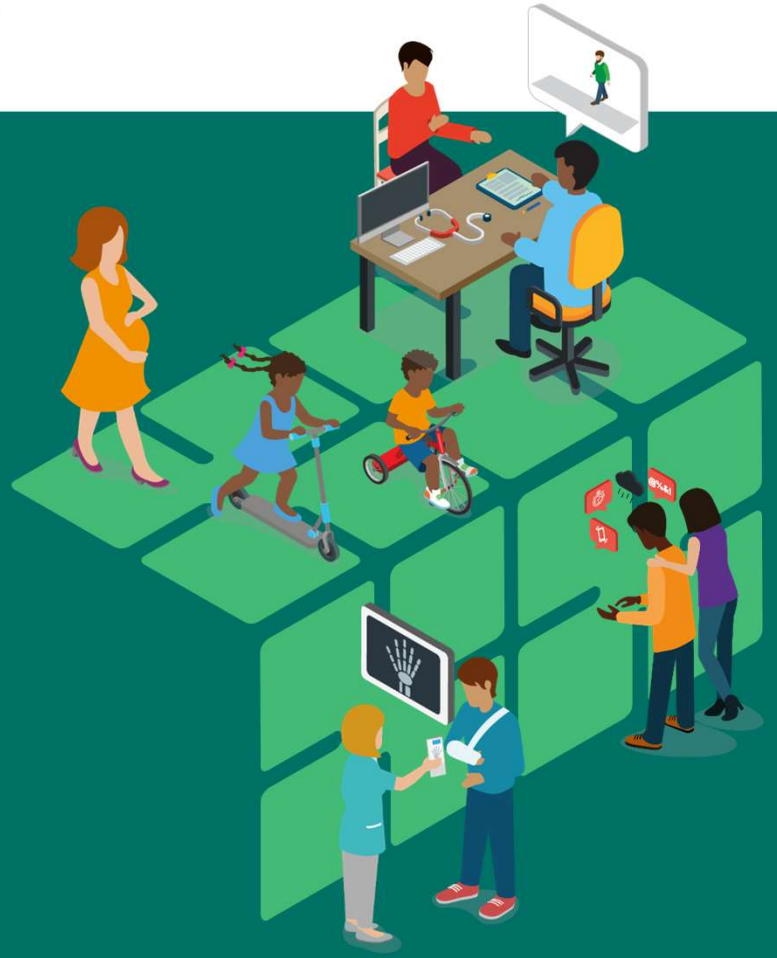
Hertfordshire and West Essex Integrated Care System

Approved Training Provider

NHS Hertfordshire and West Essex Integrated Care Board

Basic Observation training and clinical frailty scoring



November 2023

Working together
for a healthier future

Why do we take clinical observations?

- A set of clinical observations can give many indications of general deterioration
- Point to signs of infection
- Underlying conditions that have not yet been diagnosed
- Observations are really helpful for a clinician assessing a patient, especially via phone or video call

What is blood pressure?

Blood pressure is a measure of the force that the heart uses to pump blood around the body.

There are 2 readings:

- Systolic - pressure when the heart pumps
- Diastolic - pressure when the heart relaxes

They are written systolic/ diastolic. The units of measurement are mmHg (stands for millimetres of mercury)

What is blood pressure?

For example, if your blood pressure is "140 over 90" or 140/90mmHg, it means you have a systolic pressure of 140mmHg and a diastolic pressure of 90mmHg.

Systolic = top number of a blood pressure reading

Diastolic = bottom number of a blood pressure reading

What is blood pressure?

For most of life, we want to make sure BP readings are not too high. This will be most important for residents in MH or LD homes and fitter older residents.

In frail older age, low blood pressure can become more of a problem.

High Blood Pressure

What is normal blood pressure?

As a general guide in a younger person:

- Normal blood pressure is considered to be between 90/60mmHg and 120/80mmHg
- High blood pressure is considered to be 140/90mmHg or higher
- Low blood pressure is considered to be 90/60mmHg or lower

Blood Pressure Category	Systolic mm Hg (upper #)		Diastolic mm Hg (lower #)
Low blood pressure (Hypotension)	less than 90	or	less than 60
Normal	90 to 120	and	60 to 80
Prehypertension	120-139	or	80-89
High Blood Pressure (Hypertension Stage 1)	140-159	or	90-99
High Blood Pressure (Hypertension Stage 2)	160 or higher	or	100 or higher
High Blood Pressure Crisis (Seek Emergency Care)	180 or higher	or	110 or higher

What is high blood pressure?

