VOLUME 1, ISSUE 3

CNJ

CARE HOME NURSING JOURNAL

Four Seasons
HEALTH CARE

Student Nursing Times Awards '17

PATIENT SAFETY AWARDS WINNER

Nursing Times Awards 2017

RCN Nurse Awards 2017

BJN The Awards 2017

CONTENTS

EDITORIAL

You may not be aware of it, but in the last twelve months Four Seasons Health Care has been finalists in over sixty categories, across more than fifteen different award events. In this, our third issue of the Care Home Nursing Journal, I wanted to share with you all some more recent success that our organisation and colleagues have enjoyed.

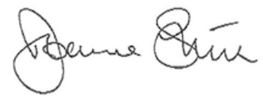
In mid-June, two of our nurse specialists: Nicola-Anne Pengelly and Elaine McShane were joint runners-up for the Cavell Trust Nursing Older People's Award. In early July we won a prestigious Patient Safety Award for our Quality of Life programme. The judges commented: "This project is an example of great team work which has delivered a real change to the community. The outcomes have real benefit and the impact is massive." Award success continued a few weeks later with colleagues from the Arches Care Home in Northern Ireland picking up two awards at the National Learning Disability and Autism Awards for 'Care of Older People with a Learning Disability' and 'Nurse of the Year'. Most recently our nurses have been shortlisted in multiple categories at the 2017 Nursing Times Awards.

Such success is because of a great many factors. Most importantly, I believe that the success of individuals, and indeed our organisation, is a result of a four letter word: TEAM. I want to extend my sincerest gratitude to all of our colleagues who make a difference to our residents every day. Thank you. I also need to extend a special thank you to all of our contributors for the third issue of our journal. I think you'll find these original articles useful to your nursing practice.

If you are interested in writing or being supported to write a piece for our journal please get in contact with our editor-in-chief Gary Mitchell via email: Gary.Mitchell@fshc.co.uk.

As an editorial team we want to share knowledge and examples of good practice so that others can learn how to enhance our resident's quality of life.

Special additional content, that compliments the contents of this issue, is available via SOAR in the Nursing Community section. Please log in to SOAR, join our Nursing Community and share your thoughts and feelings what on you liked, what you found helpful and what you would like to see more of in future issues.



Joanne Strain, Head of Nursing

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FRAILTY

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This article focuses on frailty and describes what frailty is, how we as nurses can identify frailty and support older people to live well and to make plans for the future.

What is frailty?

People often have an image of someone who is "frail", perhaps a stooped thin shuffling older lady...this is often inaccurate. Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves both physical and psychological. It is often described as not having the ability to "bounce back" from such things as infections or a physical trauma. However, frailty is not an inevitable part of ageing it is a long-term condition, like diabetes or Alzheimer's disease. Older people living with frailty are at risk of poor health and social outcomes such as dramatic changes in their physical and mental well-being after an apparently minor event which challenges their health. Frailty varies in its severity and individuals should not be labelled as being frail or not frail but simply that they have frailty. The degree of frailty of an individual changes, it naturally varies over time and can be made better and worse. Our role as nurses is to optimise the well-being of people who are living with frailty and to educate and support the person and their families so that they plan for the future.

How do we know if some has frailty?

Sometimes we think we know someone has frailty by the way they look, speak or move but more important indicators of frailty are frailty syndromes (BGS 2014).

Frailty syndromes include:

- Falls (e.g. 'collapse', 'legs gave way', 'found lying on floor')
- Immobility (e.g. sudden change in mobility, 'gone off legs' 'stuck on toilet')
- Delirium (e.g. acute confusion, worsening of pre-existing confusion/short term memory loss)
- Incontinence (e.g. new onset or worsening of urinary or faecal incontinence)
- Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants).

In care homes with nursing, the numbers of residents with frailty syndromes are large. If a resident has one or more of the syndromes above you should think about formally identifying if the individual has frailty.

It is important to check whether the resident has already has a diagnosis of frailty from the nursing or GP record or hospital discharge details. If there is no diagnosis of frailty and the person exhibits muscle weakness, poor mobility, poor balance, cognitive decline, reduced physical activity or a lack of endurance frailty should be considered.

