Welcome to our Preparing for Managing Deterioration Webinar

This webinar will begin shortly

Welcome

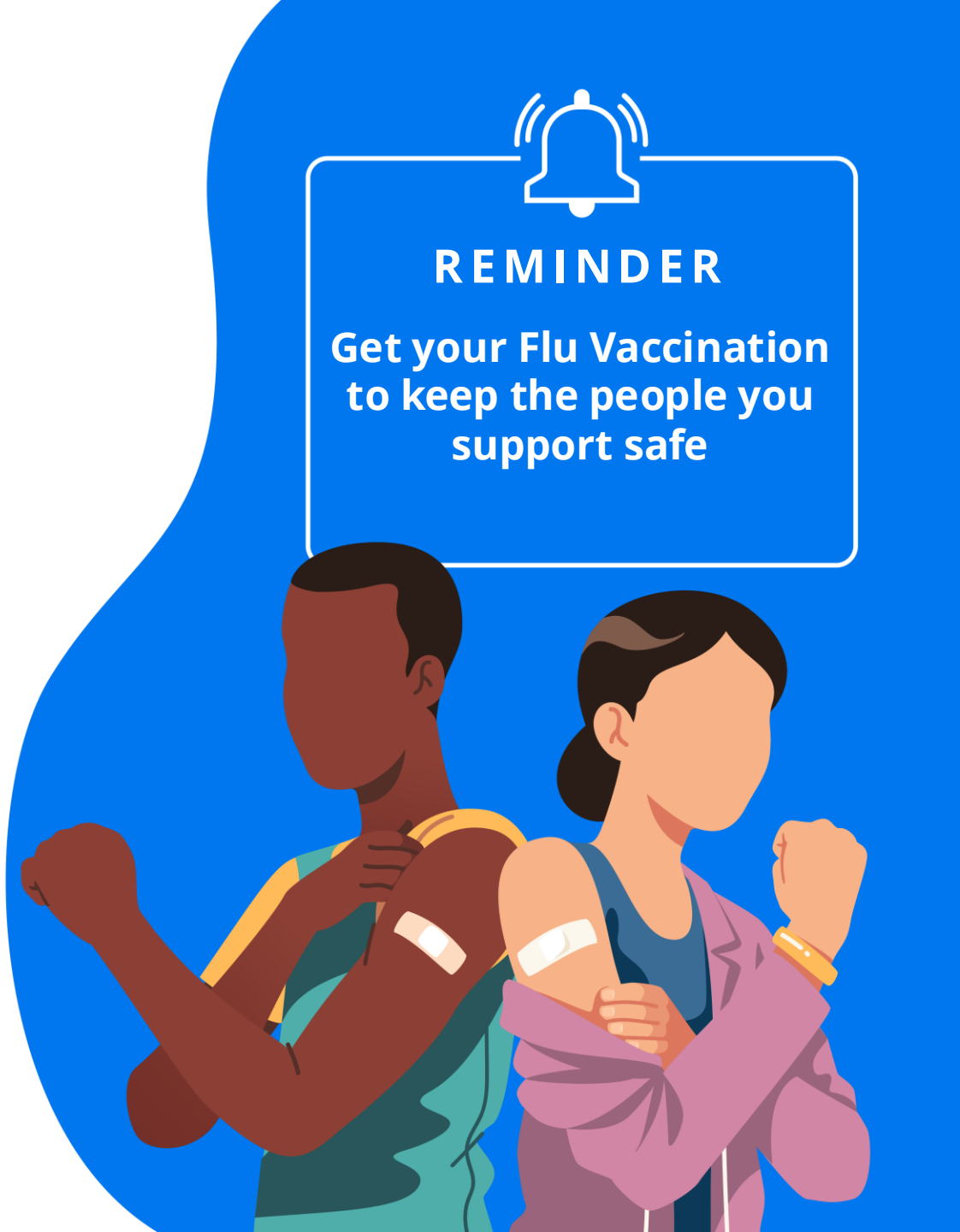
Preparing for Managing Deterioration During Winter Webinar for Manager

November 2025

Hertfordshire

HCPA Winter Preparation from November

- ✓ **Comprehensive Winter Preparation Checklist**
- ✓ **New Winter Preparation and Support Resource Website**
- ✓ **Personalised engagement to check your support needs**
- ✓ **Promotion of all non-urgent health support services**
- ✓ **Education focused on deterioration, winter wellbeing activities, and effective winter management practices**
- ✓ **Ongoing Infection Prevention and Control Guidance**



Preparing for Managing Deterioration During Winter - Webinar for Managers

Webinar presenter:
Suzy White – Physiotherapist and HCPA Prevention and Enablement Clinical Lead

hcpa

Centre of Excellence
Valid until 11/2025
skillsforcare

Care Professional Academy

Hertfordshire

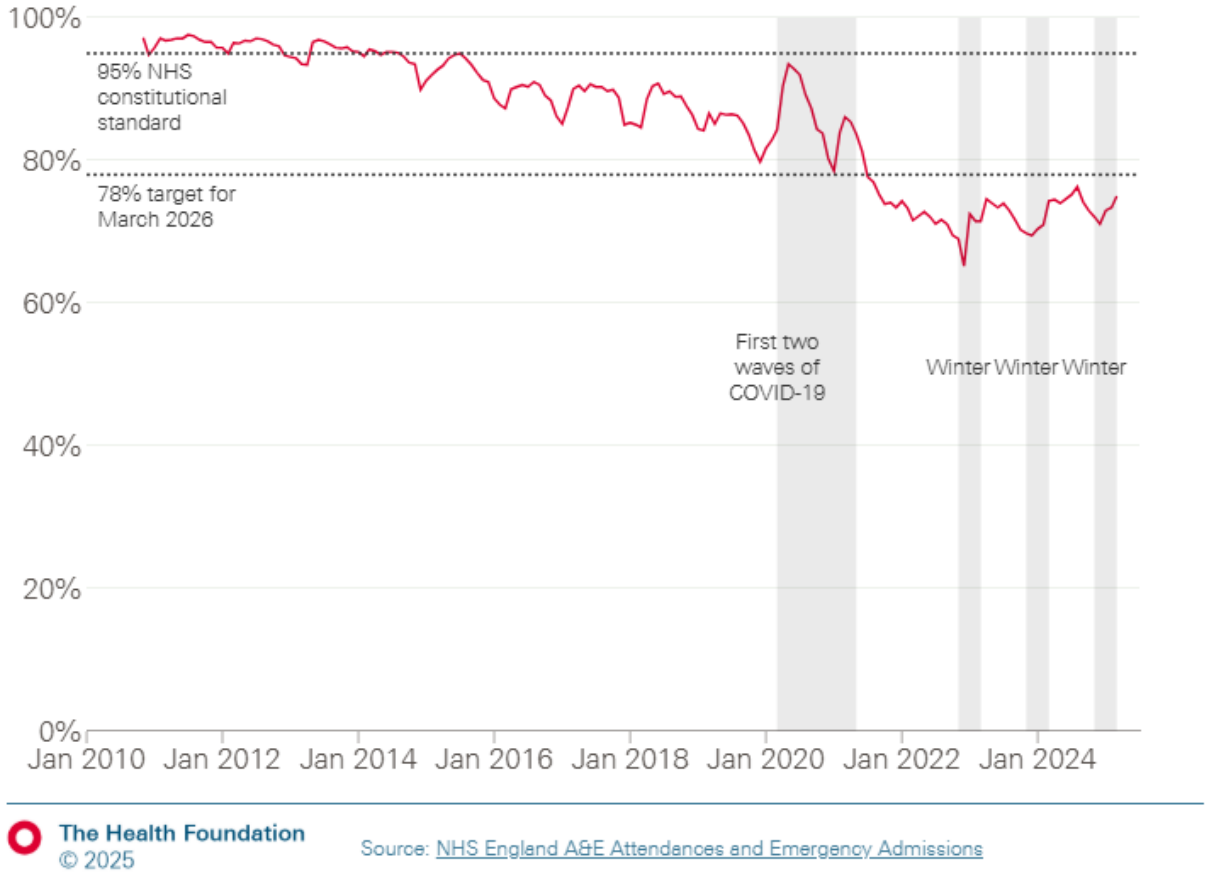
Learning Outcomes

To have a snapshot overview of the key elements required to effectively manage a person who is acutely unwell, including:

- Understanding dysphagia, aspiration pneumonia and the importance of oral health
- Understanding the importance of posture in the prevention of chest infections
- Understanding the importance of recognition of early deterioration and how to support your staff to report soft signs in a timely manner
- Understanding the importance of vital signs - temperature, pulse, respiration, blood pressure, oxygen saturations
- Understanding the importance of using the NEWS2/RESTORE2 'Track & Trigger' system, and how to use it to recognise deterioration and to determine appropriate management in an acutely unwell person
- Understanding the need for SBARD documentation to handover information clearly and appropriately
- Understanding the importance of recognising signs of sepsis
- Awareness of the importance of being able to assess an unconscious patient using the Glasgow Coma Scale
- Understanding the importance of staff recognising of signs of hypoglycaemia and hyperglycaemia
- Understanding the importance of specimens - urine, stool, vomit & sputum
- Awareness of the Hertfordshire Management of a Person who has Fallen Pathway

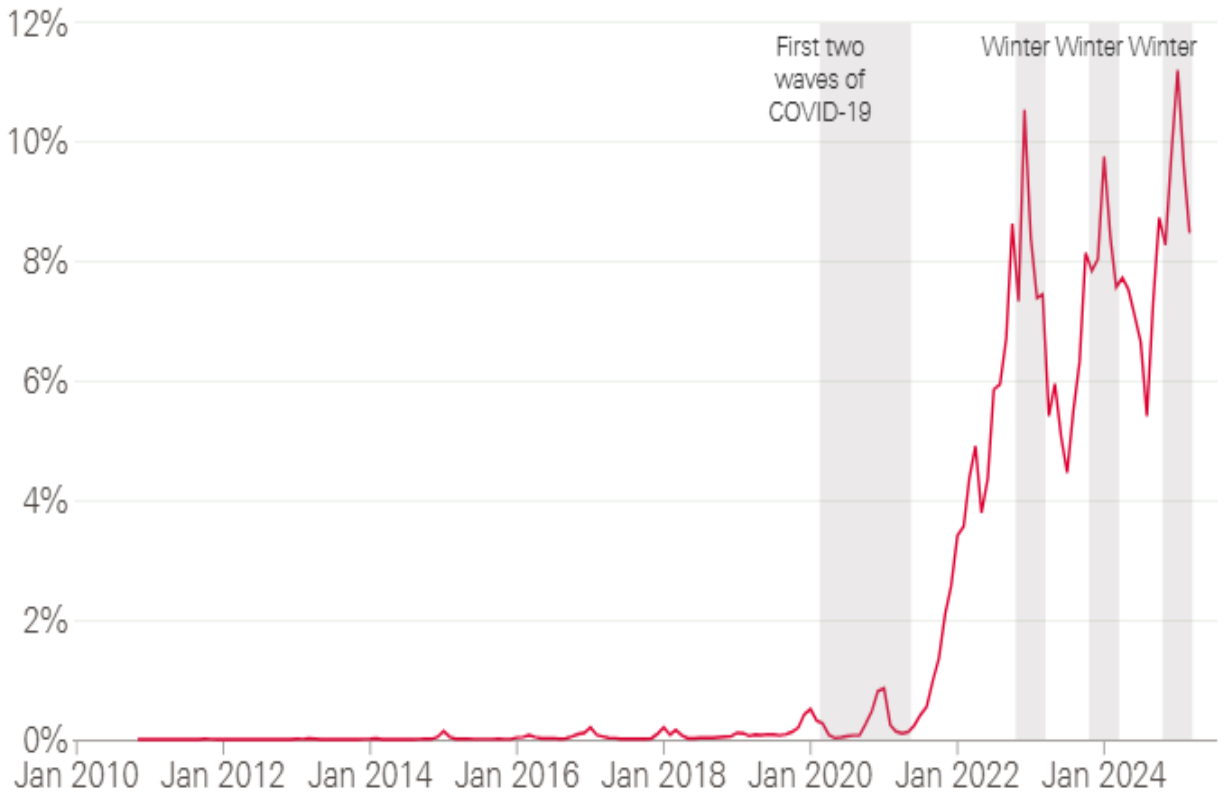
Winter 2024/2025 - New analysis shows NHS faced record winter pressures

- The NHS constitutional standard is that at least 95% of patients attending A&E should be admitted, discharged, or transferred within four hours of arrival.
- In the 2024/25 winter, 73% of all A&E patients were seen within four hours, slightly more than in 2022/23 (70%) and 2023/24 (71%) but far below the 95% constitutional standard. Performance was even worse at central emergency departments, with less than 60% of patients treated within four hours.
- The last time the NHS met the 95% standard was in the 2014/15 winter season, highlighting that performance has steadily fallen in the previous ten years.



Winter 2024/2025 - New analysis shows NHS faced record winter pressures

- Since COVID-19, the NHS has reported significant increases in 'trolley waits' where patients wait for **over 12 hours for a hospital bed** after a decision to admit, usually due to a lack of available beds.
- In winter 2024/25, a record 11% of patients waited over 12 hours to be admitted to hospital, compared to 9% in the past three winters



The Health Foundation
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Source: NHS England A&E Attendances and Emergency Admissions • Total emergency admissions includes admissions via A&E and not via A&E. Winter is defined as November to March.

