSMENT

By: Nurse
When: Secondary assessment of a specific condition is triggered by Primary Assessment
Next step: Continue to Step 4 if any test is positive. If all tests are negative, repeat Step 1 at 6-hour intervals.

DEHYDRATION

Check **fluid intake** (less than 1 litre per day)
OR
Check **urine concentration**
OR
Check **urine output** (fluid or pads)
Check **skin turgor**
Check **BP**

▶▶ **Dehydration**

Notes:

DETERIORATION OF CONGESTIVE HEART FAILURE:

Check **ankles/legs** — Increased swelling
Check **breathing** — Breathless

▶▶ **Deterioration of Congestive Heart Failure**

Notes:

LOWER RESP. TRACT INFECTION:

Check for **breathlessness/noisy breathing**
OR
Check **Oxygen saturation**
Check **cough for change in phlegm, sound, frequency**

▶▶ **Lower Respiratory Tract Infection**

Notes:

URINARY TRACT INFECTION:

Dip **urine** or **test pad** (NB potential for false positives for people with catheters) — Positive for nitrites

▶▶ **Urinary Tract Infection**

Notes:

STEP 4

ACTION

Outcomes *Please tick all that apply*

Diagnosis ▶▶ Urinary tract infection ☐ Respiratory infection ☐ Congestive heart failure ☐ Dehydration ☐ Other ☐

Action ▶▶ Initiate treatment ☐ Monitor with Stop & Watch ☐ Monitor for specific symptoms ☐

Refer to primary care ▶▶ GP ☐ Community Nurse ☐ Emergency Services ☐ Telemedicine ☐ Other ☐

By: Nurse or Manager
When: Triggered by suspected diagnosis or other concerns raised at secondary assessment (Step 3)

Time to complete: .....

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Normal Clinical Observations Values

Blood Pressure-	**100-140 Systolic Blood Pressure** **60-90 Diastolic Blood Pressure**
Heart Rate (Pulse Rate)-	**50-100 Beats Per Minute**
Respiration Rate-	**9-20 Breaths (Inhale + Exhales) Per Minute**
Oxygen Saturation-	**93-100% Oxygen Saturation (PO2)**
Temperature-	**36.5-37.5 °C (Degrees Celsius)**

Additional Tips

Always remember to take into consideration if the patient has a current illness, disease or disability that may affect the patient's observation values in any way.

e.g.- Chronic Obstructive Pulmonary Disease, etc.

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3.3 Structured method for communicating with primary care

INTRODUCTION: The Situation, Background, Assessment, Recommendation (SBAR) is a structured method for communicating information about residents to primary care. This will contribute to early detection and intervention in changes in residents' health.

WHO: Nurses use the SBAR to communicate changes in residents' health to primary care and out-of-hours staff.

WHEN: The nurse uses the SBAR to provide primary care with information about the resident who they have assessed using the ***Care Pathway*** as experiencing deterioration in their health.

HOW: In preparation for a call to primary care, the nurse should make a note of any relevant information using the four elements: Situation, Background, Assessment and Recommendation in sequence. Only the most relevant data is included. Presenting the information about the resident using the structured format will help primary care staff to quickly understand the situation.

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S

Situation:
I am (name) a Nurse at (Care Home name)
I am calling about (resident X)
I am calling because I am concerned that…..
(e.g. BP is low/high, temperature is XX, breathing has changed)

B

Background:
Resident X has been living with us since (X date)
They have been receiving (X medicines/X intervention)
Their last assessment indicated a risk of (X)
Resident (X)'s normal condition is… (e.g. alert/drowsy/confused, pain free)
Their condition has changed in the last (XX mins/hours/ days/weeks)

A

Assessment:
I think the problem is (X)
And I have…
(e.g. increased fluids, given analgesia)
OR
I am not sure what the problem is but resident (X) is deteriorating
OR
I don't know what's wrong but I'm really worried

R

Recommendation:
I need you to ….
See the patient (when?) / Consider prescribing (X drug) /
Make a referral to (X) / Advise me what to do (when? what next?)
AND
Is there anything I need to do in the meantime?
(e.g. stop the fluid / repeat the obs)