There are some simple assessments that can be done, these include:

- Gait speed: taking more than 5 seconds to walk 4 metres
- 'Timed up-and-go test' (TUGT): a cut off score of 10 seconds to get up from a chair, walk 3 metres, turn round and sit down.
- One should note that sometimes there are health problems that can cause "false positives" for example a fit older person with isolated knee arthritis or a fracture causing slow gait speed.

What to do if you suspect someone has frailty that has not already been recognised or has not been reviewed for some time?

The evidence based intervention or "gold standard" is Comprehensive Geriatric Assessment, sometimes called comprehensive old age assessment. It is defined as 'a multidimensional, interdisciplinary diagnostic process to determine the clinical, psychological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up'. This can be done by a team lead by an appropriate nurse, usually an older peoples advanced nurse practitioner, GP or geriatrician and sometimes by allied health professionals such as a physiotherapist. It is important that your residents have access to this assessment and you may need to make referrals to your local services.

What interventions can we do as nurses?

As nurses we are very well placed to help our residents live well with frailty. We are educated to deliver person-centered care and to produce sophisticated care plans and this is exactly what people living with frailty need. There is evidence that in individuals with frailty, a person-centred, goal-orientated comprehensive approach reduces poor outcomes and may reduce hospital admission. Care plans which are individual often focus on exercise and nutrition as well as ceilings of care and personal wishes. They can also set out the interventions someone needs if they have an acute exacerbation of their long term conditions. We know that people with frailty who join a care home are likely to have short life expectancy and their care plans may also include end of life wishes.

As well supporting the resident through their frailty journey, their friends and family will also need education and support. There are many misconceptions about what frailty is and the role families can play in preventing further decline. Nurses have a clear role in explaining frailty; this might be done through education sessions, support groups posters or individual conversations. For example, we know that exercises that improve strength and balance (Clegg et al. 2013) can be helpful and families might like to support residents in undertaking them. Equally nurses should make sure the exercises or exercise groups in your place of work focus on these elements.

Similarly improving nutritional intake to ensure residents have a normal BMI is important this should be done through the provision of nutritious food. There is limited evidence about effective nutritional interventions but recommendations include optimising protein intake and promoting adequate vitamin D intake (Fiatarone et al. 1994).

National Voices (2014) suggest the following mechanism for co-creating a care plan to help improve the well0being of someone living with frailty.

Step one: Prepare

- Always start from the point of view of the person
- Gather necessary information and make it available upfront
- Allow time to reflect and consider options

Step two: Discuss

- Take a partnership approach
- Focus on staying well and living well and, for some, dying well
- Identify the actions a person can take
- Identify what care and/or support might be needed from others

Step three: Document

- The main points from discussions are written up, included as part of the person's health and/or social care records, and owned by the person and shared, with explicit consent

Step four: Review

- Consider options for follow up and set a date for review

What else can we ensure happens?

Nurses have a key role in coordinating care for residents particularly those who are living with frailty. An important intervention is the regular review of medication as older people are more sensitive to drug dosage and drug actions. When administering medication registered nurses should be considering the efficacy of the medication the resident is taking, its interactions, side effects and appropriateness. Regular medication review is important. Polypharmacy affects older people most with the increasing prevalence of long-term conditions with age. The oldest 15% of the population are known to receive 40% of all drug prescriptions (Nicholl 2006). Registered nurses should refer residents to GPs and pharmacists for regular review or if they are concerned by the effects of medication.

Equally ensuring access to dental and optical care is very important for people living with frailty, good nutrition status is affected by a resident's oral health and falls risk is increased with visual impairment. In addition to providing excellent physical health care support the nurse must encourage activities that have been shown to improve mental well-being. Care home staff are uniquely placed to develop a deep understanding of a residents mental health needs and support the activities and interests of individuals. Careful consideration of the presence of depression or dementia is important and to recognise when referral to others is required. There is a wide range of research about frailty and encouraging both staff and residents to engage with this agenda through groups such as Enrich http://enrich.nihr.ac.uk/pages/research-ready-care-home-network is also important.

Where can I get support for my role?

There are many resources to support nurses, in your own organisations colleagues will have a wealth of experience and local NHS staff will also have a lot to offer. Frailty is of national importance and there are a large number of online resources. A good place to start is the Royal College of Nursing webpage https://www.rcn.org.uk/clinical-topics/older-people/frailty. There is a wide range of research about frailty and encouraging both staff and residents to engage with this agenda.