High blood pressure is considered to be 140/90mmHg or higher (**150/90mmHg or higher if you're over the age of 80**)

Risks of high blood pressure

High blood pressure, or hypertension, rarely has noticeable symptoms.

If a blood pressure is too high, it puts extra strain on your blood vessels, heart and other organs, such as the brain, kidneys and eyes.

High blood Pressure

Persistent high blood pressure can increase your risk of a number of serious and potentially life-threatening health conditions, such as:

- Heart disease
- Heart attacks
- Strokes
- Heart failure
- Peripheral arterial disease
- Aortic aneurysms
- Kidney disease
- Vascular dementia

What is Low Blood Pressure?

Low blood pressure is a reading of 90/60mmHg or less. It does not always cause symptoms. It is a common problem in older residents and an important cause of falls.

Low blood pressure, or hypotension, can sometimes have the following symptoms:

- Light headedness or dizziness
- feeling sick
- blurred vision
- generally feeling weak
- confusion
- Fainting

Low Blood Pressure

If a resident suffers with low blood pressure the following may help:

- Get up slowly from sitting to standing
- Take care when getting out of bed - move slowly from lying to sitting to standing
- Raise the head of your bed by about 15cm (6 inches) contact appropriate healthcare professional for equipment
- Eat small, frequent meals - lying down or sitting still for a while after eating may also help
- Increase the amount of water you drink

How to take an electronic blood pressure

It is really important that the person is relaxed, so:

- Sitting back in their chair
- Arm supported at chest height
- Calm and NOT talking

If in bed:

- Lying with pillows and arm by their side

Video - [How to take someone's blood pressure]

How to take a temperature using a tympanic thermometer

- Gain consent and wash your hands
- Place a cover over the probe of the thermometer, this provides infection control
- Hold the thermometer in your dominant hand
- With your non dominant hand straighten the residents external ear
- Gently pull the upper ear outward and back
- Insert the probe gently into the residents ear canal
- Seal the probe tightly without causing discomfort and wait for the beep
- Remove the probe and discard the plastic cover
- Record the temperature as shown on the display of the thermometer
- Clean all equipment ready for next use

How to take a temperature using a tympanic thermometer

Video - [Taking a Tympanic Temperature]

Why do we take a pulse oximeter reading?

A pulse oximeter measure the amount of oxygen in the blood.

It is known as an oxygen saturation – how much is the blood “saturated” or filled with oxygen. Called a %Sp02.

Most pulse oximeters also record a heart rate (pulse).

How to take a pulse oximeter reading

- Gain consent and wash your hands
- Ensure any nail varnish is removed from the finger you are preparing to use as this can give a false reading
- Place oximeter over the end of the finger with display facing up and wait for the display to confirm a %
- The oximeter display shows the percentage of oxygen in your blood. For someone who's healthy, the normal blood oxygen saturation level will be around 95–100%
- Record as appropriate
- Clean all equipment ready for next use

Video - Use of a pulse oximeter

Heart Rate or Pulse Readings

- The Heart Rate or Pulse is the number of times the heart beats in a minute.
- This is also measured by most blood pressure readings.
- Most pulse readings will be between 60 and 100 beats per minute.

Practical session

Recording observations

Ensure following is recorded:

- Date and time reading is taken
- Both readings are recorded
- Position of resident; sitting/standing or bedbound
- Any other concerns, that you have observed

Recording observations

Date	Time	BP reading	Pulse	Sitting	Standing	Comments

Key tasks

	Performance criteria	Comments	Competence achieved (date/sign)
1	Give the individual relevant information and support in a manner sensitive to their needs		
2	Gain valid consent to carry out the task of taking an electronic blood pressure reading		
3	Check the individual's identity and confirm the planned action		
4	Apply standard precautions for infection and prevention control		
5	Use the appropriate equipment to obtain an accurate measurement		