The NHS Winter Preparedness document

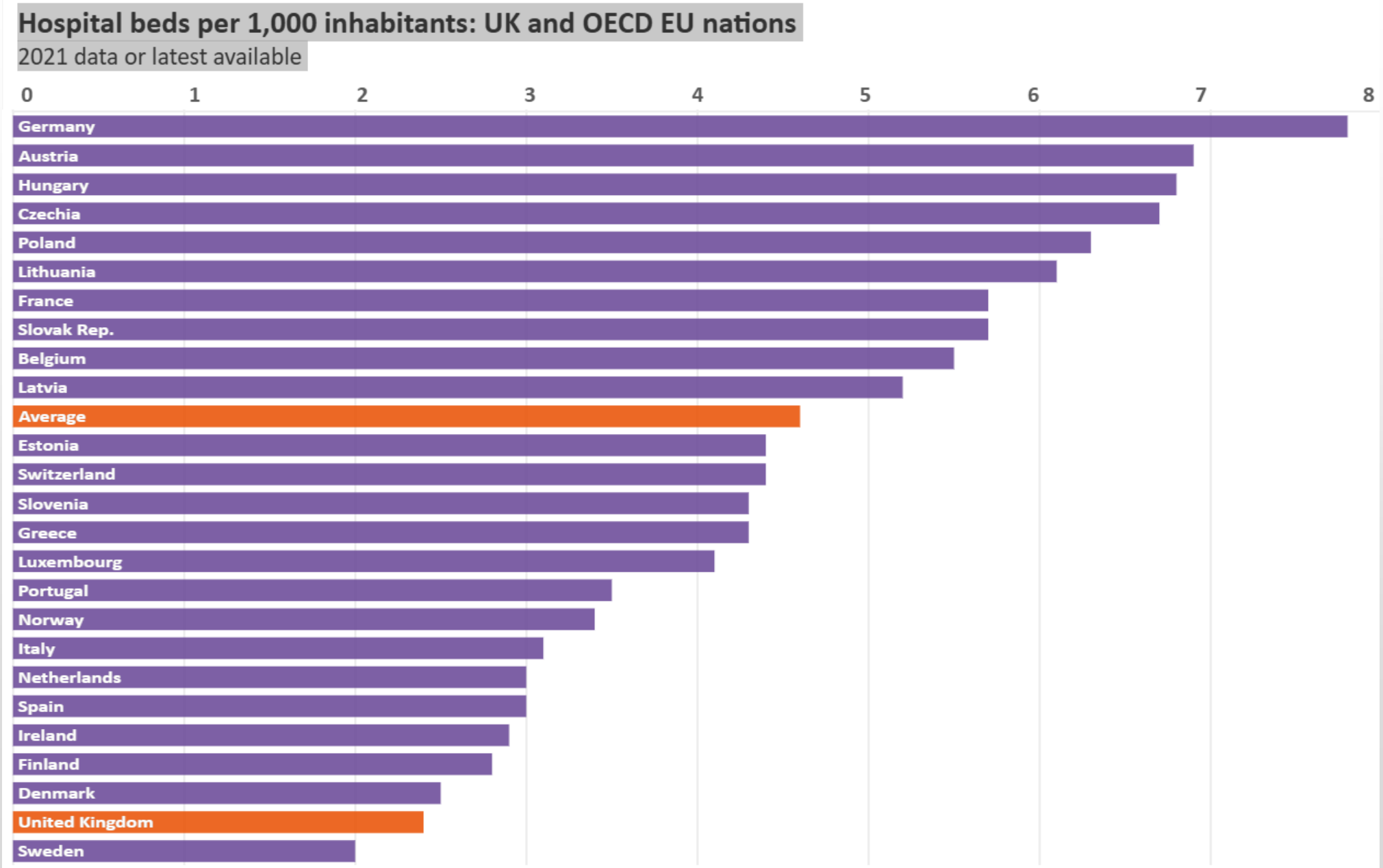
- This briefing looks at some of the reasons there are additional pressures on the NHS during the winter, and how the NHS in England seeks to address this, ensuring hospitals can cope through the colder months
- Pressures identified in winter 2024/25, direct the plans for the NHS in England to prepare for winter 2025/26
- Whilst the focus is often on ambulance and hospital services, general practice and other non-hospital care can also face heightened demand

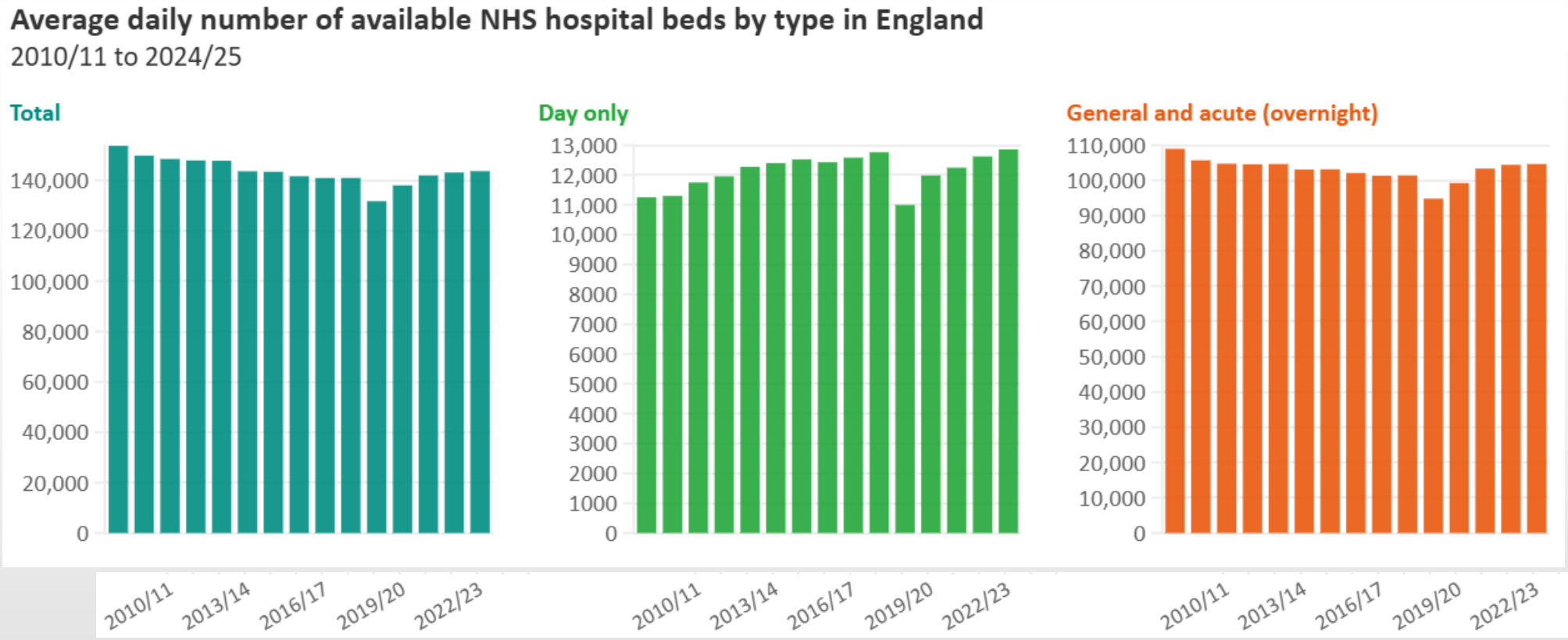
Why are there winter pressures?

- **Increased demand and complexity** – Cold weather increases hypothermia, falls, RTCs, increases risk of heart attacks and strokes, weakens immune system, worsens effects of long-term conditions, and flu, norovirus and pneumonia and some gastrointestinal viruses tend to be more common in winter

- **High bed occupancy** – Bed crisis = bed occupancy over 100% in peak winter, levels above the 85% threshold for safe care delivery since 2010, UK has fewer beds per 1000 population than most of Europe, and has higher levels of occupancy than most of Europe

The UK has fewer hospital beds than comparable nations





Overall bed stock has declined

Prior to the pandemic, the total English NHS hospital bed stock reduced by 8.3% between 2010/11 and 2019/20 as the average daily total of available beds fell from 153,725 to 140,978.

The ratio of beds that are overnight versus day-only has also undergone change. Between 2010/11 and 2019/20 the overnight bed stock shrunk by 10% while the number of day-only beds increased by 13.4%. From 2019/20 to 2023/24 the overnight bed stock slightly increased by 1.8% whereas the number of day-only beds declined by 1.1%.

Prevention and managing demand

The British Geriatrics Society has published actions and checklists for healthcare professionals to prepare older patients for winter.

12 actions to help manage winter pressures | British Geriatrics Society

12 actions to help manage winter pressures

1. Upskilling - Encourage everyone in your service to equip themselves with the skills they need to care for older people with frailty, including general staff and those delivering other specialist services

2. Proactive Care Plans - Implement proactive care plans and advance care plans (known as anticipatory care plans in Scotland) in primary and community settings, especially care homes, to consider future health needs including end of life care. Those based in the acute setting may be able to do this as part of the discharge process. Age UK Advance Care Plan booklet.pdf

3. Vaccination - Encourage all people aged 65 and over, and all care home residents and staff , to receive vaccinations against Flu and Covid-19.

In addition, people aged 75-79 will be offered a vaccine for RSV for the first time this year

Prevention and managing demand

12 actions to help manage winter pressures

4. Collaboration - Get to know your local social worker with the aim of developing better connections between health and social care

5. Technology - Make better use of technology available through social care to support people at home. These might include smart devices that help people to carry out day-to-day tasks or devices to help healthcare professionals to monitor someone's health remotely

6. Medication Management - Address polypharmacy and waste by asking patients to 'show me your meds please.' Medication-related complications are thought to contribute to up to 30% of admissions in older people. Deprescribing reviews should be completed as part of routine inpatient care for older people

7. Safe Care Environments - Seek to minimise use of temporary care environments (also known as 'corridor care') for older people – this includes 'boarding', as these environments increase the risk of delirium, falls and pressure area damage for older people with frailty

Prevention and managing demand

12 actions to help manage winter pressures

8. Frailty Identification - Identify patients with frailty as soon as they arrive at the hospital through proactive use of the Clinical Frailty Score in triage.
The Acute Frailty Network have developed an app to help staff to determine a patient's clinical frailty score (CFS) CFS APP — Specialised Clinical Frailty Network and therefore ensure that the person accesses appropriate pathways and care such as front door frailty services. Once a patient has had their CFS assessed, this should be recorded to make further decision-making easier. Avoiding hospital admission for older people improves flow across the hospital system

9. Mobilisation - Encourage older people in hospital to get up, get dressed and get moving to avoid deconditioning.
This is a real risk for older people in hospital – hospital inpatients have muscle strength reduced by up to 10% in the first seven days of admission

10. Prevent Delirium - Recognise and treat delirium as a medical emergency and prioritise its prevention and recognition.
The incidence of *inpatient* delirium in older people is around 20%. Useful tools to identify delirium are the 4AT Rapid Assessment Test 4AT and the single question in delirium (SQiD) test SQiD

4AT

(label)

Patient name:

Date of birth:

Patient number:

Assessment test for delirium & cognitive impairment

Date: **Time:**

Tester:

CIRCLE

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	**0**
Mild sleepiness for <10 seconds after waking, then normal	**0**
Clearly abnormal	**4**

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	**0**
1 mistake	**1**
2 or more mistakes/untestable	**2**

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	**0**
	Starts but scores <7 months / refuses to start	**1**
	Untestable (cannot start because unwell, drowsy, inattentive)	**2**

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No	**0**
Yes	**4**

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

4AT SCORE ☐

GUIDANCE NOTES Version 1.2. Information and download: **www.the4AT.com**

The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more *suggests* delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. Items 1-3 are rated *solely on observation of the patient at the time of assessment.* Item 4 requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item. **AMT4 (Abbreviated Mental Test - 4):** This score can be extracted from items in the AMT10 if the latter is done immediately before. **Acute Change or Fluctuating Course:** Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?"

Single Question in Delirium

SQID

Delirium is a common and treatable condition that often affects older people with frailty in hospital.

Delirium may be present on admission, but often develops during the hospital stay.

Identification of delirium should prompt specific measures to identify the cause of delirium and to manage the condition appropriately (see TIME bundle and Delirium/Dementia Care Pathway).

One way of identifying delirium is to ask the Single Question in Delirium (SQID):

Is your patient more confused or drowsy than normal?

A positive response should prompt consideration of the presence of delirium.

SQID should be asked on a daily basis by nursing or multidisciplinary staff.

'SQID+ve' or 'SQID-ve' should be clearly written into the nursing record at least once in every 24 hour period, and the result should be routinely included in any handover and/or multi-disciplinary communication (e.g. at board rounds).

