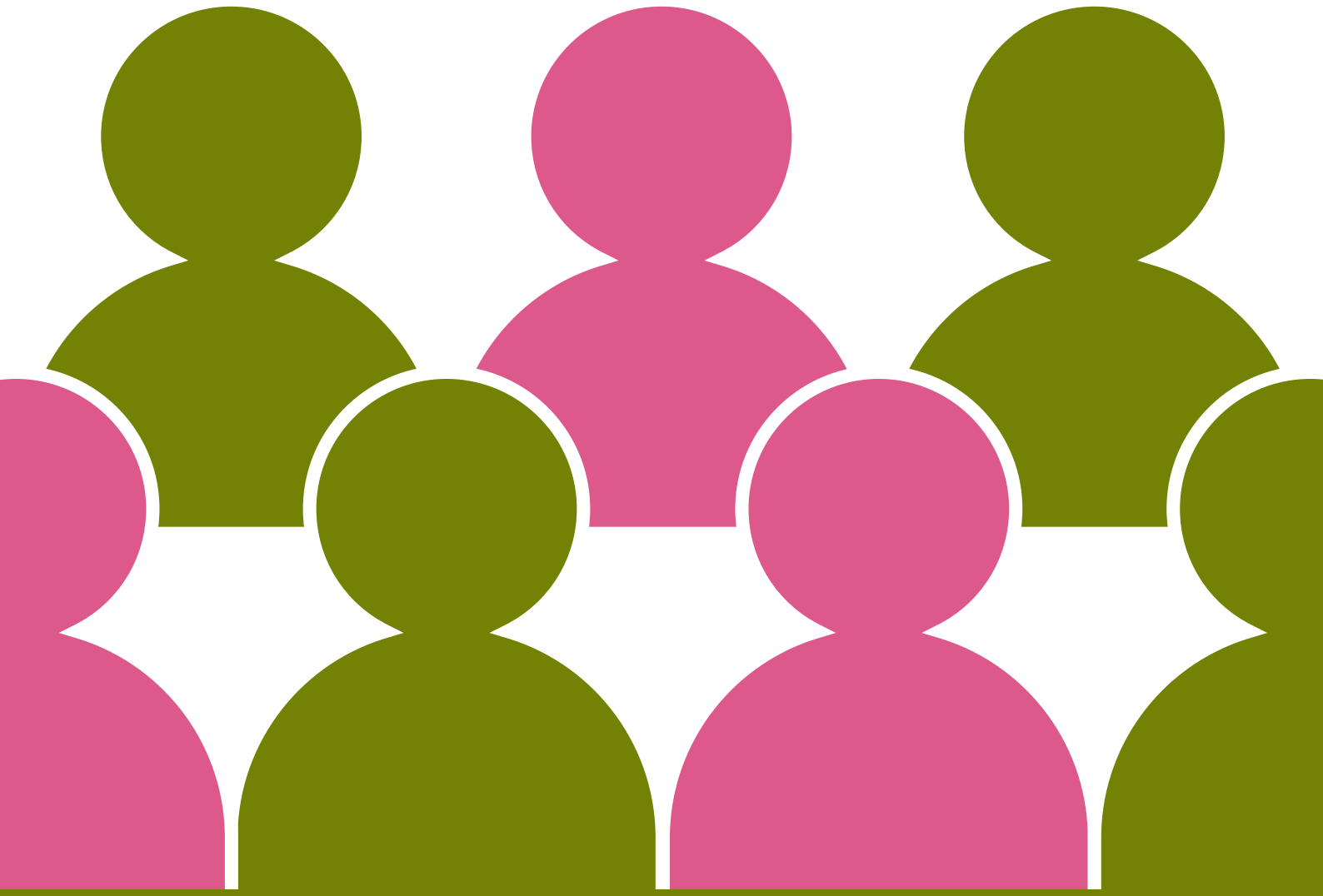
REACT TO

HOME ROUNDS

# Home Rounds and the Multidsciplinary Team (MDT)

## Their role within the Care Home



Integrated Care System

Nottingham & Nottinghamshire

# Introduction

## This React To Home Rounds resource provides:

- Training and information for care homes about the home round and wider multi-disciplinary team (MDT) processes in line with Enhanced Health in Care Homes Framework guidance
- Best practice guidance around what good looks like for care home and healthcare MDT working. This includes:
  - what a care home can expect from healthcare services and what care home staff can practically implement to support
  - improved communication with local healthcare services
- Practical resources and process around how to identify if a resident is unwell as well as an escalation framework to support access to the right service at the right time

**This document as well as other PDF resourses and the four accopanying films can be found on the React To Home Rounds web page:**
**www.reactto.co.uk/resources/react-to-home-rounds**

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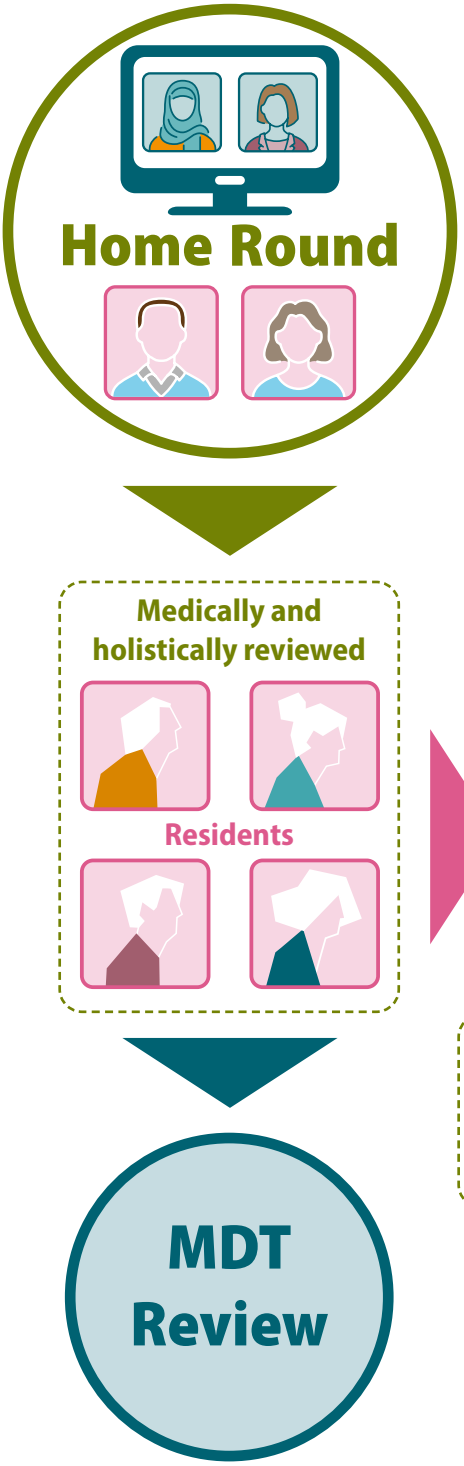
# What is a Home Round?