Key tasks

	Performance criteria	Comments	Competence achieved (date/sign)
6	Reassure individual throughout the process and answer any questions and concerns they may have within your own realm of competence		
7	Escalate any concerns from the reading to the appropriate healthcare professional		
8	Seek a further recording of the measurement by another staff member if you are unable to obtain the reading or are unsure		

Key tasks

	Performance criteria	Comments	Competence achieved (date/sign)
9	Identify and respond immediately if there are any significant changes in the residents condition		
10	Recognise and report any measurement which falls outside of normal reading to the residents GP		
11	Record your findings accurately in the appropriate documentation		
12	Clean used equipment and return to usual place of storage		

Restore 2

Deterioration and escalation tool for residential and nursing homes

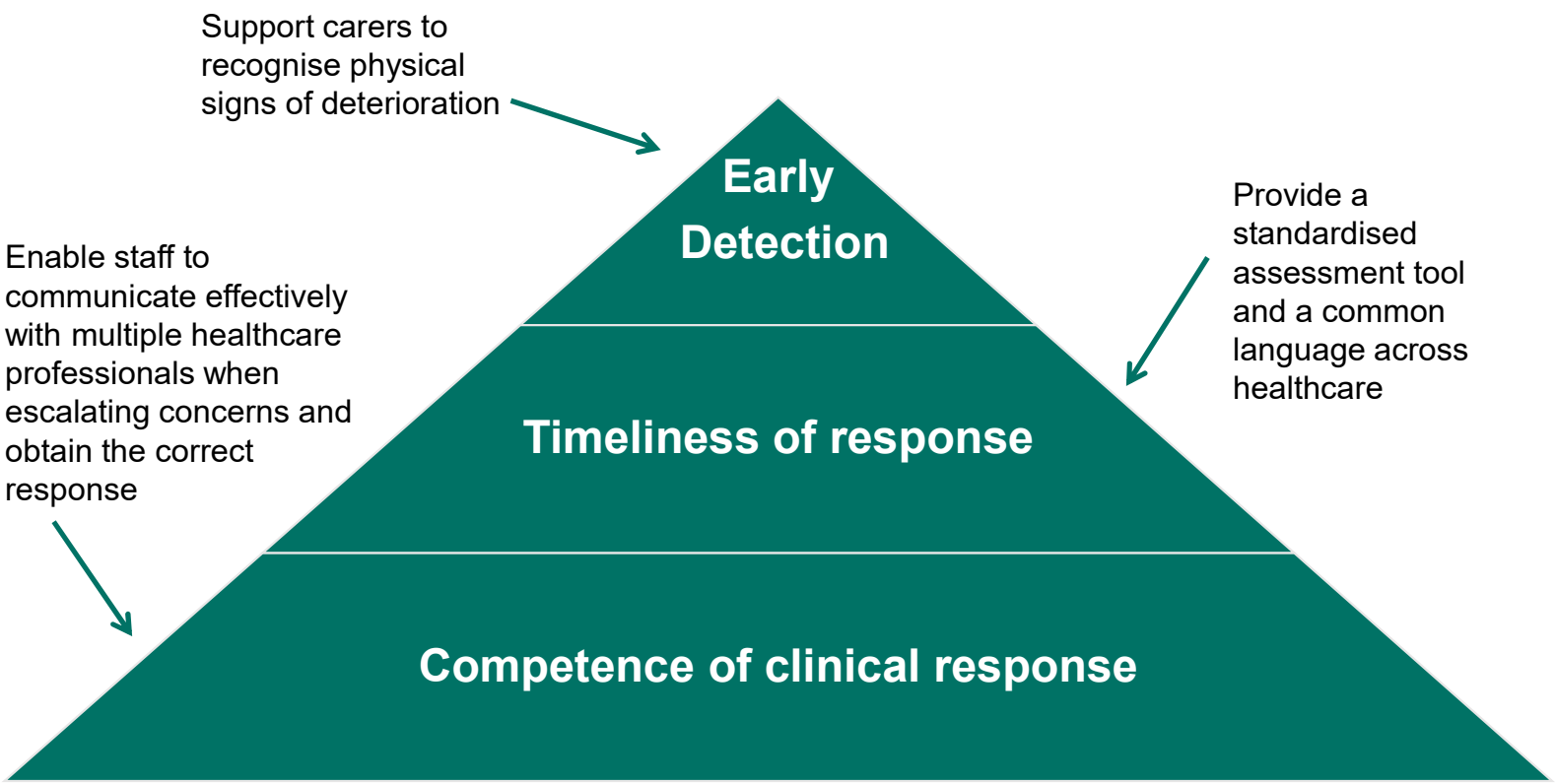
What is Restore 2?