Prevention and managing demand

12 actions to help manage winter pressures

11. Prevent Pressure Ulcers - Prioritise pressure area care for older people who are admitted to hospital.
The majority of pressure injuries are hospital-acquired and they are associated with increased morbidity and mortality. Hospital-acquired pressure ulcers increase length of stay by an average of 5-8 days per pressure ulcer. Make sure you complete a Bodymap assessment immediately before the person leaves your service and immediately on their return from hospital

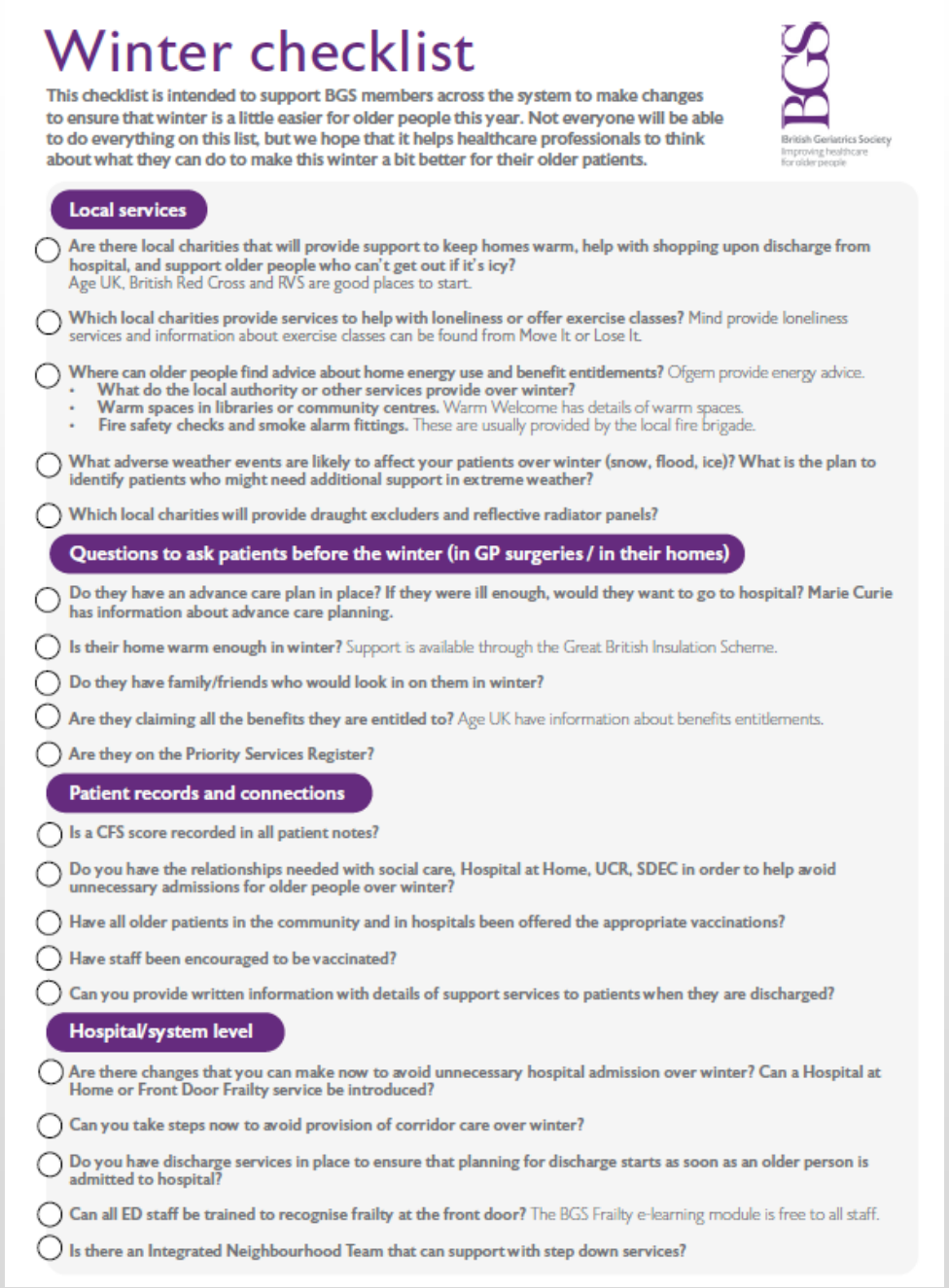
12. Alternatives to Hospital - Consider whether older people could be treated in a Hospital At Home service as an alternative to hospital admission.
While hospital may be the best option for some older patients, it is a risky environment for many older people, especially when pressure on the system is at its highest.

Preparing for winter: A checklist for healthcare professionals caring for older people

Published and last updated **06 August 2025**

British Geriatrics Society

Winter in the NHS is tough. This checklist is intended to support BGS members across the system to make changes to ensure that winter is a little easier for older people this year. Not everyone will be able to do everything on this list. But we hope that it helps healthcare professionals to think about what they can do to make this winter a bit better for their older patients.



Winter checklist

BGS
British Geriatrics Society
Improving healthcare for older people

This checklist is intended to support BGS members across the system to make changes to ensure that winter is a little easier for older people this year. Not everyone will be able to do everything on this list, but we hope that it helps healthcare professionals to think about what they can do to make this winter a bit better for their older patients.

Local services

- ◯ **Are there local charities that will provide support to keep homes warm, help with shopping upon discharge from hospital, and support older people who can't get out if it's icy?** Age UK, British Red Cross and RVS are good places to start.
- ◯ **Which local charities provide services to help with loneliness or offer exercise classes?** Mind provide loneliness services and information about exercise classes can be found from Move It or Lose It.
- ◯ **Where can older people find advice about home energy use and benefit entitlements?** Ofgem provide energy advice.
  - **What do the local authority or other services provide over winter?**
  - **Warm spaces in libraries or community centres.** Warm Welcome has details of warm spaces.
  - **Fire safety checks and smoke alarm fittings.** These are usually provided by the local fire brigade.
- ◯ **What adverse weather events are likely to affect your patients over winter (snow, flood, ice)? What is the plan to identify patients who might need additional support in extreme weather?**
- ◯ **Which local charities will provide draught excluders and reflective radiator panels?**

Questions to ask patients before the winter (in GP surgeries / in their homes)

- ◯ **Do they have an advance care plan in place? If they were ill enough, would they want to go to hospital? Marie Curie has information about advance care planning.**
- ◯ **Is their home warm enough in winter?** Support is available through the Great British Insulation Scheme.
- ◯ **Do they have family/friends who would look in on them in winter?**
- ◯ **Are they claiming all the benefits they are entitled to?** Age UK have information about benefits entitlements.
- ◯ **Are they on the Priority Services Register?**

Patient records and connections

- ◯ **Is a CFS score recorded in all patient notes?**
- ◯ **Do you have the relationships needed with social care, Hospital at Home, UCR, SDEC in order to help avoid unnecessary admissions for older people over winter?**
- ◯ **Have all older patients in the community and in hospitals been offered the appropriate vaccinations?**
- ◯ **Have staff been encouraged to be vaccinated?**
- ◯ **Can you provide written information with details of support services to patients when they are discharged?**

Hospital/system level

- ◯ **Are there changes that you can make now to avoid unnecessary hospital admission over winter? Can a Hospital at Home or Front Door Frailty service be introduced?**
- ◯ **Can you take steps now to avoid provision of corridor care over winter?**
- ◯ **Do you have discharge services in place to ensure that planning for discharge starts as soon as an older person is admitted to hospital?**
- ◯ **Can all ED staff be trained to recognise frailty at the front door?** The BGS Frailty e-learning module is free to all staff.
- ◯ **Is there an Integrated Neighbourhood Team that can support with step down services?**

Keeping people well

Respiratory disease figures

- Respiratory disease affects one in five people and is the **third biggest cause of death** in England (after cancer and cardiovascular disease). Lung cancer, pneumonia and chronic obstructive pulmonary disease (COPD) are the biggest causes of death.
- **Hospital admissions** for lung disease have risen over the past seven years at three times the rate of all admissions generally.
- Respiratory diseases are a **major factor in winter pressures** faced by the NHS; most respiratory admissions are non-elective and during the winter period these double in number.

NHS England » Respiratory disease

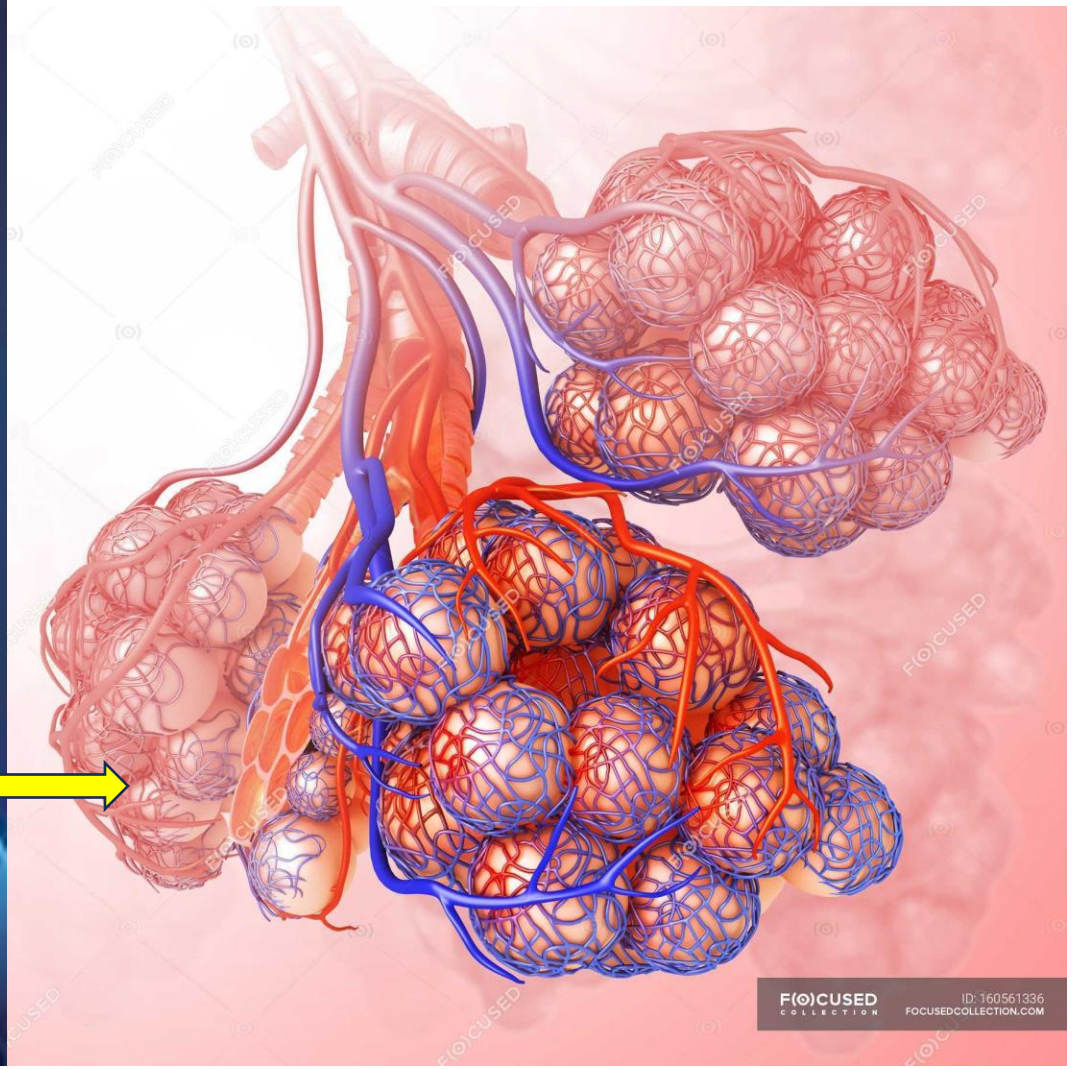
Respiratory Anatomy and Physiology

- Why breathing is important
- Structures of the respiratory system and the areas affected by a cold (URTI) versus a chest infection (LRTI) or pneumonia
- How the epiglottis prevents aspiration

Question....

How big an area do the lungs of one person cover, if you were to stretch them out flat?