**A home round is a meeting between the care home and the local health provider team supporting the home.**

A home round may also be known as a 'weekly check-in' 'ward round' or 'board round'. This can be confusing! All these terms should be referring to the same meeting - the Home Round which is described here.




This meeting may be provided face to face or virtually to your home and should happen weekly.

In certain circumstances, such as in the case of a care home supporting those with learning difficulties to Live Well, it may be agreed with the care home and the GP practice that a weekly home round is not always required. In this case, both the care home and practice should have agreed protocols in place of how they seek review for a resident should they need it.

A home round should provide the opportunity for the care home's residents to be medically and holistically reviewed. This will be required when the resident is new to the care home, returning to the care home from secondary care or may be required when there is a concern regarding a new presenting healthcare issue or concern in function.

**So, the home round enables targeted healthcare support by providing a way for your resident's healthcare needs to be addressed or escalated for further Multi-Disciplinary Team (MDT) review if needed.**

All care homes will have access to teams that support the Enhanced Health in Care Homes approach, including homes that support adults, those with learning difficulties and mental health problems as well as older people care homes

Skilled health and social care professionals, including staff from the care home, work together to support residents through the Enhanced Health in Care Homes service.

**It is important to note that the Enhanced Health in Care Homes (EHCH) framework contract states a requirement for residents to be able to access this home round meeting on a weekly basis if required.**

# Setting up a Home Round – What 'good' looks like

## Preparing who to discuss

The care home should consider and agree, wherever possible in advance, which residents require discussion at the home round. Identification could be through the use of:

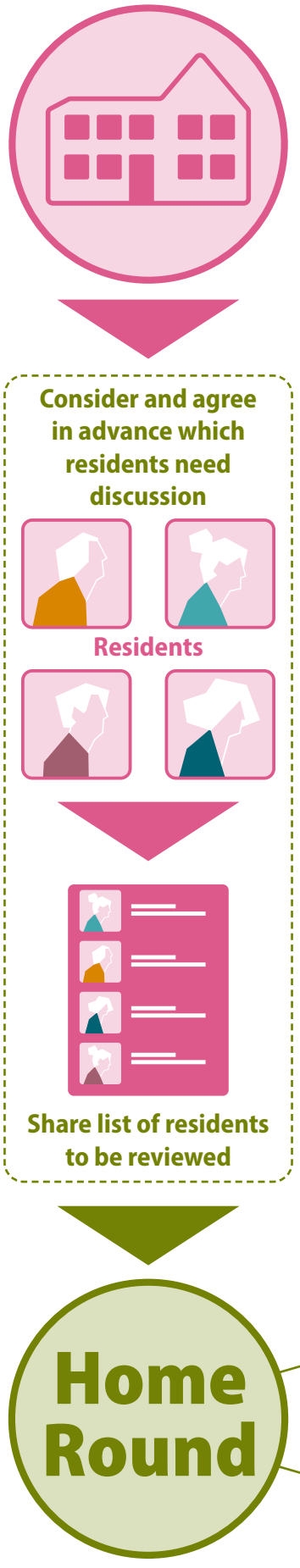
- validated tools
- clinical judgement
- feedback from care home staff

Film 4 and the chapter in this resource '**Is my resident unwell?**' will show you how to go about this.

A list of residents to be discussed at the home round should be shared between the care home and healthcare provider, **ideally 1-2 days prior to the meeting**, so that any further information gathering can be done.

The health provider may ring the home to establish who will need to be reviewed and information can then be shared using a secure email system such as NHS.net email can then be used to share information.

As it has become more usual to have virtual (online) home rounds, it is necessary to have a reliable and fast internet connection. The use of a NHS.net or other secure email provider to support exchange of patient information is also required.




Residents that require discussion should include:

- Any recent discharges from hospital (in the last 7 days). The healthcare care home team should have been made aware of the new admission occurring at the actual time of admission
- Any ambulance or Out of Hours call outs
- Any resident who has had a fall
- Anyone who has a change in their behaviour – they might seem to 'not be themselves', for instance they may be sleepy or more confused than usual
- Anyone with changes in their physical symptoms such as pain, constipation, breathlessness, swollen ankles, or red legs

In the event of deterioration immediately prior to the meeting, the urgency of need should be assessed and if appropriate the resident's should still be brought to the meeting for healthcare review.


## When should the home round be scheduled?

The home round should occur at the same time on the same day whenever possible. It should be at a time that works best for the residents' needs and supports required attendance - e.g. avoiding mealtimes.

## The home round itself

The home round should be led by a healthcare provider clinician with advanced assessment and clinical decision-making skills.