Ask receiver to repeat key information to ensure understanding

The SBAR tool originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA

This version has been further adapted for use in care homes by the BHiRCH project

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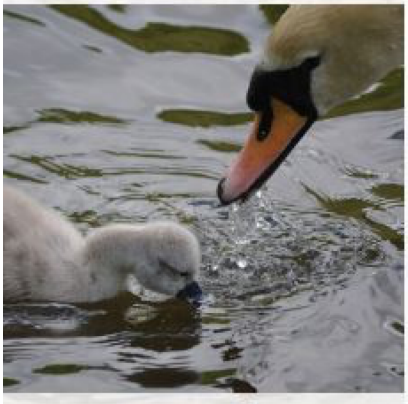
4. Support for introducing and embedding change

We recognize that introducing and embedding change in care homes is challenging. In this project we have a strand of work devoted to supporting you in introducing and embedding change in care practice regarding early detection and intervention of changes in residents' health in your care home.

This includes:

- **The Promoting Action on Research Implementation in Health Services (PARIHS) framework**
- **Practice Development Champions**
- **Practice Development Support Groups**
- **Practice Development Workbook**
- **Telephone support**
- **Online resources**

To read more about the PARiHS framework see references on page 20



4.1 The Promoting Action on Research Implementation in Health Services (PARiHS) framework for change

The PARiHS framework is guiding our approach in supporting you to introduce and embed change. It proposes that implementing change is a function of a dynamic relationship between the following three inter-related elements:

4.1.1 ***Evidence*** refers to the variety of knowledge that informs decision-making. It includes research evidence, professional opinion, audit data and feedback from residents and care partners. In this study the evidence-based intervention being implemented is based on a combination of findings from the literature, focus groups and consensus workshops with care home staff and care partners.

4.1.2 ***Context*** refers to the place or setting where the care practice happens – in this case the care home setting. We know that no matter how good the evidence is, the potential for evidence-based practice can be hampered, or indeed facilitated, depending on the context. In this project the work of the Practice Development Champion and the Practice Development Support Group will be to identify and address any contextual issues that might prevent the components of BHiRCH from being introduced and embedded in practice.

4.1.3 ***Facilitation***. In this study we rely on Practice Development Champions and their Practice Development Support Group to facilitate introducing and embedding a change in practice regarding early detection and intervention for changes in residents' health.

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4.2 Practice Development Champions

INTRODUCTION: Practice Development Champions will lead and coordinate the development and monitoring of action plans to change practice regarding early detection and intervention of the four health conditions focused on in this project. They will train, support and work alongside nurses and care staff to ensure effective introduction and embedding of the intervention. They will maintain a momentum for change and practice development in early detection and intervention for changes in residents' health.

WHO: Practice Development Champions are nurses who work in the care home.

HOW: Two Practice Development Champions (nurses) are identified in each care home. They are selected based on the person specification (see page 16).

WHAT THEY DO:

- Facilitate sharing of collective knowledge (thoughts, experiences, feelings), including the telling of stories and use of group reflection, about current practice re early detection and intervention.
- Facilitate establishing agreement on achievable goals and objectives re early detection and intervention.
- Develop action plans to achieve the goals and objectives and identify how they will know when they have been achieved.
- Assist in determining the resources, work, communication and supporting conditions required to achieve the goals and objectives.
- Shape a workable model of change for their care home.
- Bring together a range of evidence to review progress with the project.
- Establish, implement and monitor a communications strategy so that all care home staff and family members, close friends and primary care staff know about the goals and objectives.

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Practice Development Champion person specification

The Practice Development Champion will:

- Be a Registered Nurse.
- Have been working in the nursing home for at least 6 months.