Restore 2 is a deterioration and escalation tool for residential and nursing homes.

This approach allows care home staff to communicate with outside healthcare professionals including GP's by:

- Using evidence based methods to help care home staff recognise and communicate concerns about early deterioration in a resident
- By using these tools care homes are able to speak the same language, using proven techniques such as NEWS 2 and SBAR

Restore 2


Support carers to recognise physical signs of deterioration
Early Detection
Provide a standardised assessment tool and a common language across healthcare
Enable staff to communicate effectively with multiple healthcare professionals when escalating concerns and obtain the correct response
Timeliness of response
Competence of clinical response

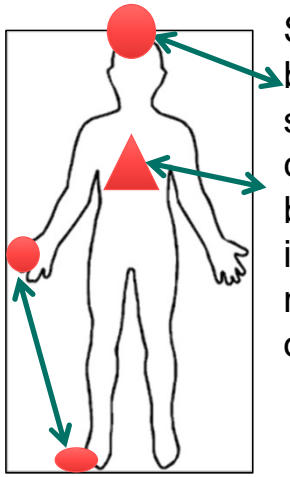
Restore 2

Video - An introduction to RESTORE 2

Restore 2

Signs of deterioration provide relevant prompts for staff and an entry point into NEWS2 observations

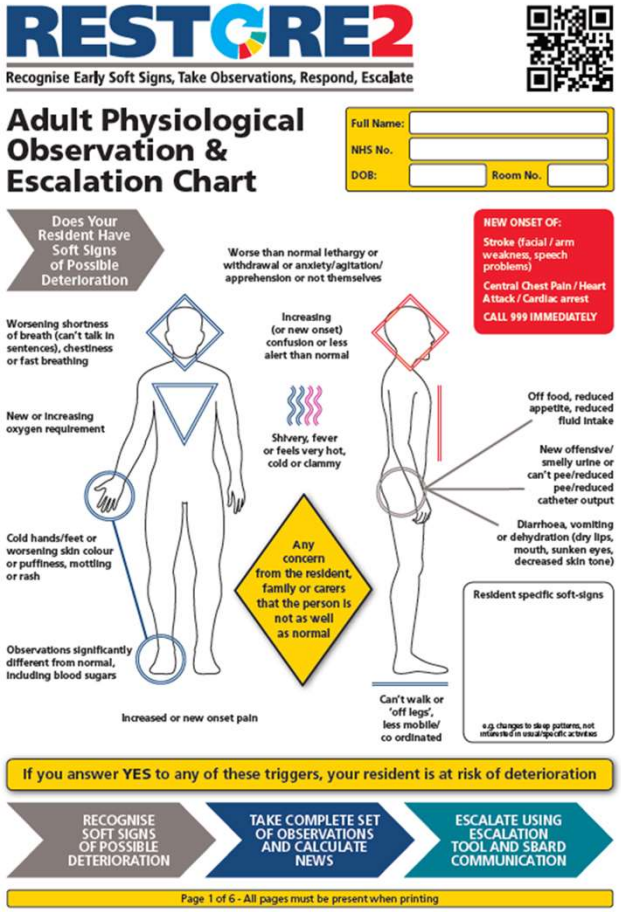
Does your resident have signs/ symptoms?



Shortness of breath, can't talk in sentences, chestiness/ rapid breathing, new or increasing requirement for oxygen

Cold hands/ feet, change in skin colour, puffiness, mottling or rash. Definitive change in clinical observations

Restore 2



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

Worse than normal lethargy or withdrawal or anxiety/agitation/ apprehension or not themselves

Worsening shortness of breath (can't talk in sentences), chestiness or fast breathing

Increasing (or new onset) confusion or less alert than normal

New or increasing oxygen requirement

Shivery, fever or feels very hot, cold or clammy

Off food, reduced appetite, reduced fluid intake

New offensive/ smelly urine or can't pee/reduced pee/reduced catheter output

Diarrhoea, vomiting or dehydration (dry lips, mouth, sunken eyes, decreased skin tone)