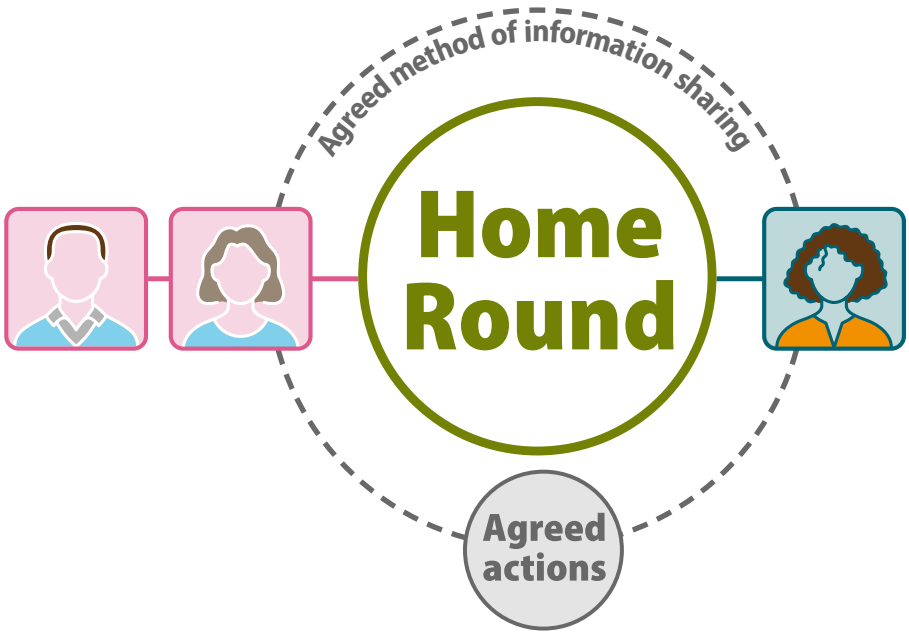
The care home staff attending should ideally be regular and identified as the home round lead and have a good day-to-day knowledge of the residents being discussed. For example, This might be a senior for the residential beds and a nurse for nursing. There should be a named lead and a deputy for when they are absent.

The home round should:

- Support discussion of the residents' wider holistic needs
- Ensure all new residents have had a holistic assessment and personalised care plan created and put in place (A holistic assessment incorporates all of an individual health and wellbeing needs)
- Ensure all residents discharged from secondary care have had a healthcare holistic assessment
- Where appropriate, discuss and complete end of life planning and ReSPECT documentation – ensure ReSPECT forms are ready for completion and sign off
- Provide an opportunity to Identify any gaps or concerns in care provision
- Identify any medication management and further assessment support required e.g., medication ordering: Is Proxy medication ordering in place? Or advice around the storage of medication
- Refer, as needed, to any other health care professionals (including the GP) and follow up the outcomes of referrals

## After each home round

Any agreed actions should be documented and the method of information sharing between the care home and the healthcare provider agreed to ensure all parties understand what is expected.



# Healthcare options for my residents

**When a resident moves into a care home it can be a very unsettling time for them and it is important to ensure the right support is available. Care Home staff are experienced and have great skills in getting to know new residents and helping them feel at home.**

'**What is at my fingertips**' is a useful tool which can be found in the accompanying PDF resources. Your care home may have this version already but both show the same information. It highlights the healthcare options you have available for your residents.


**This poster is available as a PDF and can be found at the bottom of the React To Home Rounds web page:**
**www.reactto.co.uk/resources/react-to-home-rounds**

1

## New Resident Pathway

- Home Round Review
- MDT Meeting
- Local Care Home Service
- GP
- Pharmacist

### 1. New Resident Pathway

- Firstly, register the new resident with the aligned GP
- The care home healthcare team should be informed on any new resident as soon as possible after their arrival and prior to the home round ready for further discussion at the home round meeting
- A new resident will have a full holistic assessment carried out by your local care home team. A personalised care and support plan should be agreed
- A Pharmacist or other suitably qualified healthcare professional will carry out a medication review

2

## Routine/Planned Care

- MDT Meeting
- Local Care Home Service
- GP
- Pharmacist
- Home Round Review
- Community Services (e.g. therapy, nursing, dietician)

### 2. Routine and Planned Care

As part of the ongoing care that you provide for your resident, you will be considering their physical, mental, social, and emotional needs. There is help at hand for any concerns that arise:

- If a resident has complex needs or significant deterioration in health, they can be supported by the MDT. This decision will be made at the home round through discussion with you, and the local healthcare care home team
- You can ask for your resident to be discussed at the next weekly home round to review their personalised care and support plan
- From the home round referrals can be made to the wider community team, such as physiotherapists, dietician, speech & language therapists
- A pharmacist review can be requested with regards to medication queries

3

## Managing Deterioration

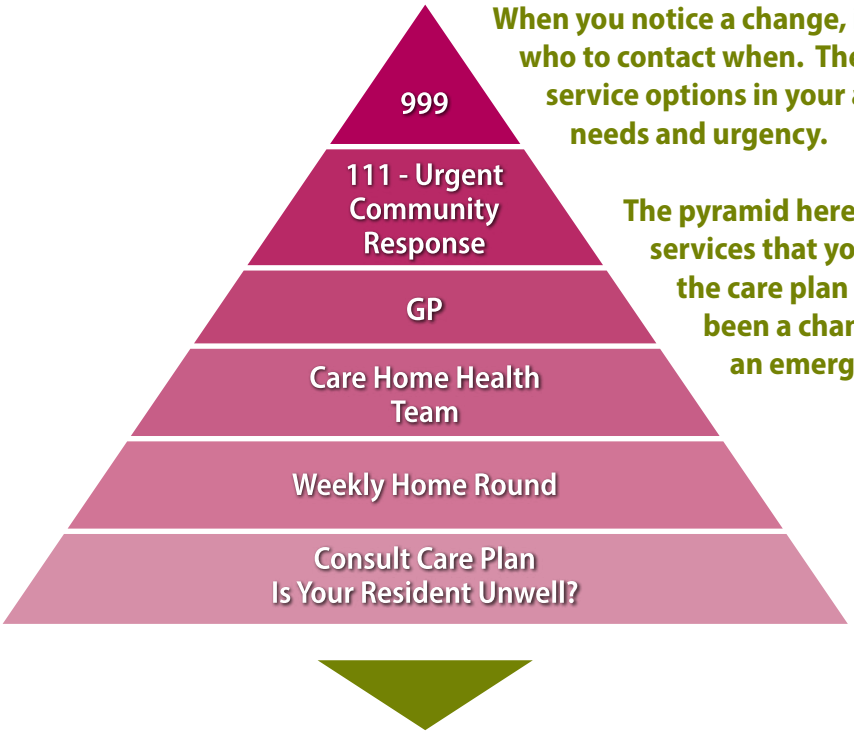
- **THINK!** Consult care plan, review for deterioration, escalate if appropriate

### 3. Managing Deterioration

There may be occasions when you feel your resident requires a rapid response from the Healthcare team. Identifying soft signs and recording NEWS2 scores can help with ensuring you seek the right help for your resident.