The lungs and alveoli



Respiratory Anatomy and Physiology continued

- How breathing has 2 distinct parts – ventilation and respiration
- What can go wrong with the respiratory system
- Optimal respiratory function relies on:
    - Adequate ventilation
    - Adequate perfusion and pulmonary vasculature
    - Normally functioning conducting airways
    - Normally functioning gas-exchange airways (in the alveoli in the lungs)

Posture and Breathing

A. Sit in a slumped position in your chair – imagine you are one of the individuals you care for who has slipped down the bed, and is hunched with chin on chest

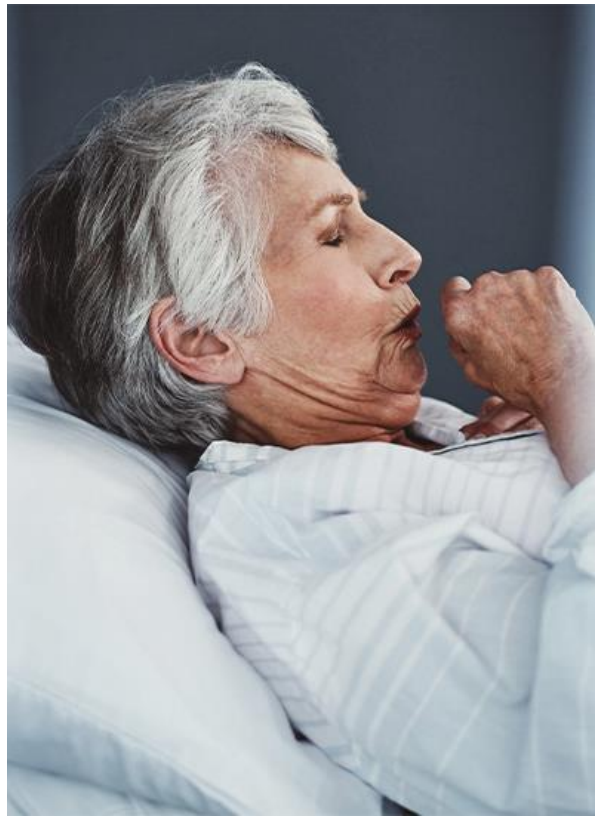
- **Try to take a deep breath**
  - *Notice how difficult this is. Imagine you need to generate a deep enough breath to cough to clear your chest in this position*

B. Change your position to sit up straight

- **Now take a deep breath**
  - *Is this easier?*

Posture and Chest Infections

- A cough is required to ‘clear’ our chest (airway)
- We need to take deep breaths in order to cough
- Poor posture can impact upon a person’s ability to take a deep breath therefore they may be unable to generate a cough and thus are likely to be at a greater risk of developing a chest infection



Dysphagia

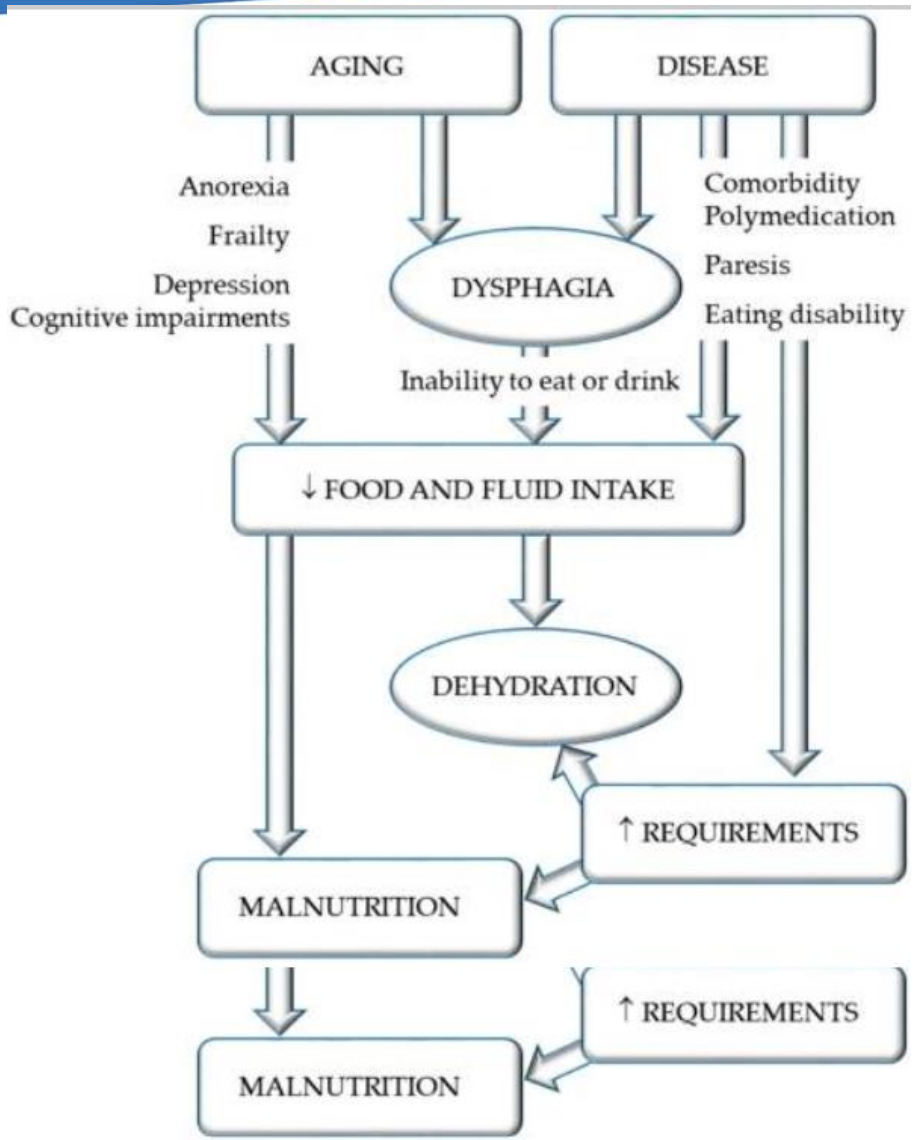
- “Dysphagia is the medical term for swallowing difficulties”
  - “Some people with dysphagia have problems swallowing certain foods or liquids, while others can't swallow at all. Other signs of dysphagia include: coughing or choking when eating or drinking”

https://www.nhs.uk/conditions/swallowing-problems-dysphagia

- Complications associated with dysphagia:
  - Aspiration pneumonia
    - What is aspiration?
    - What is aspiration pneumonia?
    - What is silent aspiration?

Effects of Dysphagia

- Aspiration pneumonia
- Increased hospital admissions
- Dehydration
- Malnutrition
- Reduced quality of life
- Social isolation
- Depression



Strategies for Safer Swallowing

- S tay Alert Ensure the person is and remains alert for all food and drink.
- T ime Allow adequate time to support the person to eat and drink.
- R egular mouth care Oral hygiene is of key importance.
- A ids Glasses and hearing aids must be worn and fit comfortably – swallowing requires multi-sensory stimulation.
- T eeth If worn, dentures should fit well and be cleaned regularly.
- E nvironment Reduce distractions at mealtimes to support concentration and awareness.
- G ood positioning The person should always be positioned in as upright a position as comfortable for all food and drink.
- I ndependence When we feed ourselves – or participate in feeding ourselves – our body prepares itself to swallow.
- E ncouragement Allow adequate time to support the person to eat and drink.
- S tay flexible Every single person is different, and their abilities can fluctuate not only from day to day, but from meal to meal.

Basic Health Observations

Soft Signs

- LOOK
- LISTEN
- FEEL
- SMELL

RESTORE2

Recognise Early Soft Signs, Take Observations, Respond, Escalate

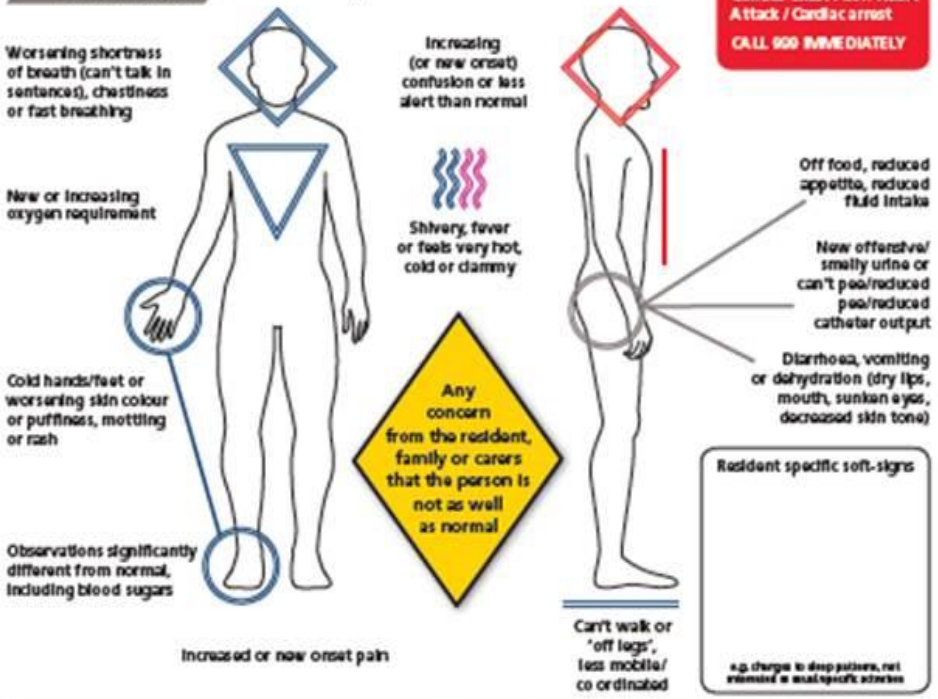
Adult Physiological Observation & Escalation Chart

Full Name:
NHS No.
DOB: Room No.

Does Your Resident Have Soft Signs of Possible Deterioration

NEW ONSET OF:
- Stroke (facial / arm weakness, speech problems)
- Central Chest Pain / Heart Attack / Cardiac arrest