Cold hands/feet or worsening skin colour or puffiness, mottling or rash

Any concern from the resident, family or carers that the person is not as well as normal

Resident specific soft-signs

Observations significantly different from normal, including blood sugars

Increased or new onset pain

Can't walk or 'off legs', less mobile/ co ordinated

e.g. changes to sleep patterns, not interested in usual/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

Page 1 of 6 - All pages must be present when printing

Restore 2

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 carefescalated 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

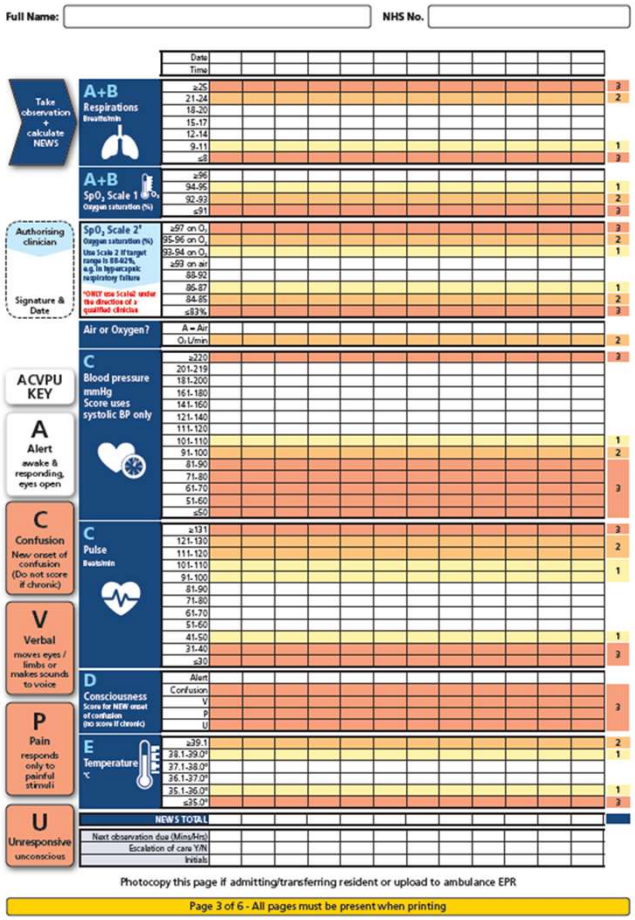
- All residents should have had the opportunity to discuss their end of life preferences in advance of any crisis
- RESTORE2 must be used in conjunction with the expressed wishes of the resident e.g. treatment escalation plans or advanced care plans.
- RESTORE2 can be used in residents with an agreed 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**
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**

Page 2 of 6 - All pages must be present when printing

Restore 2



Full Name: NHS No.

Date / Time

Take observation + calculate NEWS

A+B Respirations Breaths/min: ≥25 (3), 21-24 (2), 18-20, 15-17, 12-14, 9-11 (1), ≤8 (3)

A+B SpO_2 Scale 1 Oxygen saturation (%): ≥96, 94-95 (1), 92-93 (2), ≤91 (3)

Authorising clinician

Signature & Date

SpO_2 Scale 2* Oxygen saturation (%) — Use Scale 2 if target range is 88-92%, e.g. in hypercapnic respiratory failure. *ONLY use Scale2 under the direction of a qualified clinician: ≥97 on O_2 (3), 95-96 on O_2 (2), 93-94 on O_2 (1), ≥93 on air, 88-92, 86-87 (1), 84-85 (2), ≤83% (3)

Air or Oxygen? A = Air; O_2 L/min (2)

ACVPU KEY

A Alert — awake & responding, eyes open

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

C Blood pressure mmHg Score uses systolic BP only: ≥220 (3), 201-219, 181-200, 161-180, 141-160, 121-140, 111-120, 101-110 (1), 91-100 (2), 81-90, 71-80, 61-70 (3), 51-60, ≤50 (3)

C Pulse Beats/min: ≥131 (3), 121-130 (2), 111-120, 101-110 (1), 91-100, 81-90, 71-80, 61-70, 51-60, 41-50 (1), 31-40 (3), ≤30 (3)

D Consciousness Score for NEW onset of confusion (DO score if chronic): Alert, Confusion, V, P, U (3)