If the resident's NEWS2 score is elevated you should:

- Use the NEWS2 escalation tool to help you to identify when escalation to 111 or 999 is required.
- Check for and follow any ReSPECT form
- We will look at the NEWS2 escalation tool in film 3




**When you notice a change, it can be difficult to know who to contact when. There are several healthcare service options in your area which treat differing needs and urgency.**

**The pyramid here illustrates the hierarchy of services that you can access – from checking the care plan to making sure there has been a change right up to calling 999 for an emergency response.**

Consult Care Plan
Is Your Resident Unwell?

## The first thing to consider is:

- What's normal for the resident – what's their baseline?
- What is in their care plan?
- If it's not an emergency, what are your options?

Weekly Home Round

## When it can wait until the weekly home round

- Residents who have been seen by the ambulance service but who have not needed transfer to hospital
- A resident who has attended the Emergency Department / A and E
- An existing resident who you are concerned about such as: a resident losing weight, becoming more frail, reduced mobility
- Non injury fall
- Medication reviews
- New Permanent Resident and Post Hospital Discharges

Care Home Health Team

## When to Contact the Care Home Health Team

Contact the Care Home Health Team when there is a non-urgent change in presentation which requires assessment and treatment and that may require referral on to other community services.
Examples of when the care homes teams may support include:

- EOL care support
- Support around long term condition management

## GP

### When to contact the GP

Consider contacting the GP when there is deterioration that is non-urgent but cannot wait until home round – such as possible infection, rash, advice about end-of-life care etc.

## 111 - Urgent Community Response

### When is it Urgent Community Response (UCR)?

Consider contacting Urgent Community Response when there's a non-emergency change in health need that requires a response within 2 hours to keep the patient at home and prevent further deterioration. This is different to an emergency need – where there is an immediate threat to life. Examples of where a resident may have an urgent need include:

- **Exacerbation of a chronic condition, where the condition can be safely treated out of hospital, but the individual is at risk of hospital admission, e.g., Respiratory concern**
- **Palliative patient presenting in crisis (consideration should be made to the ReSPECT form and end of life wishes).**
- **Sudden deterioration in function - is the resident suddenly struggling with their everyday activities?**
- **Light headedness, nausea or vomiting**
- **Mobility – new onset sudden decrease in mobility**
- **Feeling 'unwell' - increased or new onset of pain, fever, loss of appetite, elimination.**

**If you dial 111 you can access direct support from clinicians by going on to dial *6**

***6 can be entered anytime after the 'press 1 for a text' option has been heard in the initial messages once connecting.**

**After pressing *6 you will then hear the following message *'This service is for healthcare professionals only – please hold while your call is transferred'*.**

## 999

### When it's an emergency

999 should be used only for life threatening presentations and serious injury. Examples of when a resident may have an emergency need include:

- **Chest pain**
- **New discomfort or pain in the arm or shoulder**
- **New jaw neck and back pain**
- **New shortness of breath**
- **Sweating, clamminess or greyness**
- **Head injury**
- **Signs of fracture**
- **The stroke symptoms - 'FAST'**
- **New onset or prolonged seizure (more than 5 minutes)**

# What is a Multi-Disciplinary Team Meeting?

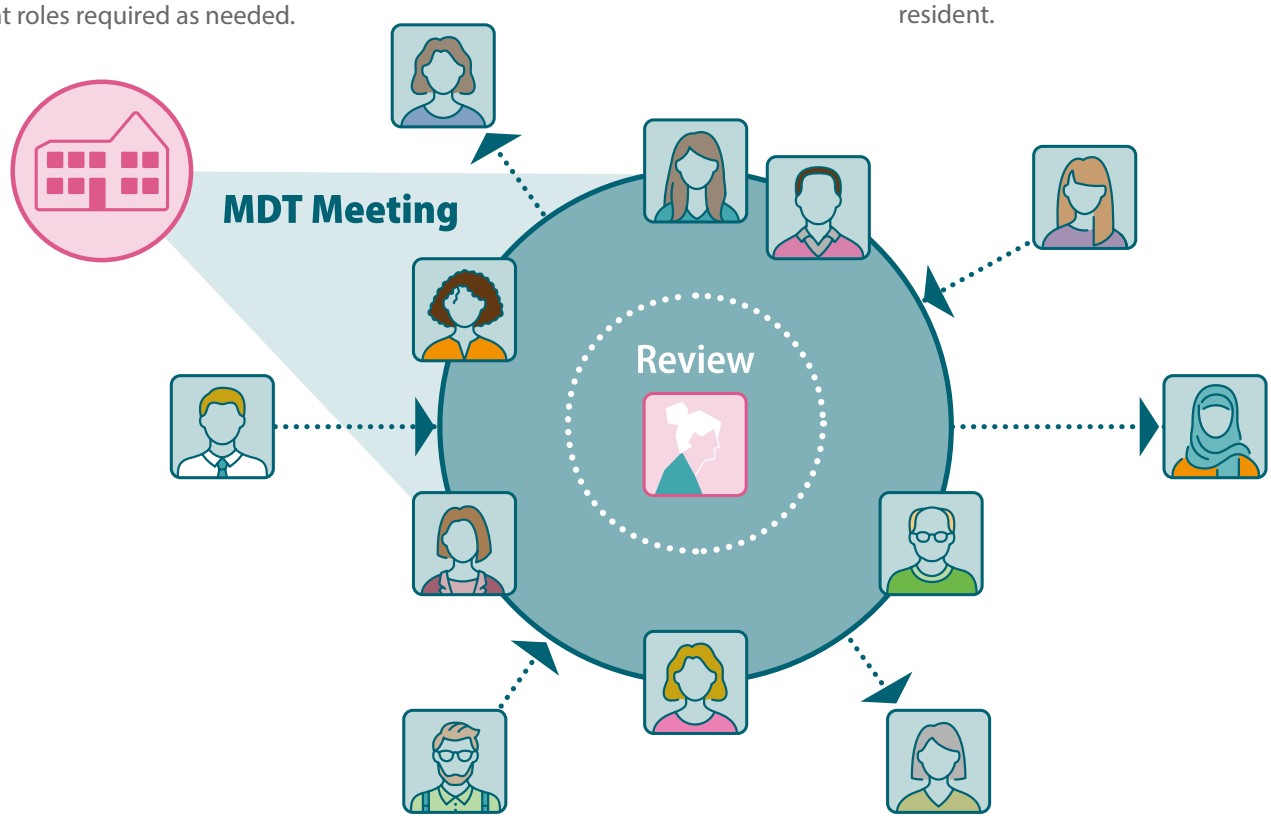
**The Multi-Disciplinary Team (MDT) meeting brings community health, social care, and general practice formally together to jointly agree care solutions for those residents with complex needs.**