CALL 999 IMMEDIATELY

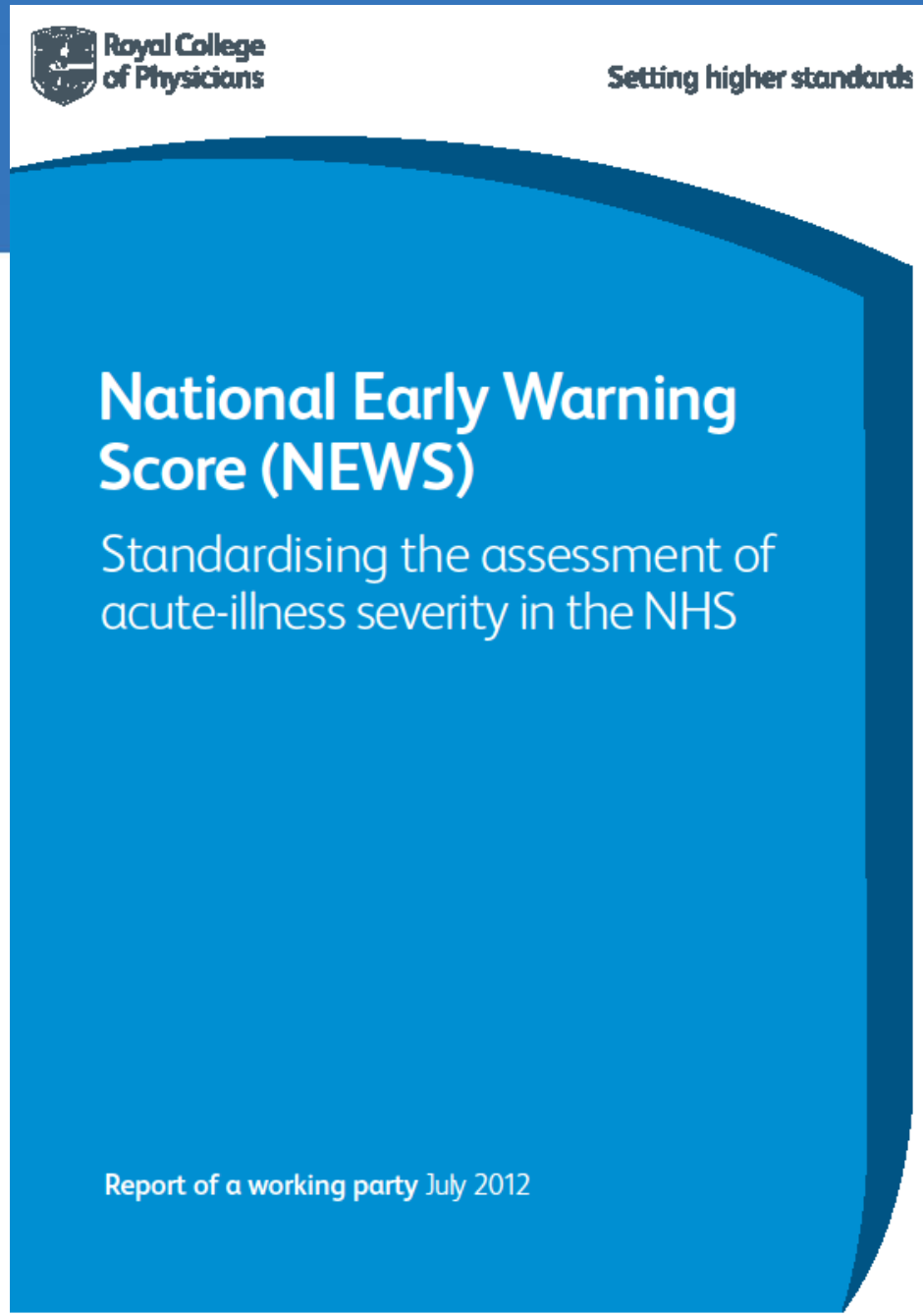


Resident specific soft-signs

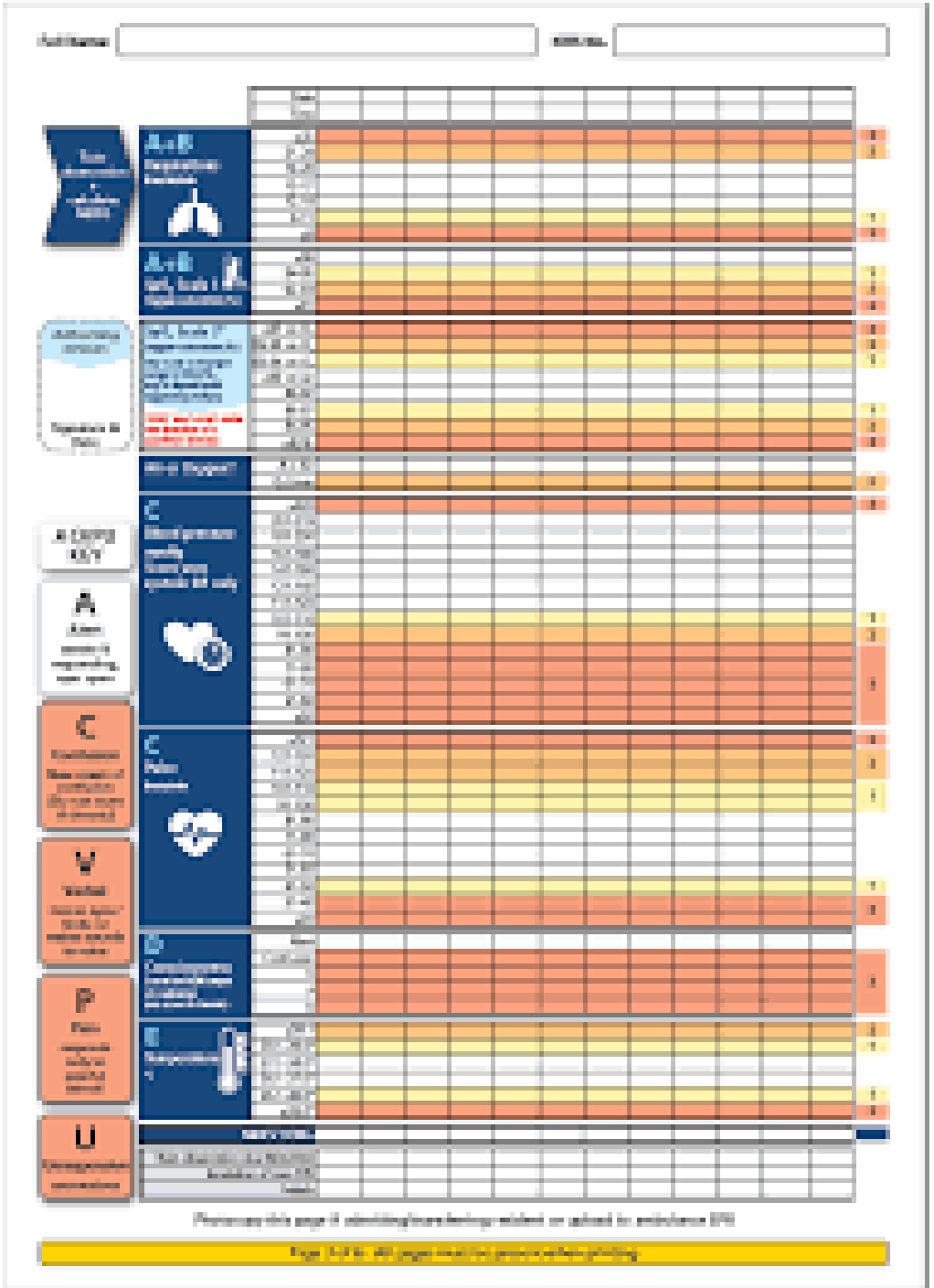
e.g. changes to sleep patterns, not attended to meal/specific activities

If you answer YES to any of these triggers, your resident is at risk of deterioration

RECOGNISE SOFT SIGNS OF POSSIBLE DETERIORATION → **TAKE COMPLETE SET OF OBSERVATIONS AND CALCULATE NEWS** → **ESCALATE USING ESCALATION TOOL AND SBARD COMMUNICATION**



Citation for this document:
Royal College of Physicians. National Early Warning Score (NEWS): Standardising the assessment of acute illness severity in the NHS. Report of a working party. London: RCP, 2012.



NEWS2

National Early Warning Scores (NEWS2)

Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

Vital signs – what are they?

The NHS Vital Signs:

- **Respiratory Rate**: The number of breaths per minute.
- **Oxygen Saturation**: The amount of oxygen in the blood
- **Blood Pressure**: The pressure exerted by the blood against the walls of the arteries.
- **Heart Rate**: The rate at which the heart beats, measured in beats per minute (bpm).
- **Temperature**: The body's temperature
- **Level of Consciousness**: Measured using AVPU or GCS scales

Changes in vital signs can indicate deteriorating health in any person

- Heart failure
- Infection
- Acute respiratory problems
- Shock
- Pulmonary embolism
- Pneumonia
- Dehydration
- Other serious acute illness

Baseline observations

- Do you measure and record them?
- When?
- Why are they useful?

Discuss equipment for taking vital signs

Respiratory rate

- Rate – how many times the person breathes (inspiration, expiration and pause) in 1 minute
- Normal rate of respiration of an adult is 12-16 breaths per minute at rest (in line with British Thoracic Society Guidelines)
- Rhythm or pattern – can be short, prolonged, heavy e.g. Cheyne-stoking, paradoxical, hyperventilation

PRACTICAL - Counting Respiratory rate

In pairs:

- Use Stopwatch – set for 1 minute
- Count how many breaths your partner takes in 1 minute
- Watch rise and fall of chest
- in + out = 1 breath
- Discuss

Oxygen saturations

Oxygen saturations

- A pulse oximeter measures the percentage of haemoglobin cells that are saturated with oxygen
- Normal levels are between 98-100%
- Below 96% indicates hypoxia
- This may be different for patients with COPD whose ‘normal’ range can be 88-92%

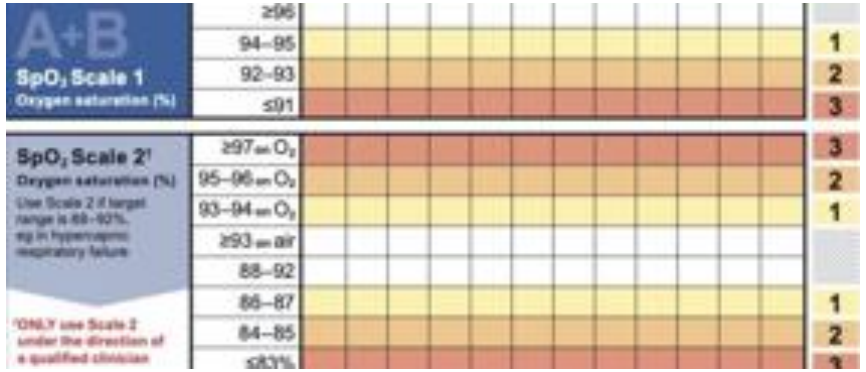
PRACTICAL - Measuring Oxygen Saturations

In pairs

1. Ensure person's nail is clean and free of nail varnish
2. Place probe on the index finger and wait for reading
3. Ensure person's hand is as still as possible
4. Monitor the reading for approximately 15 seconds
5. Clean the probe after use
6. Measure the oxygen saturations on another person
7. Record your own reading on the NEWS2 chart with a dot in the appropriate box on the **Scale 1 row**

Sp02 - Scale 1 / Scale 2

- Scale 1 is for everyone EXCEPT if it is written in the care plan, after being decided by a Clinician that the person requires Scale 2
- Scale 2 is for people who tend to retain carbon dioxide (C02), because if they do, their target oxygen saturations will likely be much lower - 88-92%
- **DO NOT USE Scale 2 unless indicated by a Clinician**



- **Cross this row out instead**

Air or Oxygen?

- Is the person on oxygen?
- OR
- Are they breathing air as normal?

Blood pressure

- Blood pressure is defined as the pressure of blood in the circulatory system
- **Systolic Blood Pressure** – this is the maximum pressure in the artery following the contraction of the ventricles of the heart (systole)
- **Diastolic Blood Pressure** – this is the level to which the arterial pressure falls during relaxation of the ventricles (diastole)
- Normal BP in adults under 80 ranges from 100/60 to 140/90 mmHg

Hypertension | Health topics A to Z | CKS | NICE

- Important! What is normal for each individual?

Low blood pressure – symptoms & risks

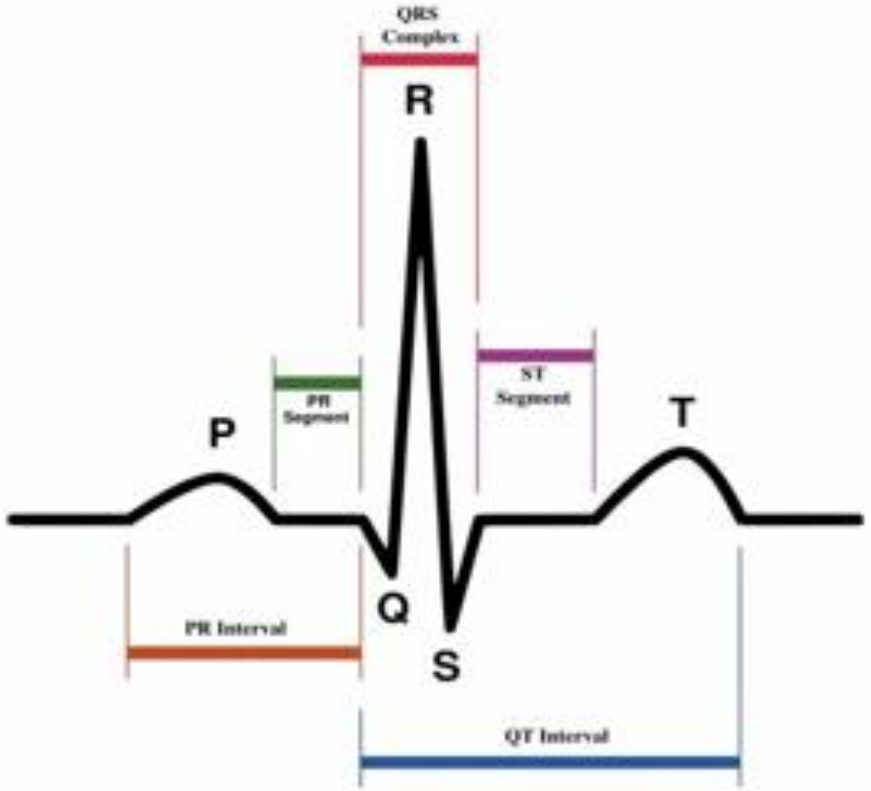
- Dizziness
- Drowsiness
- Unconsciousness
- Falls and subsequent injury
- Heart Attack
- **Indicates sepsis**

Physiological parameter	Score						
	3	2	1	0	1	2	3
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220

PRACTICAL – Measuring blood pressure

1. Measure the blood pressure on another person
2. Taking only the ***Systolic*** reading (the higher, top figure) for the NEWS2 score, record your own reading on the NEWS2 chart with a dot in the appropriate box

Heart rate/pulse



The pulse is the pressure wave transmitted through the artery with each beat of the heart e.g. following the expansion and contraction of arteries during each cardiac cycle

It can be palpated on any artery that lies close to the surface of the body

Heart rate/pulse

- Adult pulse rate – between 50 to 100 beats per minute at rest
- If the pulse rate is >100 this is classed as tachycardia (high heart rate)
- If the pulse is < 50 beats per minute this is classed as bradycardia (low heart rate)
- Radial pulse is palpated unless there is an indication for alternative pulse assessment at another pulse point

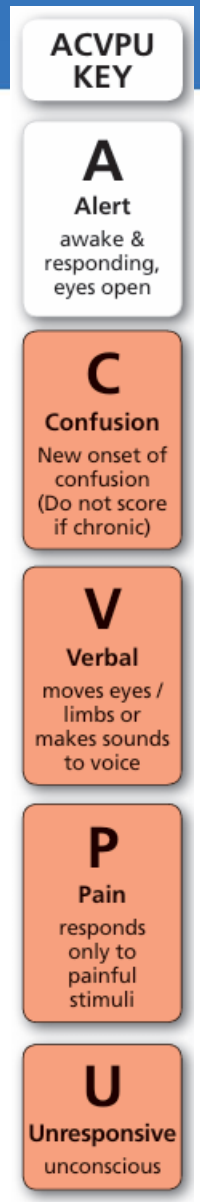
What can affect heart rate?

- INFECTION
- ALCOHOL
- DRUGS
- MEDICATION
- FOOD & DRINK
- DEHYDRATION
- EXERCISE
- ANXIETY/EMOTIONAL
- STRESS
- FEAR
- SMOKING
- CARDIOVASCULAR DISEASE
- STRAINING/EFFORT
- FITNESS LEVEL

PRACTICAL – Measuring heart rate

1. Check you can find your own pulse on yourself
2. Measure heart rate on another person, counting the beats in a whole minute
3. Record your own reading on the NEWS2 chart with a dot in the appropriate box

Consciousness

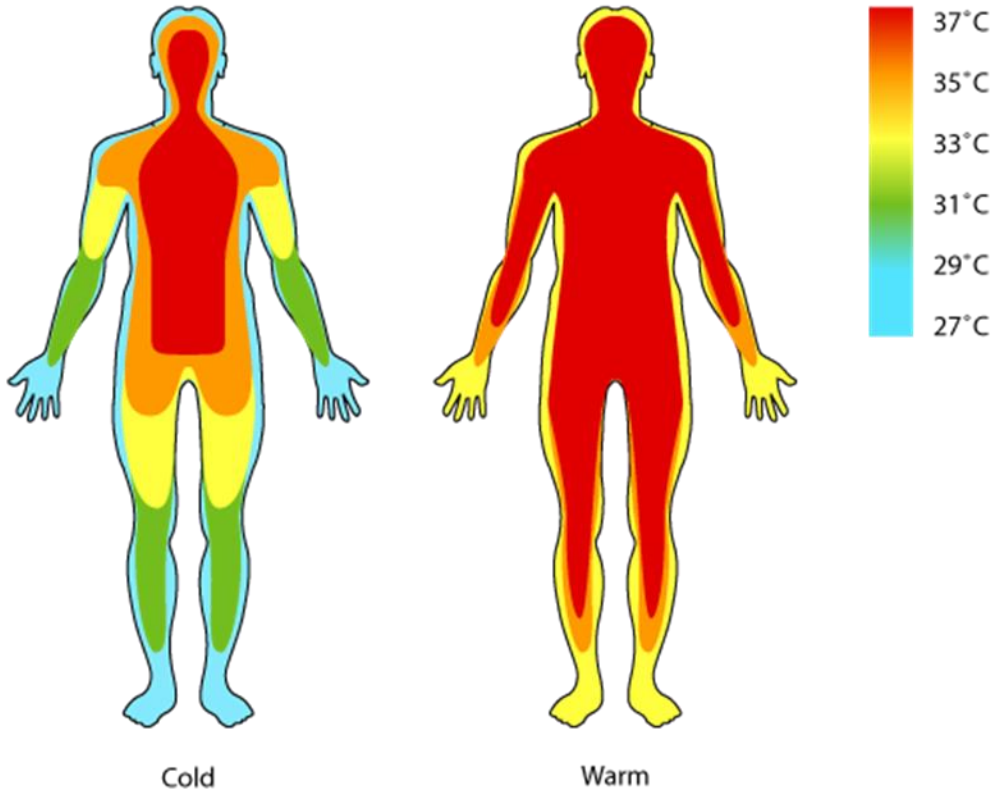


- ACVPU KEY
- A = Allert
- C = Confusion: **New onset of confusion** (Do not score if chronic)
- V = Verbal: Moves eyes / limbs or makes sounds to voice
- P = Pain: Responds only to painful stimuli
- U = Unresponsive: Unconscious

If you notice you get a score of 3 for anything that isn't 'Alert'

- Record your own level of consciousness on the NEWS2 chart with a dot in the appropriate box

Body temperature



What is the normal range of body temperature for an adult?