E Temperature °C: ≥39.1 (2), 38.1-39.0 (1), 37.1-38.0, 36.1-37.0, 35.1-36.0 (1), ≤35.0 (3)

NEWS TOTAL

Next observation due (Mins/Hrs)

Escalation of care Y/N

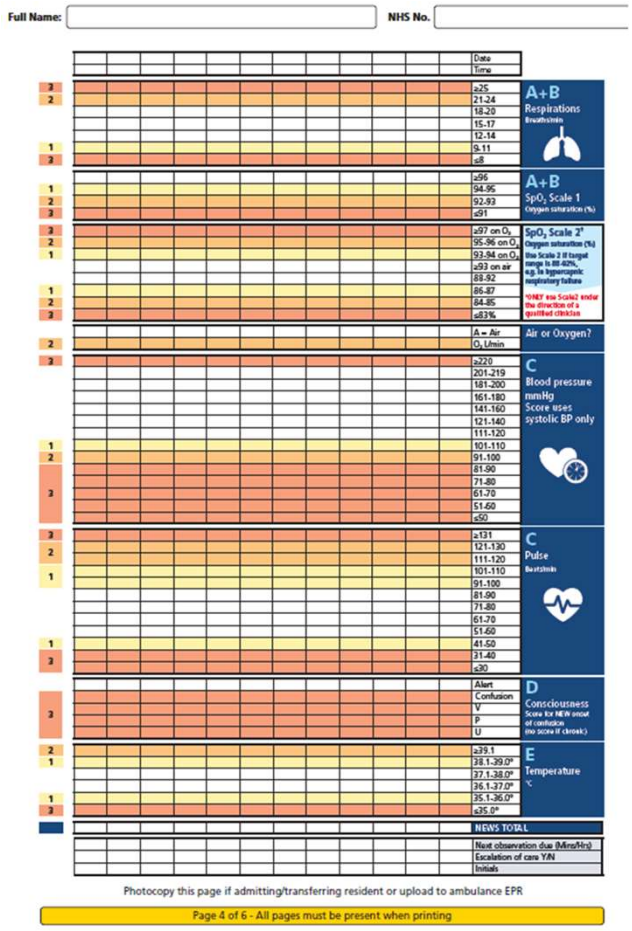
Initials

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

Page 3 of 6 - All pages must be present when printing

Hertfordshire and West Essex Integrated Care System

Restore 2


Full Name:
NHS No.
Date
Time
A+B
Respirations
Breaths/min
A+B
SpO2 Scale 1
Oxygen saturation (%)
SpO2 Scale 2†
Oxygen saturation (%)
Air or Oxygen?
A = Air
O2 L/min
C
Blood pressure
mmHg
Score uses systolic BP only
C
Pulse
Beats/min
D
Consciousness
Alert
Confusion
V
P
U
E
Temperature
°C
NEWS TOTAL
Next observation due (Mins/Hrs)
Escalation of care Y/N
Initials
Photocopy this page if admitting/transferring resident or upload to ambulance EPR
Page 4 of 6 - All pages must be present when printing

Restore 2

SBARD Escalation Tool and Action Tracker
(get your message across)

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

Name:

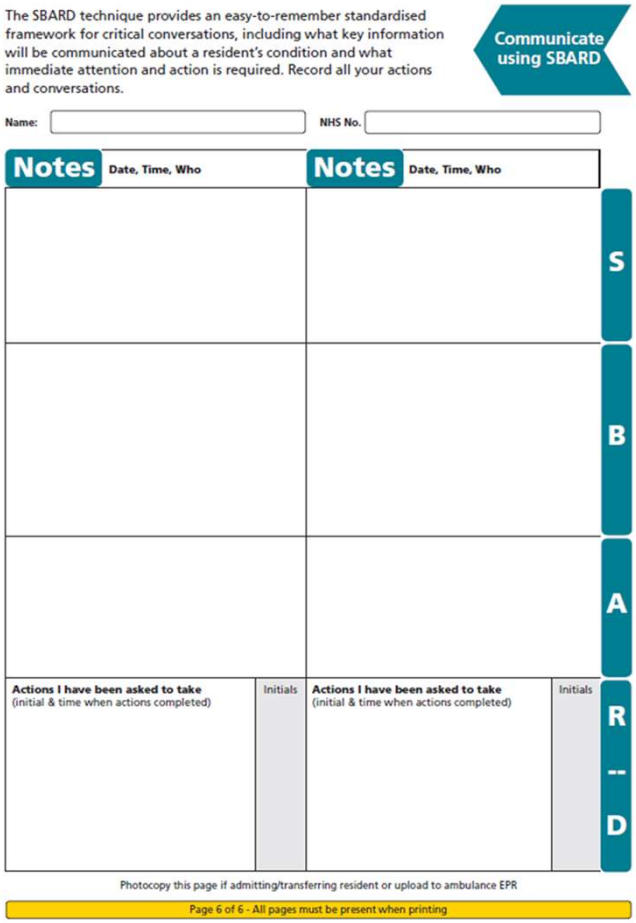
NHS No.