This meeting will not be attended by all members of the MDT but will support 'referral on' and 'co-opting in' of the relevant roles required as needed.

The MDT meeting provides an opportunity for those residents who require further assessment, discussion and 'referral on' to be reviewed.

The aim is to support residents to remain in their care homes by preventing their conditions deteriorating, avoiding emergencies and maintaining long-term care.

A Care Home should ensure that the resident, and relevant carers or support, are aware that the resident is to be discussed at any MDT meeting and that the outcomes are fed back to the resident.




## Who will be at the meeting?

Care home staff should be invited to attend the meeting where their residents are discussed and leave prior to discussion of residents that are not at their home.

There will be core members at the meeting and others who will be co-opted in as required. However, all those individuals who may be relevant to support the resident should be able to be accessed via this meeting.

### The core members may include:

- GPs or Geriatrician
- Care Co-ordinator or Care Navigator
- Practice Nurse
- Care Homes Nurse
- Social Care Lead
- Care Homes Representatives
- Community Nursing Lead
- PCN Clinical Pharmacist (or other appropriate Clinical Pharmacist)
- End of Life Team representative

### Those co-opted in 'as required' may include:

- Specialist Nurse (e.g. Diabetes, Respiratory, Heart Failure)
- Frailty Lead
- Falls Lead
- Dietician
- Speech and Language Therapist
- Occupational Therapist
- Physiotherapist
- CPN
- Dementia Outreach Team
- Any other relevant team members

# Is my resident unwell?

**How do I know if my resident is unwell?**
**How unwell are they?**
**How do I decide on the most appropriate referral?**

**The document 'Is my resident unwell?' is a tool that has been designed to help carers answer such questions.**

As a carer you spend a lot of time with residents which enables you to get to know them very well. Sometimes it can be obvious that someone is unwell. Other times the signs can be much harder to spot. It is common to hear carers say that their resident 'isn't themselves today'. This is because the carer has noticed a change in their resident. These changes are known as soft signs.

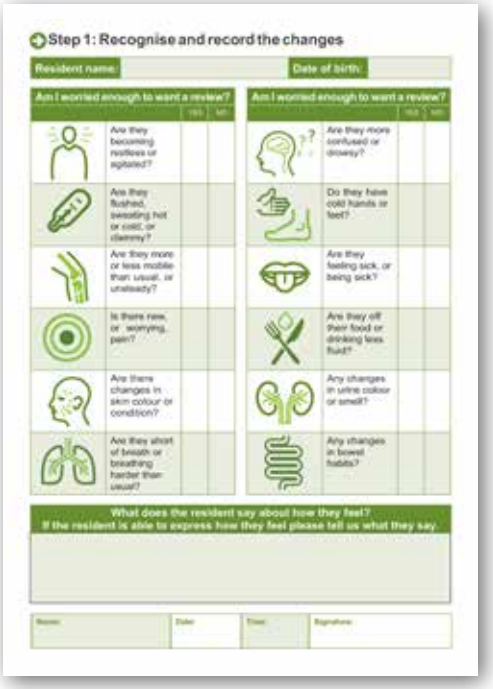
Soft signs are the early indications that someone might be becoming unwell. As a carer you're ideally placed to recognise small changes in your residents. Soft signs can present in many ways.


**'Is my resident unwell?' is available as a PDF and can be found at the bottom of the React To Home Rounds web page:**
**www.reactto.co.uk/resources/react-to-home-rounds**

**A resident's behaviour may change. They may become more restless, agitated, lethargic, withdrawn, argumentative, or tearful. They may be less interested in their personal care or activities of daily living. You can probably think of many more of your own.**

## Step 1: Recognise and record the changes

This checklist can be used to help with identifying soft signs. Not every question will be relevant to every resident.
You will see a picture icon and written prompts.


Step 1: Recognise and record the changes

Resident name: Date of birth:

Am I worried enough to want a review?

Are they becoming restless or agitated?

Are they flushed, sweating hot or cold, or clammy?

Are they more or less mobile than usual, or unsteady?

Is there new, or worrying, pain?

Are there changes in skin colour or condition?

Are they short of breath or breathing harder than usual?

Am I worried enough to want a review?

Are they more confused or drowsy?

Do they have cold hands or feet?

Are they feeling sick, or being sick?

Are they off their food or drinking less fluid?

Any changes in urine colour or smell?

Any changes in bowel habits?

What does the resident say about how they feel?
If the resident is able to express how they feel please tell us what they say.