In this article we have seen the major role nurses have in recognising frailty, helping residents with frailty to live well and to help prepare for the future in coordinating the support of resident's needs. Nurses are uniquely skilled and have an essential role to play not simply for the resident but for the wider health and social care community.

RECOGNITION AND PREVENTION OF DELIRIUM IN CARE HOMES

Dr Eleni Fixter
Member of the #icanpreventDelirium Project, Tees, Esk andWear Valley NHS Trust.

What is Delirium?

Delirium is an acute confusional state that occurs when people are medically unwell. Symptoms start suddenly and can be frightening for the resident but also for family and carers.

1 in 4 of the elderly population will experience delirium in the acute hospital and 17% of all care home residents will have it at any one time. Delirium is common however half of all cases go undiagnosed which can increase falls, worsen cognitive function and can ultimately lead to early death. The #icanpreventDelirium project is about raising awareness of Delirium and empowering staff to Suspect, Spot and Stop Delirium.

Suspect Delirium

The extremes of age are most at risk of delirium, it is often seen in paediatric intensive care and also in those over the age of 65. The middle age groups can experience an episode of delirium however the triggers needed are much greater, for example extreme trauma. In our older population the triggers are smaller, such as simple constipation or dehydration.

Sensory impairment such as visual or hearing loss, as well as a pre-existing dementia or brain injury can also make people at higher risk of delirium. This is because the brain is already in a vulnerable and fragile state.

Causes of Delirium

PINCHME

Pain , Infection, Nutrition, Constipation, Hydration/ Hypoxia, Medication, Environment

Spot Delirium

There are two main presentations to be aware of.

Hypoactive delirium, where the resident may present as withdrawn with reduced alertness, and hyperactive delirium for those who appear more agitated and alert. Some people can have a mixed type and can swing between the two extremes. It can be difficult in separating a Delirium from worsening Dementia but there is one question to ask which can help:

"Is this resident more confused lately?"

This is known as the Single Question to Identify Delirium (SQiD) and it can recognise the acute (within a matter of days) change of presentation in people with delirium.

As well as confusion, other symptoms to spot are reduced concentration and alertness. Is the resident difficult to rouse or hyperactive? Look for changes in behaviour and the way the resident communicates, are they more difficult to follow in conversation? Delirium can lead to altered perceptions; are they suddenly experiencing hallucinations or voicing other bizarre beliefs? Importantly these new presentations can change and fluctuate rapidly over the course of the day from their normal presentation to one that is very unusual for them, and back. Family and carers are best placed to recognise this.

The 4AT is another specific, simple and practical tool that checks if the person is alert, orientated and attentive to diagnose delirium. No specific training is required to use this tool, which can be found at www.the4at.com

Stop Delirium

Firstly identify and treat the underlying cause of delirium whether it is pain, constipation or any number of factors. There is no specific treatment for delirium itself only ways to manage particular symptoms associated with it and therefore non-pharmacological management is best practice.

DELIRIUM CAN BE PREVENTED AND TREATED

SUSPECT IT	SPOT IT	STOP IT
Age 75+	Acute confusion	Treat cause
Cognitive impairment	Poor concentration	Explain and reassure
Visual / hearing loss	Poor communication	Environment
Infection / dehydration	Change in behaviour	Physical needs
Pain / trauma	Hallucinations	Psychological needs
	Fluctuations	Social needs

Reassure the resident and engage with the family. Reduced attention is one of the symptoms of delirium, and so adapting communication is crucial in helping overcome distress. Making eye contact, speaking in short simple sentences, using frequent orientation and introductions in all contacts is extremely important.

Think environment, the resident may be experiencing distressing hallucinations, a well-lit and quiet environment may benefit in reducing this. Familiar objects and people present can help keep them orientated and settled. Ensure people are wearing hearing aids and glasses if they would normally, as sensory impairment can exacerbate symptoms. Allow for free movement and mobilisation if possible to reduce distress and duration of the episode.

Even if you treat the underlying cause of the delirium, symptoms can persist for up to 6 months. Continue with the above approach and try to avoid and manage complications such as immobility, malnutrition, pressure sores, over-sedation and falls. Be vigilant of the underlying cause reoccurring, as early recognition and treatment can help prevent further episodes of delirium.