		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

Page 5 of 6 - All pages must be present when printing

Restore 2



The SBARD technique provides an easy-to-remember standardised framework for critical conversations, including what key information will be communicated about a resident's condition and what immediate attention and action is required. Record all your actions and conversations.

Communicate using SBARD

Name: NHS No.

Notes	Date, Time, Who	Notes	Date, Time, Who	
				S
				B
				A
Actions I have been asked to take (initial & time when actions completed)	Initials	**Actions I have been asked to take** (initial & time when actions completed)	Initials	R -- D

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

Page 6 of 6 - All pages must be present when printing

Hertfordshire and West Essex Integrated Care System

Restore 2 Mini

Get your message across

Raise the Alert within your home e.g. to a senior carer, registered nurse or manager.

If possible, **record the observations** using a **NEWS2** based system.

Report your concerns to a health care professional e.g. Nurse/GP/GP HUB/111/999 **using the SBARD Structured Communication Tool.**

		Key prompts / decisions
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)	

Don't ignore your 'gut feeling' about what you know and see. Give any immediate care to keep the person safe and comfortable.

RESTORE2™ mini

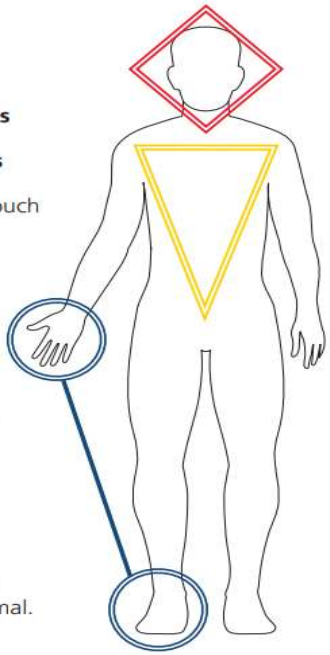
Recognise Early Soft Signs, Take Observations, Respond, Escalate

Ask your resident – how are you today?

Does your resident show any of the following **'soft signs'** of deterioration?

- Increasing **breathlessness** or **chestiness**
- Change in **usual drinking / diet habits**
- A **shivery fever** – feel **hot or cold** to touch
- Reduced mobility – **'off legs'** / less co-ordinated
- New or increased confusion/ agitation / anxiety / pain
- Changes to usual level of **alertness / consciousness / sleeping** more or less
- **'Can't pee'** or **'no pee'**, change in pee appearance
- **Diarrhoea, vomiting, dehydration**

Any **concerns** from the resident / family or carers that the person is not as well as normal.



If YES to one or more of these triggers – take action!

Rockwood clinical frailty scale

Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

Rockwood clinical frailty scale

The Rockwood Frailty scale is easy to use and looks at how an individual functions in everyday life. Knowing how frail someone is helps us to know what help they need.