A resident's behaviour may change. They may become more restless, agitated, lethargic, withdrawn, argumentative, or tearful. They may be less interested in their personal care or activities of daily living. You can probably think of many more of your own.

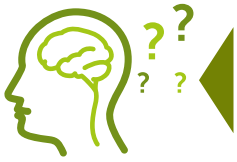
A resident may have a change in their complexion such as flushing, sweating, becoming hot, shivering, goose bumps, getting paler, cold, or clammy.

A resident may have a change in their mobility: Have you noticed they are more unsteady on their feet? Are they not walking around as they normally do? Have they had any falls, are they leaning to one side?

Your residents may be expressing new pain. Do they have any non-verbal signs of pain such as holding their head or guarding their abdomen? Has their need for pain medication increased?

Does your resident have any rashes, mottling of skin? Are there any signs of blueness around nose and mouth?

Has your resident had any changes from their normal breathing pattern? Do they sound chesty? Are they short of breath when mobilising? Can they complete a sentence without getting short of breath? Can they eat and drink without becoming breathless? Do they need their inhalers more? Are they coughing up anything? Do they have fast or unusually slow breathing? Can they lie down, or do they require more pillows. Are they asking to sleep in a chair?



Are they more confused or drowsy? Are they sleeping more than usual, not wanting to get out of bed, or less alert than usual? Is there increasing or new onset confusion? Please remember that residents with dementia can often have confusion which you are used to; if they become unwell, the level of confusion may suddenly increase and can be a soft sign.

Their hands or feet may be unusually cold to touch. Do they have any new swollen ankles or feet?

Has your resident complained of feeling sick or been sick? What did the vomit look like, how much was there, how many times were they sick? Has your resident got dry lips, dry tongue, complained of a sore mouth?

A resident's appetite may have changed: Are they off their food? Has their fluid intake decreased? Do they need a fluid/food chart starting? Has their weight changed? Are they prescribed supplements and do they take them?

Are there any changes in colour or smell in your resident's urine? Is it dark or smelly? Is there any blood in their urine? Are they needing to go to the toilet more often? Have they recently become incontinent? Is there any pain when they pass urine? When taken to the toilet can they pass urine straight away?

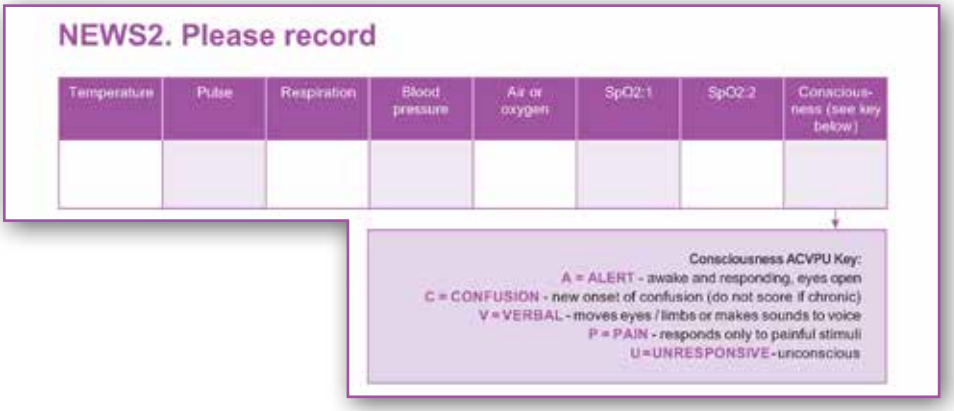
Have there been any changes in bowel habits? Are they usually continent and now are not? Do they have laxatives, if so have they been taking them? When were their bowels last opened?

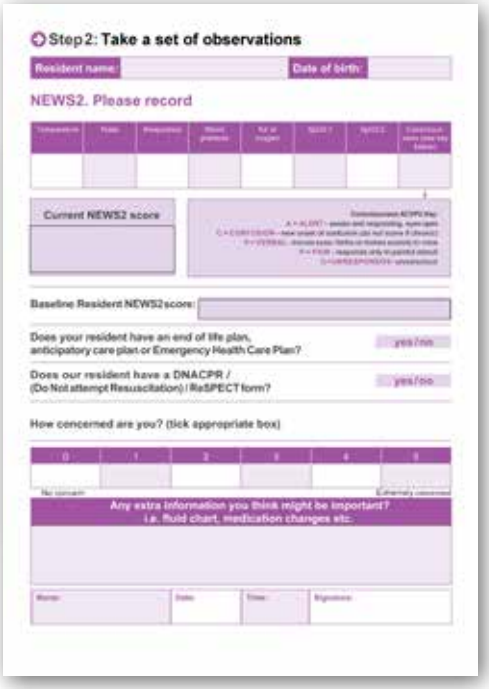
In addition to these signs what is your resident telling you about how they feel? Allow them time to express how they feel in their own words and in their own way.

Often family and friends will pick up on subtle changes in a person's behaviour, manner, or appearance. Speak to them as well, and be sure to listen and act on their concerns regarding change even if you haven't noticed them yourself


## Step 2: Take a set of observations

Many carers feel confident to take a set of observations and there are just as many who feel less confident.




**Here are links to films of how to take observations. These are useful for those of you new to caring or as a refresher for more experienced carers. Guidance around training and assessment of competency for taking observations should be followed within your employing conversation.**