People can often recall their experience of delirium and can be left with frightening and upsetting memories of their experience. Again, reassurance and explanation can help support the resident.

These simple measures can help alter outcomes and improve the experiences of people with delirium. Suspect it, Spot it and Stop it, together we can prevent Delirium.

For further information on the #icanpreventDelirium Project, please follow us on twitter, watch our YouTube video, or email eleni.fixter@nhs.net

Follow on Twitter #ICANPREVENTDELIRIUM

Causes Of Delirium

PINCHME

PAIN
INFECTION
NUTRITION
CONSTIPATION
HYDRATION/HYPOXIA
MEDICATION
ENVIRONMENT

OVERCOMING THE CHALLENGES FACING CARE HOMES IN THE UNITED KINGDOM: A NORTHERN IRISH ORGANISATIONAL CASE STUDY

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(Managing Director)

Ruth Burrows
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Background

As highlighted in an earlier paper by Cousins et al. (2016), there are many challenges which face care homes in the UK today. Cousins et al. (2016) provide an overview which should be reviewed in conjunction with this paper. In summary however, the challenges facing care homes that were previously discussed include:

1. **The current model of funding within the UK relating to care home nursing.**
2. **Delivering appropriate education to care home staff.**
3. **The valued and unique role of overseas nursing staff.**
4. **The care home career pathway.**
5. **Recruitment and retention of care home nurses.**

Organisational Case Study

Within Northern Ireland, Four Seasons Health Care operates approximately 60 care homes. This organisational case study describes a number of initiatives that have taken place within Four Seasons Health Care in Northern Ireland, since 2013, in response to some the challenges that face the care home sector as were detailed previously (Cousins et al. 2016).

Developing staff knowledge through creative approaches to learning

As highlighted by a commissioned report by the RCN Foundation (Spilsbury et al. 2015), there are a number of barriers to delivery of quality education to people who work within care homes. The rationale for this often relates to poor care staff attendance at training (Cousins et al. 2016). It is acknowledged that this can be difficult to resolve because care staff who are signed up for training may have to cover a shift at short notice, issues around chronic short-staffing within care homes is well documented (Spilsbury et al. 2015). Other reasons that staff may not complete training include: non-payment for training, inability to access NHS training or trainers unable to access scholarly material to design educational packages. In response to these difficulties, it has been recommended that care homes seek to operationalise creative approaches to learning and development.

Within Northern Ireland we developed an initiative to make care home staff more aware about the prevalence of falls within care homes. In this initiative, the team began by analysing the data generated within our internal DATIX system, which held all the documented information on falls throughout all Four Seasons care homes. On analysis of these it was noted that the cause of falls were often recorded as 'not known'. This posed a number of questions, but ultimately meant that we were not able to understand the cause of falls and how then these could be stopped.

Through critical thinking and discussion with multidisciplinary members of the team, the weakness that was noted in the system was that although there were procedures in place for falls, nurses did not appear to be critically reviewing the data so the incidence of falls did not seem to be reducing, in other words, lessons were not being learnt from previous falls.

This led to the central aim of this was: How could an initiative be developed to, not only raise awareness about falls, but ultimately to reduce their prevalence in clinical practice?

An educational resource was designed which was piloted within 18 Four Seasons care homes. Each care home sent 5 members of their clinical team to garner a deeper understanding about falls. The educational resource was based around evidence based practice and was supplemented by a free online course from Future Learn (2016) called 'Ageing Well: Falls'. Incidentally, this course was designed and delivered by the University of Newcastle in 2 hour blocks over a period of 4 weeks. This was very informative and provided a theoretical underpinning for our educational resource.

In practice, it was advocated that care homes would now place a laminated sheet at their nurse's station which listed the days of the month. If a fall occurred on the unit, the care staff would cross the laminated sheet with an 'X'. If no fall occurred then the day would not have an 'X' beside it. The idea behind this was to provide a visual aid so as to illuminate the prevalence of falls within any unit. If people could see that falls were occurring regularly then this would encourage the health care team to critically evaluate the situation.