One of the most common ways a person who has frailty will present in primary care (including acutely) is with one or more frailty syndromes (previously known as 'the geriatric giants'):

- Falls
- Immobility
- Delirium- A temporary mental state characterized by confusion, anxiety, incoherent speech, and hallucinations.
- Incontinence
- Susceptibility to side-effects of medication (e.g. adverse effects of polypharmacy)

Rockwood clinical frailty scale

No indication of frailty following assessment

The following actions can be completed by any professionals involved in the person's care:

- Signpost to:- Regular sight and hearing checks- Health promotion advice - STP Heathy Aging resource pack
- Raise awareness of: Eating well and staying hydrated - Dehydration
- Home hazards and wearing the correct footwear - Skin health - recommend regular moisturising- Local and National campaigns that occur at different times of the year e.g. Slipper's Swap campaign- Appropriate foot care Staying active
- Further assessment (as appropriate) - recommend an annual medication review. Postural hypotension assessment

Rockwood clinical frailty scale

Ensure integrated care pathways are in place

Integrated care pathways are essential for successfully managing the needs of people with frailty as these individuals are especially at risk. Without integrated care, patients with frailty are more likely to be inappropriately admitted as an emergency and to spend longer in hospital once they are medically fit for discharge.

Healthcare professionals must ensure that important information is shared in a timely fashion in the best interests of the individual across all the organisations involved in their care. The role of the third sector, voluntary sector, and public services is significant and a positive asset to be harnessed. Other emergency services such as the fire service are also often a source of information and practical help (for example, in assessing fire risk, installing alarms and other items of equipment).

SBAR tool - to support you to structure your conversations when discussing your residents with professional colleagues

S	**SITUATION** • Your name and Care home name • Name of patient , age, DOB • What is the concern, what has happened? Describe symptoms which are different than normal. Does the patient have capacity to tell you what is wrong?	**Examples of symptoms you might describe:** • Falls – are there injuries? • Confused, disorientated, dizzy, unsteady • Drowsy or hard to rouse • Hot / flushed /sweating. Cold / clammy / shivering / pale • Breathing harder or faster, slower or shallower • Complaining of pain, grimacing, posture indicating pain if unable to communicate - describe where pain is • Weakness in legs or arms / facial differences • Coughing / bringing up phlegm / wheezing • Vomiting / nausea - how long for • Change in urinary continence / Smelly urine, blocked or problem with catheter • Change in bowel habit /Diarrhoea • Not eating or drinking / loss of appetite • Bleeding from what area?
B	**BACKGROUND** • How long have symptoms been present? • Did they come on suddenly? • Does the person have any other long term illness? • Have they already been seen by the GP for this change? If so was any medications started? What instructions were given to the home? • Have you got a list of their current medication? • Has the patient recently been into hospital? If so what for? • Does the patient have a current DNAR in place? If yes be clear why you are ringing	
A	**ASSESSMENT** • What actions have you already taken? Is the patient in a safe place? • Has the person lost consciousness? Be very clear is it a true loss of consciousness? If yes how long for in minutes. • Are there any obvious signs of injury or bleeding?	**Examples of assessment actions you might describe:** • First aid options used /Recovery position • Pressure on bleeding area • BP, Pulse, respiration rate, temperature, urine analysis - give results
R	**RECOMMENDATION** • Explain what you need - be specific about the request and timeframe • Make suggestions i.e. ECP or Dr or advice only • Clarify expectations **Note: an ambulance can take from 9 – 60 minutes depending on urgency**	**Examples of recommendations you might describe:** • Review by GP urgently • Ambulance • Call back from Clinical Advisor • Clarify what is happening as a result of call – when you can expect a visit or ambulance

SBAR COMMUNICATION TOOL- AIDE MEMOIRE

FINAL

If an ambulance is sent these are suggestions of what do whilst waiting for the ambulance to arrive?

Reassure the resident and stay with them, continue to monitor for signs of deterioration which may mean a further call to the service. Ask another staff member to follow the check list. Do you need an escort? Do you need to ask senior management to attend the home?

In no particular order:-

1. Inform relatives.

2. Prepare the RED BAG; Photocopy medication charts and bag all medication. Is there any in the fridge, room or cupboards?

3. Photocopy main care plan details or grab sheet making sure the details are up to date. Especially where you have allergies or special instructions around other medical conditions. Include copy of DNAR form. Is there any special information which may help staff to communicate or deliver care for the resident, (i.e. strategies to adopt when the patient is anxious especially with dementia residents)? Are there any triggers which are not recorded?

4. Prepare an overnight bag for the resident. Remember to take items that may offer reassurance. Maintaining the residents' dignity is paramount so having their own belongings may help.

SBAR link to assist in e-learning

SBAR Communication in Care Homes - e-Learning for Healthcare (e-lfh.org.uk)

Thank you

Any questions?