Body Temperature

- Normal body temperature ranges from 36.1-38 degrees centigrade regardless of changes in the environment
- A temperature of >38ºC is classed as pyrexia (high temperature)
- A temperature of ≤ 35ºC is described as hypothermia

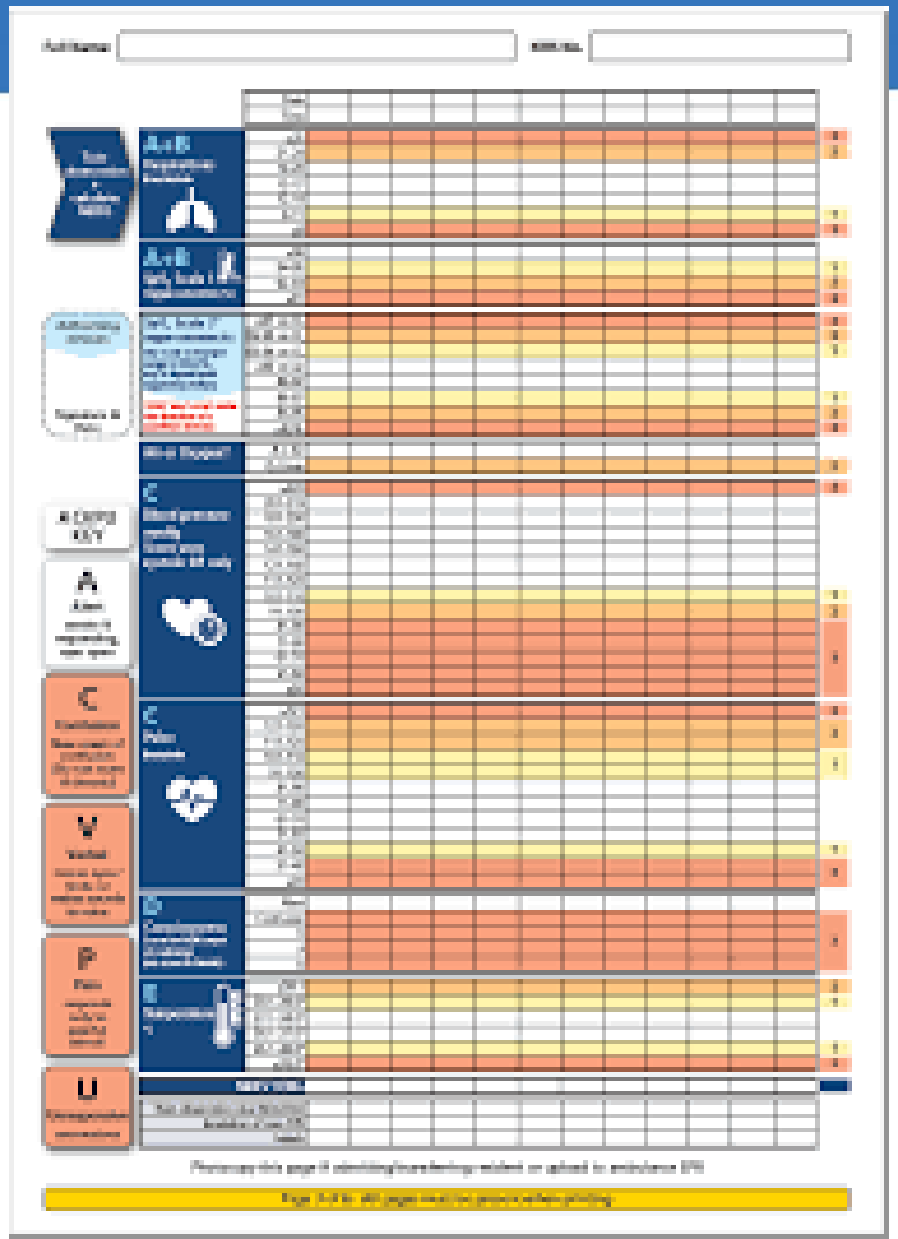
Causes of pyrexia

- Chest infection
- Wound infection
- Urinary Tract infection
- Septicaemia
- Brain injury or spinal injury resulting in an inability to regulate temperature

PRACTICAL – Measuring Temperature

1. Measure temperature on another person
2. Record your own reading on the NEWS2 chart with a dot in the appropriate box

NEWS2 Score



Add up your column score, using the numbers at the side or using this easy to read chart

Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

NEWS2 - Clinical Responses for Care and Residential settings

NEWS2 Escalation (get the right help early)

	Suggested Actions (always consider the resident's total NEWS2 in relation to their normal reference score)	Observations
0	Observe – likely stable enough to remain at home Escalate if any clinical concerns / gut feeling	**At least 12 hourly until no concerns**
1	Immediate senior staff review, escalate if concerned. Repeat observations within 6 hours. If next observations remain elevated with no obvious cause arrange for GP review suggested within 24 hours. If NEWS is worsening, move to appropriate escalation point.	**At least 6 hourly**
2	Immediate senior staff review, if no improvement in NEWS (or the same) **within 2 hours**, seek GP telephone assessment within 2 hours +/- GP review within 6 hours. If NEWS is worsening, move to appropriate escalation point.	**At least 2 hourly**
3-4 Single Observation 3	Repeat observations within **30 minutes**. If **observations = NEWS +3 or more**, seek urgent GP telephone or face to face review within 2 hours. If NEWS is worsening, move to appropriate escalation point.	**At least every 30 minutes**
5-6	Immediate clinical review/advice required. Refer to GP using surgery bypass number or use NHS 111 to contact out of hours. Urgent transfer to hospital within 1 hour may be required.	**Every 15 minutes**
7+	Admission to hospital should be in line with any appropriate, agreed and documented plan of care. Blue light 999 call with transfer to hospital (15 minutes), follow guidance of call handler	**Continuous monitoring until transfer**

Full Name: NHS No.

How to use RESTORE2

RESTORE2 which includes the National Early Warning Score (NEWS2) promotes a standardised response to the assessment and management of unwell residents. It is not a replacement for clinical judgement and should always be used with reference to the persons care/escalated plan and any agreed limits of treatment. If you are concerned about the resident or if one observation has changed significantly ALWAYS ACT ON YOUR CONCERNS AND SEEK ADVICE from a competent clinical decision maker e.g. GP, Registered Nurse or AHP.

- This chart uses aggregated (total) NEWS - it is important that you understand the residents normal NEWS (the score when they are stable and as well as usual) to support appropriate escalation. You should try and establish what is normal for residents on admission with a member of the multi-disciplinary team (e.g. General Practitioner, frailty practitioner).
- **Only a Medical Professional can authorise use of the hypercapnic respiratory failure scale for residents who normally have low oxygen levels as part of a diagnosed condition (e.g. COPD)**
- Use this chart for all your routine observations as per your local policy. If your resident shows ANY of the soft signs of deterioration, record their observations and NEWS immediately on the chart and follow the escalation tool as appropriate, using SBARD to communicate
- There may be a need to re-consider what is normal for the resident following any sustained improvement in their condition or non-acute deterioration.

What's normal for this resident

Print name: Date: Signature:

What is the resident normally like? What observations and NEWS are reasonable and safe for them? When would their GP want you to call them? What escalation has been agreed with the resident (or their advocate)?

End of Life (EOL) or Agreed Limit of Treatment

- All residents should have had the opportunity to discuss their end of life preferences in advance of any crisis
- RESTORE2 must be used in conjunction with the expressed wishes of the resident e.g. treatment escalation plans or advanced care plans.
- RESTORE2 can be used in residents with an agreed limit of treatment (e.g. not for hospital admission, not for resuscitation or not for intravenous antibiotics) to identify recoverable deterioration amenable to treatment. It is also useful for anticipating end of life to inform conversations with residents and their relatives - once the resident is on an EOL care pathway, RESTORE2 should be discontinued.

NEWS2 Escalation (get the right help early)

	Suggested Actions (always consider the resident's total NEWS2 in relation to their normal reference score)	Observations
0	Observe – likely stable enough to remain at home Escalate if any clinical concerns / gut feeling	**At least 12 hourly until no concerns**
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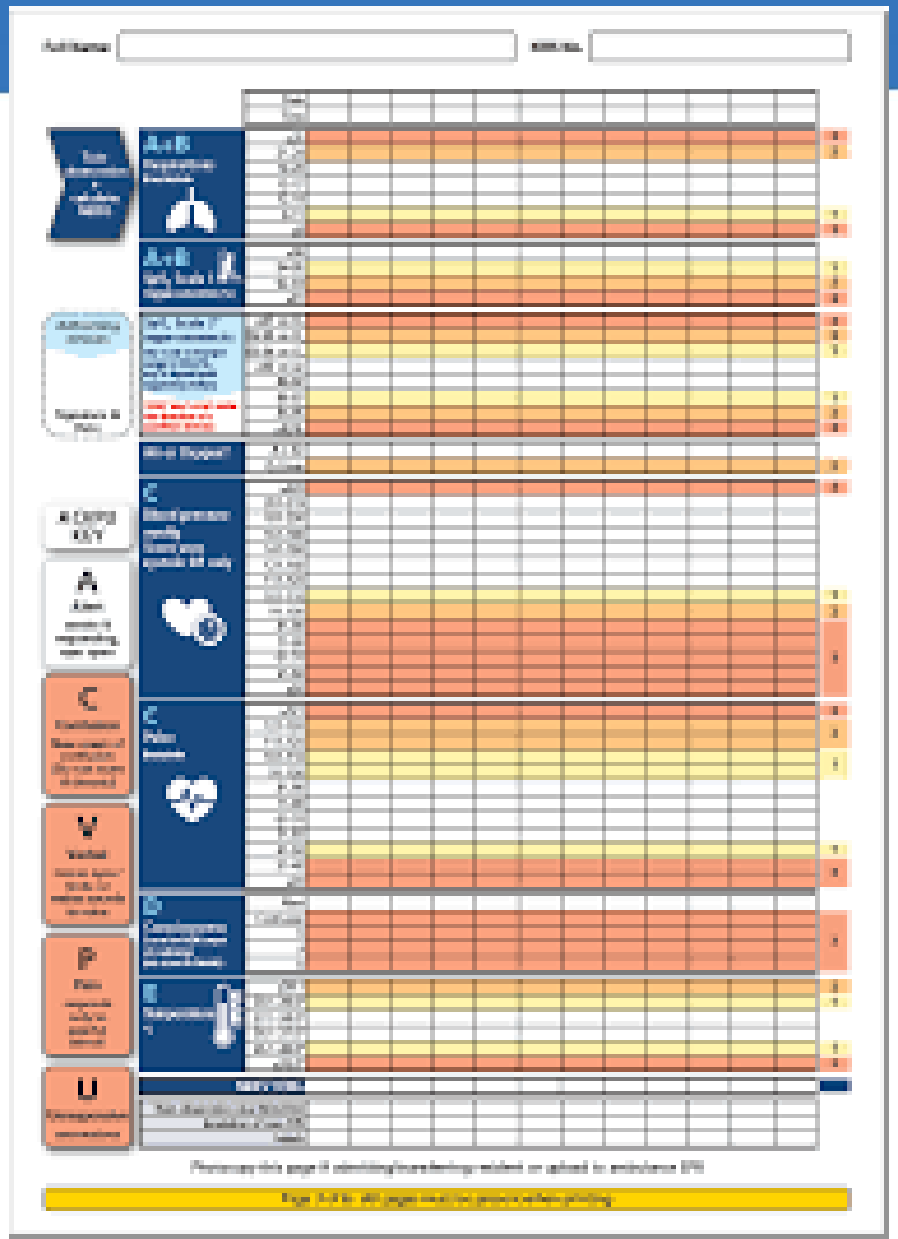
7+	Admission to hospital should be in line with any appropriate, agreed and documented plan of care. Blue light 999 call with transfer to hospital (15 minutes), follow guidance of call handler	**Continuous monitoring until transfer**

NEWS2 Score



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Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

SBARD Escalation Tool and Action Tracker

(get your message across)

REMEMBER TO SAY: The residents TOTAL NEWS SCORE is...

Name:

NHS No.