Through appreciation of creative approaches to learning, Four Seasons collaborated with local opticians, Optomise, to show our staff what it was like to have poor eyesight by providing them with lenses that distorted their vision.

The feedback from care staff was very powerful as it underlined the fact that residents with poorer vision are more likely to have a higher risk of falling. Overall, this initiative has led to the development of practice across the care homes within our organisation. Empirical data analysis, through the DATIX System, has evidenced a notable reduction in the number of falls as well as an increase level of awareness about the triggers, the impact and the future management of falls.

Facilitating the development of link nursing across care homes

Another approach to overcoming barriers to learning in practice, which is recommended by Spilsbury et al. (2015), is the generation and utilisation of a link-nursing system. Link nurses are usually defined as practitioners with a special interest in a subject area and a formal link to specialist team members (Pagnamemta, 2005). In addition to this, there is also an expectation that link nurses will have access to specialist education which they can disseminate to other members of their nursing or care team (RCN, 2012). From a commercial perspective, it often means that one or two link nurses can receive specialist training and them disseminate their knowledge to a number of other nurses in practice.

Within Four Seasons in Northern Ireland we developed an innovative link-nursing system that focused on infection control and prevention issues. In relation to infection control, Dawson (2003) stated that, IPC link staff can play an important role in their clinical area to facilitate liaison with the infection control team and to act as a resource for colleagues. Undoubtedly infection, like falls, is something that can be avoided on many occasions if clinical support is good. The development of a link nursing programme was aimed at providing meaningful education relevant to the care home environment.

Initially there was a requirement to carry out a scoping exercise in order to ascertain gaps in practice, such as hand hygiene or use of personal protective equipment. This scoping exercise was important because, unlike the aforementioned falls initiative, trends in data and reporting were less obvious. In addition, there was no formal lead in infection prevention and control within the organisation until this point.

Through structured observations, it was noted that hand hygiene or using personal protective equipment was a task that mainly fell to the non-nurses. Care assistants were the group responsible for providing the majority of assistance with personal care. Domestic colleagues were moving from room to room looking after environmental cleanliness. This meant that these staff groups were in the best position to identify practice which was good or bad and the ones who were most likely to influence positive change within care homes. Through review of the nursing role it was noted that this group were responsible for planning care relating to residents who may have active or colonised health care associated infections (HAIs). Naturally, to implement an appropriate and person-centred plan of care the clinical knowledge of nurses was also of fundamental importance.

Through structured observations it was noted that, in relation to infection control and prevention, there was a lot of education that needed to be provided to different grades of the care team. This presented a unique challenge, given the probable differences in pre-existing knowledge between the groups. In other words, link nursing had to extend to senior care assistants and domestic supervisors within care homes. The rationale behind this expansion was very simple: if the expectation is to have a higher standard of IPC practices within care homes then those care staff who have the potential to have the greatest influence in practice must be included. In order to provide continuity of care, it was determined that each care home would nominate a nurse, who would be responsible for infection prevention and control, to be their link nurse. In addition, care homes were advised to nominate senior care assistants or domestic supervisors who could demonstrate practical leadership on the ground.

Following the scoping of the plan to take forward a link programme, the following criteria was decided:

1. Every home with a nursing unit must send a nurse (but could also send a senior health care assistant and/or domestic supervisor)
2. The nominated member(s) of the care home must have an interest in infection prevention of control
3. Structured educational sessions to be provided three times per year and link to the infection control and prevention lead within Four Seasons Health Care

The content of the education package was based on audits relating to infection control, audits on documentation, observations in practice and content that care teams wanted to receive.

Education included:

- What is the role of a link nurse?
- Basic practises for infection control and prevention
- Importance of environmental cleanliness in care homes
- Holistic care of the person living with MRSA in care homes
- Holistic care of Clostridium Difficile in care homes
- Seasonal Influenza
- Identification and management of gastroenteritis outbreaks

Due to the large number of care homes that FSHC operate in Northern Ireland, each structured education package was delivered in 9 different locations so as to limit travel costs. Empirical findings, from DATIX Systems that are in place throughout FSHC care homes, from the 2013-2014 pilots were positive with a 61% reduction in outbreaks of infections such as gastroenteritis. The feedback was extremely positive so the programme was replicated for 2014-2015, with a review of the data ongoing. This very much highlighted what can come from positive and effective implementation of the link role with the significant improvement in basic and fundamental practices.