When selecting a Practice Development Champion we are looking for someone who:

- Has some knowledge of good practice in supporting health care and has an interest in the topic *(can demonstrate some essential knowledge of the management of the 4 conditions: dehydration, deterioration of congestive heart failure, lower respiratory tract infection and urinary tract infection).*
- Knows co-workers *(has been in the organisation long enough to know the staff and how they work).*
- Knows the environment *(has some insight into the culture of the setting).*
- Knows the organisation *(knows their way around the organisation, e.g. who's who, policies in place, decision-making structures).*
- Possesses effective communication skills *(could include attributes of being open minded, being creative, has experience of managing meetings/groups, able to talk in front of groups).*
- Is self-aware and resilient *(has insight into their support needs, but is also not afraid of challenge/conflict; willing to engage in own professional development).*
- Is reliable and dependable *(has time they can dedicate to this work [in writing from their manager]; carries through with responsibilities, meets deadlines or negotiates otherwise; is not intending to be on extended leave during intervention period).*
- Is respected by co-workers *(has a good relationship with co-workers which means they will be listened to with respect to new ideas).*

These criteria are ESSENTIAL and are all equally important.

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4.3 Practice Development Support Group

INTRODUCTION: The Practice Development Support Group will support the Practice Development Champions in introducing and embedding change. It will be made up of diverse stakeholders working together to close the gap between actual and potential practice, in this case the early detection and intervention for changes in residents' health.

WHO: Practice Development Champions select diverse stakeholders to be members drawn from the following groups of people:

- **Within the Care Home:** Manager; Nurses; Care Assistants; Care partners of residents.
- **External to the Care Home:** Community Nursing staff (eg Care home support team); Acute care representatives (hospital/A&E); primary care eg GP

In each care home the manager and Practice Development Champions need to decide who is available and most appropriate to help them make change, bearing in mind the need to ensure that staff on all shifts can learn about these changes.

WHEN: Practice Development Champions identify members of the Practice Development Support Group following the workshop attended by Practice Development Champions.

HOW: Criteria for identification of Practice Development Support Group members is discussed in the workshop for Practice Development Champions.

WHAT THEY DO:

- Share collective knowledge (thoughts, experiences, feelings) about current approach to early detection and intervention for residents' health.
- Agree achievable goals and objectives.
- Determine the resources, work and supporting conditions required to achieve the goals and objectives set by the Practice Development Support Group.
- Establish, implement and monitor a communications strategy so that all staff, care partners and primary care staff know about the intervention.

The detail of how Practice Development Champions will work with the Practice Development Support Group will be negotiated at each site to ensure a mutually supportive relationship with clear lines of accountability.

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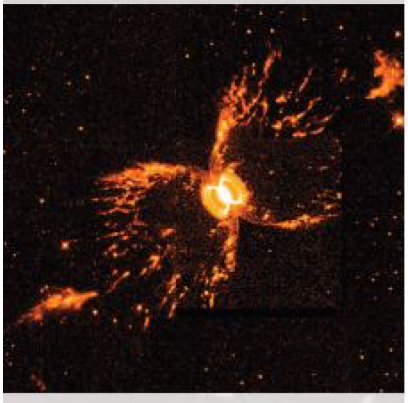
4.4 Practice Development Workbook

We have provided you with a copy of Dewing et al (2014) *Practice Development Workbook*. This has lots of guidance and examples for introducing and embedding change in care practices. If you use the workbook to support your work as the Practice Development Champion and how you work with the Practice Development Support Group, then you will be able to systematically work your way through the process of implementing necessary changes in practice. In summary, the workbook will help you to engage in the following key stages in addressing contextual issues and bringing about changes in practice:



I. **GETTING STARTED AND FORMING AS A GROUP:** When you first meet as a Practice Development Support Group you will want to have a discussion about how you will work as a group and how to get started with the project; how you will share ideas and issues; talk about your collective values that drive your desire to implement this change; share stories from your experience that can lead to shared learning and development; and, develop a shared vision for what practice could look like when you have implemented the BHiRCH processes in practice. SECTIONS 1 and 2 of the workbook will help you.