		Notes	Date, Time, Who
S	**Situation** **(briefly describe the current situation and give a clear, concise overview of relevant issues)** (Provide address, direct line contact number) I am... from... (say if you are a registered professional) I am calling about resident... (Name, DOB) **The residents TOTAL NEWS SCORE is...** **Their normal NEWS/condition is...** I am calling because I am concerned that.... (e.g. BP is low, pulse is XX, temp is XX, patient is more confused or drowsy)		
B	**Background** **(briefly state the relevant history and what got you to this point)** Resident XX has the following medical conditions... The resident does/does not have a care plan or DNACPR form / agreed care plan with a limit on treatment/hospital admission They have had... (GP review/investigation/medication e.g. antibiotics recently) Resident XX's condition has changed in the last XX hours The last set of observations was... Their normal condition is... The resident is on the following medications...		
A	**Assessment** **(summarise the facts and give your best assessment on what is happening)** I think the problem is XX And I have... (e.g. given pain relief, medication, sat the patient up etc.) **OR** I am not sure what the problem is but the resident is deteriorating **OR** I don't know what's wrong but I am really worried		
R -- D	**Recommendation** **(what actions are you asking for? What do you want to happen next?)** I need you to... Come and see the resident in the next XX hours **AND** Is there anything I need to do in the meantime? (e.g. repeat observations, give analgesia, escalate to emergency services) **Decision** **(what have you agreed)** We have agreed you will visit/call in the next XX hours, and in the meantime I will do XX If there is no improvement within XX, I will take XX action.	**Actions I have been asked to take** (initial & time when actions completed)	Initials

Photocopy this page if admitting/transferring resident or upload to ambulance EPR

hcpa

S **Situation** e.g. what's happened? How are they? NEWS2 score if available

B **Background** e.g. what is their normal, how have they changed?

A **Assessment** e.g. what have you observed / done?

R **Recommendation** 'I need you to...'

D **Decision** what have you agreed? (including any Treatment Escalation Plan & further observations)

Key prompts / decisions

Equipment

- Stopwatch/ Smartwatch/Mobile phone
- Pulse oximeter (and batteries)
- Blood pressure monitor (with additional large cuffs as needed)
- Tympanic thermometer

Sepsis

What is sepsis?

- Sepsis is a life-threatening reaction to an infection.
- It happens when your immune system overreacts to an infection and starts to damage your body's own tissues and organs.
- You cannot catch sepsis from another person.

Signs of sepsis in an adult

- Acting confused, slurred speech or not making sense
- Blue, grey, pale or blotchy skin, lips or tongue – on brown or black skin, this may be easier to see on the palms of the hands or soles of the feet
- A rash that does not fade when you roll a glass over it, the same as meningitis
- Difficulty breathing, breathlessness or breathing very fast

Symptoms of sepsis - NHS

Sepsis - preventing infections

- Keeping up to date with vaccines
- Keeping wounds clean and caring for any wounds
- Following the instructions when taking antibiotics
- Taking all your prescribed antibiotics, even if you feel better
- Eating a healthy diet
- Avoiding unclean water or unsanitary toilets
- Good personal hygiene, like washing hands and preparing food safely

Care of an unconscious person

- Unconsciousness (or coma) is a state in which a person is totally unaware of both self and external surroundings and is unable to respond meaningfully to external stimuli.
- First of all, make sure that they are unconscious, and not just asleep.
- Next, the primary care is EXACTLY the same as Basic Life Support – AIRWAY, BREATHING, CIRCULATION.
- A patient who is unconscious is at a very high risk of compounding their problems by adding to them by asphyxia, leading to death.

Glasgow Coma Scale (GCS)

- The GCS is a neurological scale which aims to give a reliable and objective way of recording the state of a person's consciousness
- A person is assessed against the criteria of the scale, and the resulting points give a person's score between 3 and either 14 (original scale) or 15 (more widely used, modified or revised scale).
- The GCS was initially used to assess a person’s level of consciousness after a head injury, and the scale is now used by emergency medical services, nurses, and physicians, as being applicable to all acute medical and trauma patients. In hospitals, it is also used in monitoring patients in intensive care units.

Elements of the GCS

Glasgow Coma Scale [3]

	1	2	3	4	5	6
Eye	Does not open eyes	Opens eyes in response to pain	Opens eyes in response to voice	Opens eyes spontaneously	N/A	N/A
Verbal	Makes no sounds	Makes sounds	Words	Confused, disoriented	Oriented, converses normally	N/A
Motor	Makes no movements	Extension to painful stimuli (decerebrate response)	Abnormal flexion to painful stimuli (decorticate response)	Flexion / Withdrawal to painful stimuli	Localizes to painful stimuli	Obeys commands

Blood sugar monitoring (BM)

- To test levels of glucose in the blood
- Levels differ for everyone, but generally 'normal' levels are 5.0 to 7.0 mmol/L before breakfast and 4.0 to 7.0 mmol/L before other meals (NICE Guidelines, July 2016)
- HbA1c levels should be below 48mmol/mol (or 6.5% on the older measurement scale)
- In diabetes, monitoring is very important to ensure stable blood sugar levels

Signs of Hyperglycaemia

- Increased thirst and a dry mouth
- Needing to urinate frequently
- Tiredness
- Blurred vision
- Unintentional weight loss
- Recurrent infections, such as thrush, bladder infections (cystitis) and skin infections
- Confusion
- Aggression
- Unconsciousness

Managing Hyperglycaemia

How to lower your blood sugar

- **Do**
  - take any diabetes medicine you've been prescribed, as advised by your doctor or care team
  - avoid eating too much sugary or starchy food
  - try to find ways to manage stress
  - exercise regularly
  - lose weight if you're overweight
  - follow advice from your doctor or care team about what to do while you're ill (sometimes called "sick day rules")
- **Don’t**
  - do not skip or change doses of your diabetes medicine unless advised by your doctor or care team

Managing Hyperglycaemia

Call the local Avoidance of Admission services or 111 if you think the person has high blood sugar and:

- They are feeling sick, being sick or have stomach pain
- They are breathing more quickly than usual or their heart rate is faster than usual
- They feel drowsy or are struggling to stay awake
- Their breath has a fruity smell (like pear drop sweets)
- They feel confused or have difficulty concentrating

Signs of Hypoglycaemia

- Feeling hungry
- Feeling dizzy
- Trembling or shakiness
- Tingling lips
- Sweating
- Feeling tired
- Confusion and difficulty concentrating
- Seizures
- Unconsciousness

Managing Hypoglycaemia

If someone has very low blood sugar (a severe hypo) and becomes unconscious:

- Do not give them any food or drink as they will not be able to swallow safely.
- Put them into the recovery position.
- Give them a glucagon injection straight away, if one is available and you know how to use it.
- If they start to recover within 10 minutes of having a glucagon injection and can swallow safely, give them some food or drink that will raise their blood sugar.
- Stay with them until they're fully recovered.

Managing Hypoglycaemia

- Get the person to eat or drink something quickly, such as a small glass of fruit juice or sugary fizzy drink, 5 glucose or dextrose tablets, 4 large jelly babies, or 2 tubes of glucose gel.
- Check blood sugar after 10 to 15 minutes.
- If blood sugar is still below 4mmol/L, ensure they have another sugary drink or snack, and check again after 10 minutes.
- Once symptoms have improved and their blood sugar is above 4mmol/L, get them to eat some biscuits, a sandwich, or a meal.

Managing Hypoglycaemia

Call 999 if:

- You think someone has very low blood sugar and they're not responding normally or they're unconscious, and:
- a glucagon injection is not available or you do not know how to use it
- you've given a glucagon injection and they have not recovered within 10 minutes
- they've been drinking alcohol

Urine samples

- Urine sampling is the process of obtaining urine for the purpose of identifying organisms that may be responsible for causing infection within the urinary tract (UTI) and to test their sensitivity to antibiotics”
- “The main value of urine culture is to identify bacteria
- Check colour of urine, odour, turbidity, obvious haematuria presence, presence of pain around suprapubic area or loin pain.
- **Do not dip-stick urine anymore**

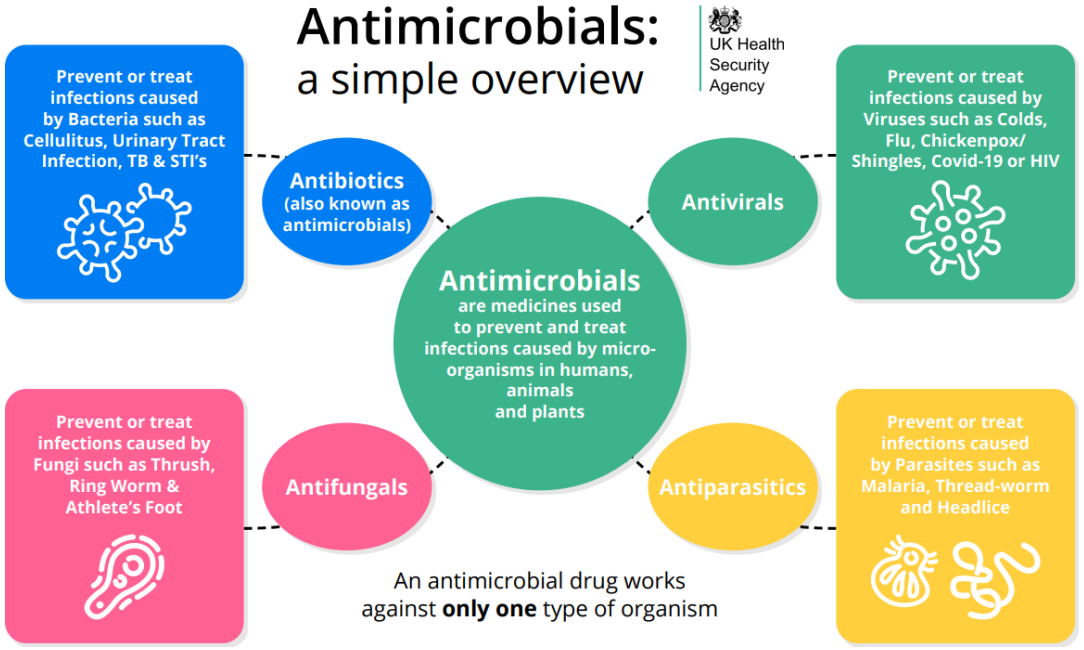
Antimicrobial resistance

What is antimicrobial resistance?

Antimicrobial Resistance (AMR) occurs when bacteria, viruses, fungi and parasites change over time and no longer respond to medicines making infections harder to treat and increasing the risk of disease spread, severe illness and death.

A recent report by UKHSA shows that antibiotic resistance continues to rise in the UK. An estimated 66,730 people had a serious antibiotic resistant infections in 2023, compared to 62,314 in 2019. It is estimated 10 million people could die every year by 2050 due to drug resistant infections. The report highlights the devastating impact of AMR in the UK and the scale of the problem we are facing.

Antibiotic resistance occurs naturally, but inappropriate use and overuse of antibiotics can accelerate this process. **This is why it is important to take antibiotics only when they are prescribed and necessary for the condition.**



Antimicrobial Resistance:
When the micro-organisms change or mutate over time and get to a point where they no longer respond to medicines previously used to treat them.

Sputum samples

- Sputum (phlegm/secretions) is a combination of mucus, inflammatory and epithelial cells, and degradation products from the lower respiratory tract
- Sputum can be collected in several different ways (pots, sputum traps, bronchial lavage)
- Sputum can have different consistencies, smells and colour, which can indicate different conditions, such as TB, pneumonia or pulmonary oedema, laryngitis, lung abscess

Stool (faecal) sample

Reason for sampling

- Isolation of bacteria eg salmonella, campylobacter, shigella and clostridium difficile. E. coli
- Isolation of parasites such as, protozoa, tape worm and amoebiasis
- Isolation of viral infections such as, norovirus and rotavirus

Stool (faecal) sample - procedure

Procedure

- Wash and dry hands with liquid soap and put on apron and gloves
- Ask the person to defecate into a clinically clean bedpan or other suitable container
- Use a disposable spoon to scoop 10 to 15mls of stool into the specimen bottle. If incontinent scoop from the bed linen
- Specimen container lid should be tightly closed
- Label, fill the form and send immediately to lab

Post procedure

- Flush the rest of the poo down the toilet. Put everything you've used to collect the poo in a plastic bag, tie it up and put it in the bin.
- Wash your hands with soap and warm running water.
- Assist to clean up by washing the person's bottom if appropriate, with soap and water and dry gently
- Apply moisturiser or prescribed cream and make them comfortable
- Remove apron and gloves and discard appropriately.
- Wash hands thoroughly with liquid soap and water

Preventing infections

Ensure best IPC practice at all times

- SICPs include:
  - Hand hygiene between tasks and between service users with soap and water or alcohol-based hand rub
  - Respiratory and cough hygiene (catch it, bin it, kill it!)
  - Regularly letting fresh air into rooms and shared areas (cleaning of shared equipment, especially after use
  - Regular cleaning of the environment with particular attention to frequently touched surfaces and shared areas and equipment
  - Appropriate use of personal protective equipment (PPE)
  - Correct handling and segregation of waste and infectious linen
  - Adult social care clients should also be supported to contribute to SICPs by handwashing, cough hygiene and other simple measures as appropriate.
  - All measures to prevent and manage infections should be risk assessed, prioritised in line with the hierarchy of controls and balanced to ensure the wellbeing of people receiving care