Transitioning organisational cultures across care homes

A common challenge for care homes, as identified by Spilsbury et al. (2015), is over coming task-orientated approaches to care. This can be difficult because, as noted earlier (Cousins et al. 2016), there is potential for care homes to feel isolated from one another and not as part of a community. According to NICE (2015), cultures within care homes are correlated to the level of quality care that is afforded to residents.

In 2015 we championed a toolkit to enable all grades of care staff to optimise the use of their language within dementia care. The development of this toolkit was in response to the DEEP (2014) (The Dementia Engagement and Empowerment Project) guidelines on language about dementia were published. These guidelines were written by 20 people living with dementia who came together for a day in Liverpool. The following words are often used to describe people living with dementia despite their potential to perpetuate stigma associated with the dementia diseases.

The words and descriptions identified by DEEP (2014) should never be used when describing dementia or people with dementia. Throughout clinical dementia audits it was noted that language such as 'senile', 'burden', 'victim', 'wanderer' and 'aggressive' were equally disempowering. Importantly, it was recognised that most people in care who use these words do not intend to do harm. In response, a small team developed a tool-kit which would help care homes, and visitors to care homes, to use more appropriate language in their practice.

A section from the toolkit for language in dementia care (SEE TABLE)

Influencing pre-registration nurse education about care home nursing

As illustrated by Spilsbury et al. (2015), undergraduate nursing education does not always promote the importance of care home nursing within their educational training. It has been suggested that one of the main reasons for this is because care homes are still not recognised as a setting which can offer registered nurses an opportunity to specialise in. As noted in Cousins et al. (2016), the role of the care home nurse is multi-faceted and larger care home providers have a responsibility to ensure that undergraduate nurses are aware of this and, most importantly, that care home nursing offers a viable long-term and rewarding career option.

Recognising the potential deficits in undergraduate education, as it pertains to care home nursing, members of the Four Seasons Resident Experience Team, have been engaging in teaching activities within Universities in Northern Ireland (Mitchell et al. 2016). In 2015 and 2016 members of the Resident Experience Team delivered a series of seminars to undergraduate student nurses about dementia care within care homes. The evaluations from students were very positive and further details of this can be found in the published study by Mitchell et al. (2016).

The continued challenge of recruiting and retaining care home nurses

While Four Seasons Health Care has enjoyed many successes, as illustrated by these 4 case studies in Northern Ireland, there is one challenge that has yet to be overcome. Unfortunately, as asserted by Cousins et al. (2016), recruitment and retention of care home nurses

remain the greatest challenge and threat to operating care homes which deliver quality care to residents. Unfortunately there is still a high annual turnover of registered nursing staff in care homes. In the UK, it is estimated that over half of care home nurses have less than three years nursing experience (Skills for Care, 2013).

Without safe staffing in care homes, that is, the right number of registered nurses and care assistants who are appropriately skill mixed, the sustainment of any good care initiative will never be realised.

Conclusion

This organisational case study has provided an overview of some of the activities which care home nurses have led, in the face of the well documented problems which the sector faces, in the UK. These initiatives have individually, and collectively, enhanced the experience of residents in our care. While there is much to be celebrated and shared, the greatest challenge and threat to further innovative projects and sustained delivery of quality care relates to recruitment and retention of care home nurses. As a specialist part of the health care system, care homes need to be valued and supported in the same way as hospitals, hospices and community settings. With the right collaborative support the care home sector can continue to advance its practice and enhance the experiences of residents who live in care homes.

The Old Culture	The New Culture
"Suffering with dementia"	"Living well with dementia" or "living with dementia"
"Elderly Mentally Infirm"	"Dementia Care"
"Wandering"	"Walking"
"Challenging behaviour"	"Distressed reaction" or "Distress" or "communication"
"Allowed to	"Has the right to"
"Feeding" or "toileting"	"Supporting with nutritional/elimination needs"
"Unit"	"home"

NEUROLEPTIC MALIGNANT SYNDROME

Colin Sheeran
Dementia Lead Project Facilitator, Four Seasons Health Care

We are all aware of the dangers of prolonged use of antipsychotic, also known as neuroleptic, medicines in elderly care. As antipsychotics have been reduced, in my opinion, there has been an increase in prescribing other classes of neuroleptic medicines in their place. Unfortunately many anxiolytics (such as Diazepam) and antidepressants (such as Mirtazapine) are being used, not for their primary therapeutic use, but for secondary benefits of controlling behaviour and sedating residents. These antidepressants, particularly Trazodone and Mirtazipine may adversely affect memory, while anxiolytics may increase confusion, reduce inhibitions and can also affect memory. In prolonged use they can also be addictive.