II. **GETTING A PLAN OF ACTION IN PLACE AND SHARING LEARNING:** A good way to think about the implementation process is as a series of small steps and changes that you make over time. Remember, 'if you are going to eat an elephant, do it in bite-sized chunks!!'. As the Practice Development Champion you would work with the Practice Development Support Group to consider getting an action plan in place (SECTION 6 of the workbook) and agreeing different activities for sharing learning in practice as you progress. SECTION 8 in particular focuses on different activities for engaging in learning in the workplace and it provides you with a range of activities to help with this. Both these sections help you to think of ways of ensuring that the leaders/managers of the care home are engaged with the work, are supportive of the changes being made and that the Practice Development Support Group is working as a collective team.

III. **GIVING AND RECEIVING FEEDBACK:** As you progress with the work, being able to give colleagues feedback on how they are doing with the change in practice is really important. It is something that many people who facilitate changes in practice don't like doing, but we know it is critical to embedding the change in practice and to our learning. SECTION 8 of the workbook has some specific activities for promoting reflection in and on practice for giving/receiving feedback. It is good to use these activities in the Practice Development Support Group to rehearse giving and receiving feedback.

IV. **REVIEWING YOUR PROGRESS:** Whilst there is an overarching evaluation plan in place for evaluating the implementation of the BHiRCH components 1-3, it also important to evaluate how the implementation of those components has happened and the effectiveness of the strategies used. Remember the PARiHS Framework and how it pays attention to the way that evidence works in different settings. How the setting impacts on the extent that components 1-3 can get embedded in practice and how effective the processes used to 'support introducing and embedding the change in practice' has been is also important to evaluate. So

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it is important for the Practice Development Champion and the Practice Development Support Group to think about and plan for how to evaluate the effectiveness of your processes. SECTIONS 4 and 5 focus on this and provide you with many useful tools and processes.

V. **CELEBRATING SUCCESS AND CARRYING ON WHEN THINGS DON'T GO SO WELL:** Celebrate every small success and use these as a platform for learning, development and sustaining commitment. Celebrate through feedback, announcements, thanking individuals and teams, sharing successes at meetings and events. However, if you are feeling stuck and need help to figure out ways of moving forward then SECTION 9 of the workbook should help you. In addition, the telephone support calls will help you to talk through things like this and plan new actions for moving forward.

4.5 Telephone support

One of the BHiRCH project team will provide telephone support to Practice Development Champions with the change process.

4.6 Online resources

Please follow this link for a range of online training materials which address the knowledge and skills needed for early detection and intervention of changes in residents' health.

http://www.brad.ac.uk/health/dementia/research/bhirch/training-materials/

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References

- DEWING. J, MCCORMACK. B, TITCHEN. A., 2014. *Practice Development Workbook: For Nursing, Health and Social Care Teams.* Wiley Blackwell. Sussex.
- KITSON. A, HARVEY. G, MCCORMACK. B., 1998. *Enabling the implementation of evidence based practice: a conceptual framework.* Quality in Health Care. Vol. 7, pp. 149-158.
- MCCORMACK. B, KITSON. A, HARVEY. G, RYCROFT-MALONE. J, TITCHEN. A, SEERS. K., 2002. Getting Evidence into Practice: The Meaning of Context. *Journal of Advanced Nursing.* Vol. 38, pp. 94-104.
- RYCROFT-MALONE. J, KITSON. A, HARVEY. G, MCCORMACK. B, SEERS. K, TITCHEN. A, ESTABROOKS. C., 2002. Ingredients for change: revisiting a conceptual framework. Quality Safety Health Care. Vol. 11, pp. 174-180.
- RYCROFT-MALONE. J, HARVEY. G, SEERS. K, KITSON. A, MCCORMACK. B, TITCHEN. A., 2004. An exploration of the factors that influence the implementation of evidence into practice. *Journal of Clinical Nursing.* Vol. 13, pp. 913-924.

Image attributions

- NASA, NSSDC., 2015. Hst Southern Crab. [online]. Available at: http://www.freeimageslive.com/galleries/space/nebula/ pics/hst_southern_crab_9932.jpg. [Accessed 24/09/15].
- PER HARDESTAM., 2015. chess-5-1454541. [online]. Available at: http://www.freeimages.com/photo/chess-5-1454541. [Accessed 24/09/15].

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