Covid-19 or Flu

Care homes

- If a person has symptoms of ARI has a high temperature or does not feel well enough to do their usual activities, they should be supported to stay away from others.
- Test for COVID-19 only if eligible for COVID-19 treatments
- If tests positive for COVID-19, arrange an assessment for appropriate treatment and follow guidance

Non care homes

- Support to follow the guidance - People with symptoms of a respiratory infection including COVID-19 - GOV.UK

All settings

- Ensure IPC precautions are followed
- Ensure adequate Ventilation
- Ensure enhanced cleaning (1,000ppm chlorine-based solution) of environment and frequent touch points
- Appropriate PPE

Vomitus sample

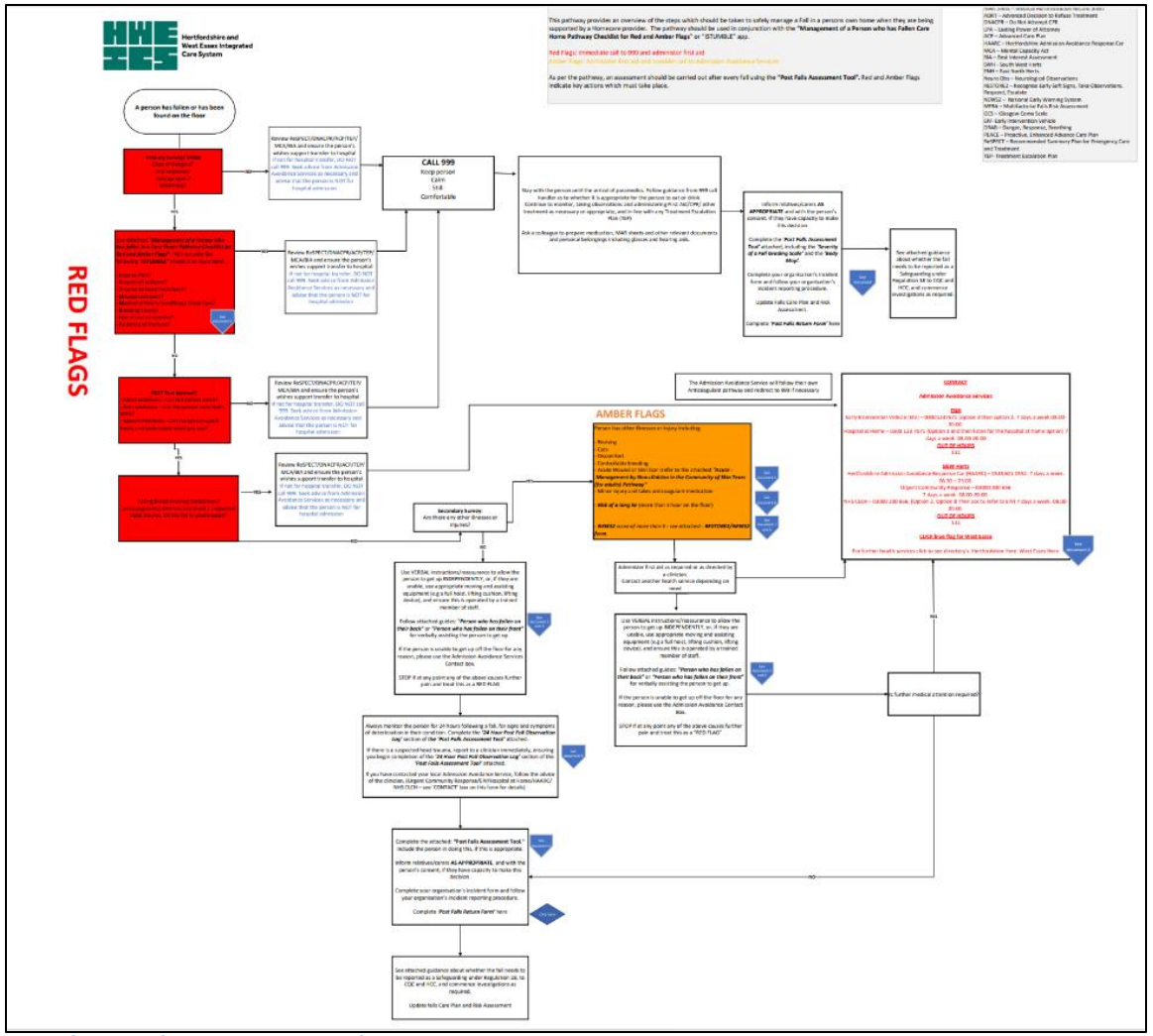
Information that can be gathered on vomitus

- Colour: blood stains may indicate a bleed within the GI tract - can be fresh blood indicating active bleeding or stale (altered) blood indicating a previous bleed
- Yellow or greenish – bile
- Milky white and with a strong smell may be organophosphate poisoning
- May contain bits and pieces of undigested food staff- may indicate poor digestion
- May contain faecal matter and smell like faeces which may indicate gut obstruction either by impacted faeces or twisted gut
- Can be projectile which may indicate an obstruction
- Can be effort less some conditions such as meningitis, increased intracranial pressure, poisoning.

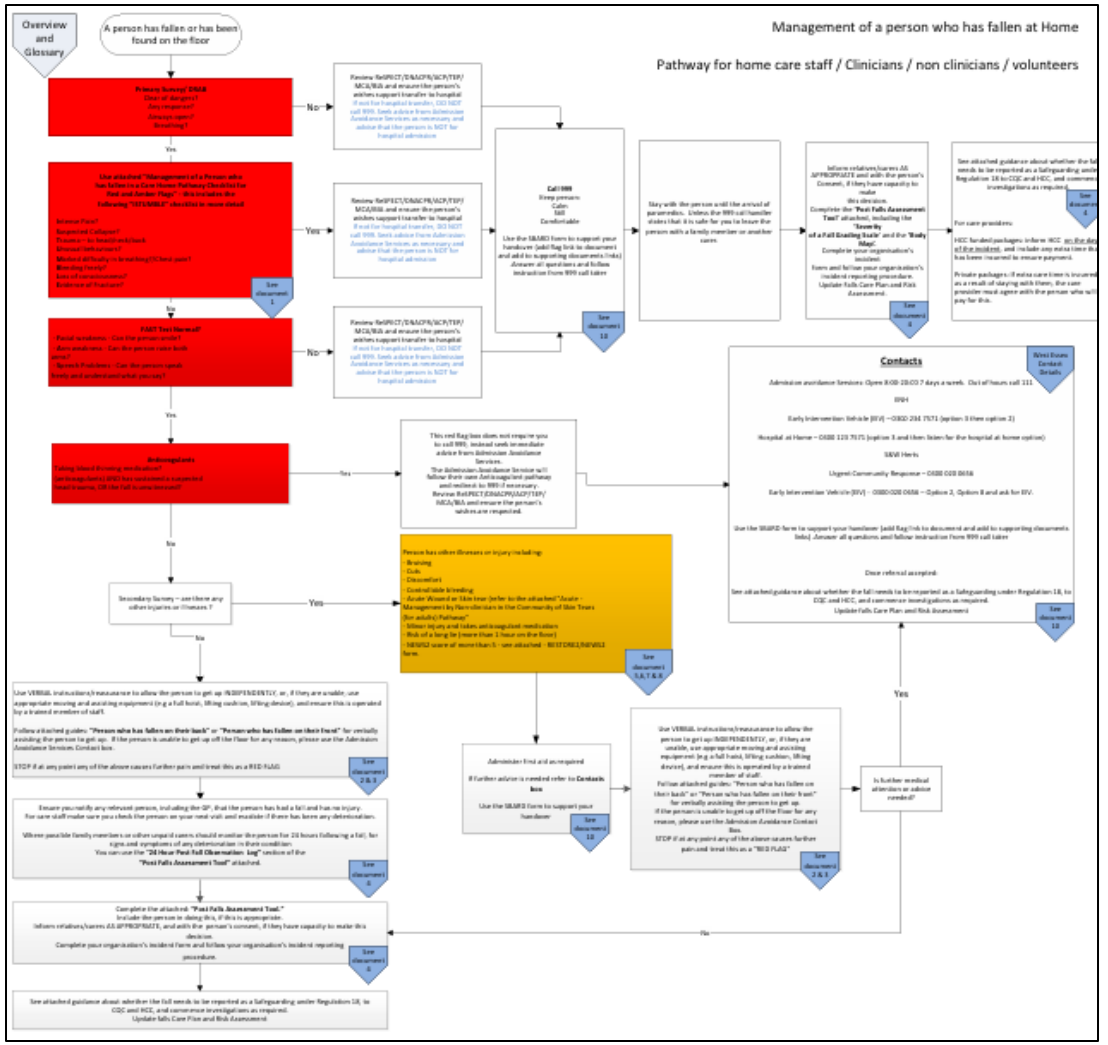
Falls figures

1. The British Geriatrics Society reports that the **cost of falls** to the NHS is more than **£2.3 billion** per year
2. Annually, **ambulances** respond to around **700,000** calls from older people who have fallen.
3. The total annual cost of **fragility fractures** to the UK has been estimated at **£4.4 billion** per year
4. It is estimated **684000 fatal falls** occur each year globally, making it the second leading cause of unintentional injury death, after road traffic injuries.

Management of a Person who has Fallen in a Care Home/at Home Pathways



[Flowchart Template]



Falls Pathways - supporting documents

Supporting Documents

1. Management of Person who has Fallen in Care Home Pathway Checklist for Red and Amber Flags
2. What to do when a person has fallen on their back
3. What to do when a person has fallen on their front
4. Post Falls Assessment Tool
5. Acute Management by Non-Clinician in the Community of Skin Tears (for Adults)
6. Complications of Long Lie
7. NEWS2 Score Chart
8. RESTORE2-Chart
9. West Essex Contact Information

Additional Supporting Documents:

Glasgow Coma Scale (GCS)

Multifactorial Falls Risk Assessment Form

Hertfordshire Care Home Support Services Directory

All the contacts you need IN ONE PLACE!

Use this QR code or link to access contact details for services available to Care Homes including admission avoidance, mental health, end of life and much more.
www.hcpa.info/supportservicedirectory

YOU SHOULD CALL 999 IN A LIFE-THREATENING EMERGENCY

Early Intervention Vehicle
7 Days a week 08:00-20:00
0300 123 7571
(option 3 then option 2)

Hospital at Home
7 Days a week 08:00-20:00
0300 123 7571
(option 2)

Admission Avoidance Response Care
7 Days a week 06:30-23:00
0345 601 0552

Urgent Community Response
7 Days a week 08:00-20:00
03000 200 656

Any questions? Contact details out of date?
Contact the HCPA Care Provider Hub:
01707 708108 / assistance@hcpa.co.uk

Hertfordshire
NHS Hertfordshire and West Essex Integrated Care Board
hcpa
East and North Hertfordshire Homes
South and West Hertfordshire Homes
Updated November 23

Hertfordshire Care Home Support Services Directory

All the contacts you need IN ONE PLACE!

Use this QR code or link to access contact details for services available to Care Homes including admission avoidance, mental health, end of life and much more.
www.hcpa.info/supportservicedirectory

YOU SHOULD CALL 999 IN A LIFE-THREATENING EMERGENCY

Admission Avoidance Response Care
7 Days a week 06:30-23:00
0345 601 0552

Urgent Community Response
7 Days a week 08:00-20:00
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hcpa
South and West Hertfordshire Homes
Updated November 23

Falls 2 hour Community Response

NHS Hertfordshire and West Essex

Providing assessment and testing for patients without the need to go to hospital

8am - 8pm 7 days a week

Person has fallen. Call the local Community Response team on:
0300 123 7571 (East and North Herts)
03000 200 656 (South and West Herts)
0300 123 5433 (West Essex)

Response team will visit patient within 2 hours and will:

- Make patient comfortable and complete full assessment to determine cause of fall
- Take blood samples, including creatine kinase (CK), urea and electrolytes (U&Es), where appropriate
- Blood test results back within 4 hours
- If raised CK levels or dehydrated, patient will be started on IV fluids.

Patient benefits

- ✓ Can stay comfortable at home
- ✓ No need for ambulance
- ✓ No waits in emergency department
- ✓ Blood results back with 4 hours - faster than if taken to hospital
- ✓ Same treatment as would take place in hospital, including fluids and follow up blood tests
- ✓ Physiotherapy, occupational therapy, home equipment and ongoing monitoring where needed

Hertfordshire Care Provider Support Service Directory

HCPA Provider Hub

HCPA Members Zone

Download our Care Home Directory poster which displays key contact information for services East & North South & West

Below you can search our Support Services Directory by viewing all services, filtering by criteria, or searching for a keyword.

View all services | Filter By | Search services | Search

Click here Support Service Directory - HCPA

Upcoming Training

HCPA has selection of fully funded training on **Preventing and Managing Deterioration During Winter including Basic Health Observations** coming up at HCPA offices for you and your staff.

Three Further Cohorts Available- **Book Now!**

- 20th November Click here to book
- 10th December Click here to book
- 21st January Click here to book

Thanks for joining us

Before you go, please leave us feedback

Scan me

Centre of Excellence
Valid until 11/2025
skillsforcare

Care Professional Academy

Hertfordshire

Slido

On a scale of 1 to 5, with 1 being not at all confident and 5 being very confident:

After this training, how confident are you to use the NEWS2 Track and Trigger System to determine how unwell an acutely unwell person is

Slido

- What are the key points that you will take away from today's training?
- And are there any other things that you feel we could have included?

Any Questions?