5 Measuring the respiratory rate

Health Education England - HEE

**https://www.youtube.com/watch?v=ccKGzZXNKYs**


8 Measuring the heart rate

Health Education England - HEE

**https://www.youtube.com/watch?v=gfR4N_s-8-0**


6 Measuring oxygen saturation

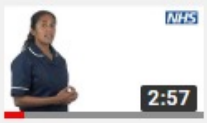
Health Education England - HEE

**https://www.youtube.com/watch?v=QabKghrtXps**


9 Measuring the level of alertness

Health Education England - HEE

**https://www.youtube.com/watch?v=mo1DCAJddkQ**




7 Measuring blood pressure

Health Education England - HEE

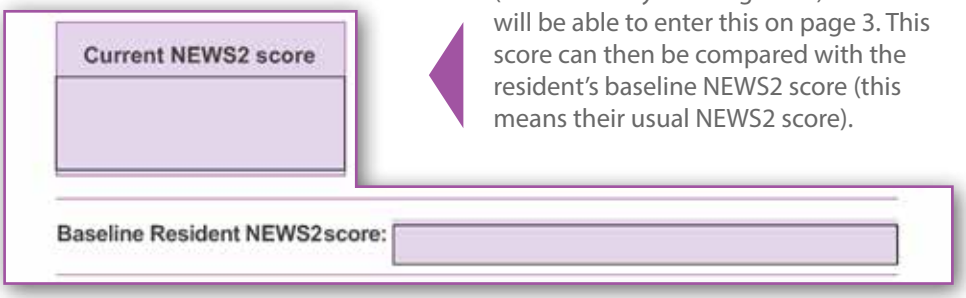
**https://www.youtube.com/watch?v=G8QkaAyqatE**

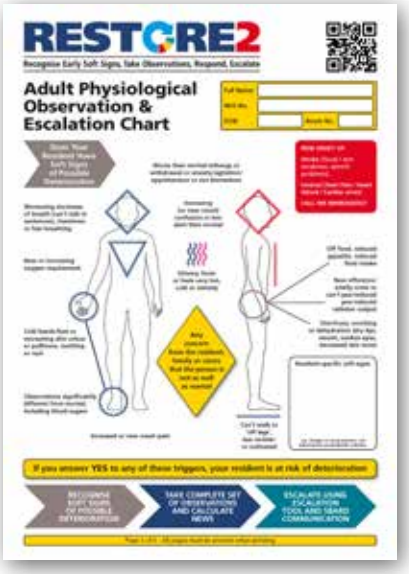

10 How to measure temperature

Health Education England - HEE

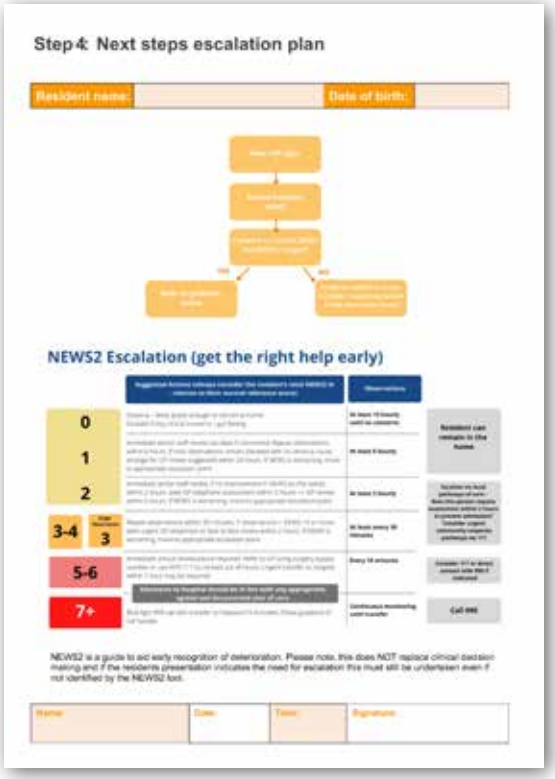
**https://www.youtube.com/watch?v=UxE6J9YBxqs**

You maybe familiar with tools such as the RESTORE 2 managing deterioration tool. If your care home is using Restore2 you will be familiar with calculating a NEWS2 (National Early Warning Scale) score and will be able to enter this on page 3. This score can then be compared with the resident's baseline NEWS2 score (this means their usual NEWS2 score).




**If you are not able to complete observations or a NEWS2 score, it will be appropriate for a carer to ask a suitable healthcare professional to assess further ensuring that the soft signs noted are communicated as a concern.**




The calculated NEWS2 score gives carers and healthcare professionals an indication of how unwell their resident is. A higher score equals more unwell. The NEWS2 Escalation Table can be found on page 5 of the tool. Dependent on the residents NEWS2 score, the table gives the carer guidance of what type of escalation is required. Whilst this is helpful, this is guidance only and other considerations as well as the NEWS 2 score should be taken into account. The table also recommends how often observations should be repeated. This is so that any further deterioration is spotted early.

Sometimes soft signs are seen because a person is becoming increasingly frail, they are becoming acutely unwell or they have a long term condition, such as dementia, that is progressing. The new soft signs can be an indication that your resident's healthcare needs are changing and the home round is an ideal time to discuss these changes and review the resident's care and support plan.

**There are several tools which can help you assist in identifying if your resident is unwell and to support recognising deterioration. Further more detailed training around using specific managing deterioration tools can be sourced outside of this training.**

## Spotting serious illness and sepsis

Some people are more at risk than others of becoming unwell very quickly and developing a serious illness such as sepsis. This is known as 'deterioration' and it is important that anyone who cares for individuals who are at risk of deterioration knows how to spot the signs, especially during the current COVID-19 outbreak.

### Introduction to sepsis and serious illness
**https://www.youtube.com/watch?v=A6sg0mkcJIY**

### Preventing the spread of infection
**https://www.youtube.com/watch?v=ZSV8eW5FwF8**

### Soft signs of deterioration
**https://www.youtube.com/watch?v=7gMo13z3BYI**

### Recognising deterioration with a learning disability
**https://www.youtube.com/watch?v=vSWCPza8dCU**

## NEWS2: What is it?
**https://www.youtube.com/watch?v=S-KWnrsOw8M**

## Calculating and recording a NEWS2 score
**https://www.youtube.com/watch?v=ellPesGSMmA**

## Escalate and Communicate

Effective communication is vital for safety critical messages between different healthcare staff

### Structured communication and escalation
**https://www.youtube.com/watch?v=Ki0BX61xhdw**

### Treatment escalation plans and resuscitation
**https://www.youtube.com/watch?v=vXrRp7AW5E4**

It is important to be aware of any end of life plans or ReSPECT form that a resident may have. Any wishes or agreed plan should be considered before using the NEWS2 escalation table. Any action taken should be in line with any end of life or ReSPECT plans.

| | |
|---|---|
| **Does your resident have an end of life plan, anticipatory care plan or Emergency Health Care Plan?** | yes/no |
| **Does our resident have a DNACPR / (Do Not attempt Resuscitation) / ReSPECT form?** | yes/no |

## How concerned are you?

Use this scale to express how concerned you are. This doesn't have to relate to how unwell your resident is. There are many reasons you may feel concerned. Your resident may be experiencing pain that is impacting on their quality of life or feeling very frustrated because of hearing problems. Your concern may be related to risk, for example, with difficulty swallowing tablets. The home round is the ideal place to discuss concerns.

**How concerned are you? (tick appropriate box)**

| 0 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| | | | | | |

No concern — Extremely concerned

## Any other information

At this point consider any additional information that you think is relevant. Examples could be your resident has had a recent change in medication or a change on their fluid charts.

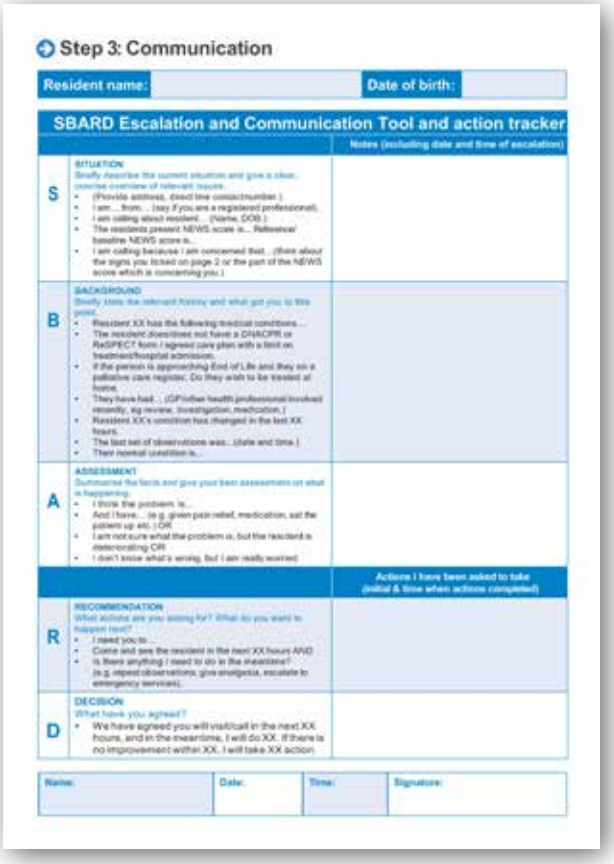
If you have identified your resident is unwell make sure you have additional information available.

If you have noticed changes that need to be discussed at a home round, have information available for the home round meeting.

| Any extra information you think might be important? i.e. fluid chart, medication changes etc. | | | |
|---|---|---|---|
| | | | |
| **Name:** | **Date:** | **Time:** | **Signature:** |

## Step 3: Communication

Next consider writing down your thoughts. You can use the SBARD format:



Step 3: Communication

Resident name: | Date of birth:

SBARD Escalation and Communication Tool and action tracker

| | | Notes (including date and time of escalation) |
|---|---|---|
| S | SITUATION<br>Briefly describe the current situation and give a clear, concise overview of relevant issues.<br>• (Provide address, direct line contact/number.)<br>• I am … from … (say if you are a registered professional).<br>• I am calling about resident… (Name, DOB.)<br>• The resident's present NEWS score is… Reference/ baseline NEWS score is…<br>• I am calling because I am concerned that…(think about the signs you ticked on page 2 or the part of the NEWS score which is concerning you.) | |
| B | BACKGROUND<br>Briefly state the relevant history and what got you to this point.<br>• Resident XX has the following medical conditions…<br>• The resident does/does not have a DNACPR or ReSPECT form / agreed care plan with a limit on treatment/hospital admission.<br>• If the person is approaching End of Life and they on a palliative care register. Do they wish to be treated at home.<br>• They have had…(GP/other health professional involved recently, eg review, investigation, medication.)<br>• Resident XX's condition has changed in the last XX hours.<br>• The last set of observations was…(date and time.)<br>• Their normal condition is… | |
| A | ASSESSMENT<br>Summarise the facts and give your best assessment on what is happening.<br>• I think the problem is…<br>• And I have… (e.g. given pain relief, medication, sat the patient up etc.) OR<br>• I am not sure what the problem is, but the resident is deteriorating OR<br>• I don't know what's wrong, but I am really worried. | |
| | | Actions I have been asked to take (initial & time when actions completed) |
| R | RECOMMENDATION<br>What actions are you asking for? What do you want to happen next?<br>• I need you to…<br>• Come and see the resident in the next XX hours AND<br>• Is there anything I need to do in the meantime? (e.g. repeat observations, give analgesia, escalate to emergency services). | |
| D | DECISION<br>What have you agreed?<br>• 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. | |

| Name: | Date: | Time: | Signature: |
|---|---|---|---|
| | | | |

**S** ›

**The S stands for Situation**
This is where you would briefly describe the current situation, giving information on who you are, who you are concerned about and details of soft signs and NEWS2 scores.

**B** ›

**The B stands for Background**
This is a about relevant medical history of your resident, if they have a ReSPECT, how their situation has changed recently and how they are normally.

**A** ›

**The A stands for Assessment**
This is where you would give your best assessment of what you think is happening. Remember you know your resident well. Such as ' I think the problem is…'' I have done this…..'

**R** ›

**The R stands for Recommendation**
What actions are you asking for? What do you want to happen next? Is there anything else you can do?

**D** ›

**The D stands for Decision**
Write down what has been agreed. Is someone visiting, is there a time scale for this?

### So, by:

- using a tool to identify soft signs
- considering most appropriate escalation needed
- and communicating concerns in a structured way, such as using the SBARD format

**You can decide on the most appropriate course of action and onward referral for your resident.**