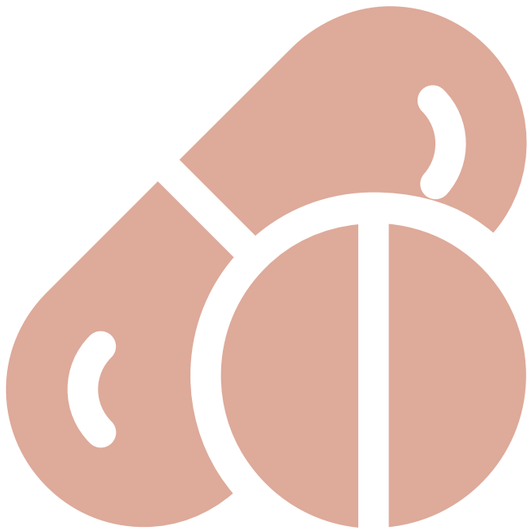
The unwanted effects of antipsychotic, or neuroleptic, medications are also well documented. These include drowsiness increase in falls, postural hypotension, Parkinson like symptoms and increased risk of cardiovascular events. However, what is less well documented is the risk of Neuroleptic Malignant Syndrome.

Neuroleptic Malignant Syndrome (NMS) is a rare, but life-threatening, reaction to neuroleptic medication that is characterised by fever, muscular rigidity, altered mental status, and autonomic dysfunction. NMS often occurs shortly after the initiation of neuroleptic treatment, or after dose increases. It can cause delirium, autonomic instability and raised creatinine phosphate levels and kidney failure.

The incidence of NMS has decreased over the years as prescribing has changed. The last incident I can remember was in 2013 but therein may be the danger. I have noticed that NMS is not widely understood amongst my colleagues less experienced in Mental Health. In a younger person the changes described above would raise immediate concerns and I am confident we would act promptly. In an older person living with dementia they could be mistaken as symptoms of dementia or complications of old age. If they are not recognised early they can lead to death.

With early recognition treatment is simple. Supportive care, withdrawal or reduction in the antipsychotic medicine and fluids to restore creatinine phosphate balance will be effective. If it is not recognised symptomatic treatments for fever, muscle rigidity and autonomic changes will increase risk of lasting harm or death.

My advice to all nurses and senior care assistants is to be aware, don't ignore symptoms whether sudden or gradual onset and don't be afraid to raise the possibility of NMS with prescribers.



USING URINALYSIS TO DIAGNOSE URINARY TRACT INFECTION IN CARE HOMES

Louise Morris
Care Home Assistant Practitioner Project Lead, Four Seasons Health Care

According to NICE, a urinary tract infection (UTI) is defined by a combination of clinical symptoms and the presence of bacteria in the urine. Asymptomatic bacteriuria is the occurrence of bacteria in the urine without causing symptoms. Urinalysis can detect bacteria in the urine, therefore, should clinicians use urinalysis as a screening tool to exclude urinary tract infection?

This article reviews the literature around the effective use of urinalysis dipstick testing to diagnosis urinary tract infection and highlights when urinalysis should be used as well as best practice for obtaining an accurate result.

UTI incidence increases with age (PHE, 2017) and urinalysis is commonly used to detect UTI for elderly in long-term care. Deville et al. (2004) demonstrated that the urine dipstick test appears to be useful to exclude the presence of infection if the results of both nitrites and leukocytes were negative. They found that the sensitivities of the combination of testing for both nitrites and leukocytes can vary between 68% and 88% in different patient groups. They conclude that although the combination of positive test results can be very sensitive, the usefulness of the dipstick test alone to rule in infection is unreliable. A later study by Bhavsar et al. (2015) found that without clinical information, screening of UTI by the presence of leukocytes and/or nitrites gave poor results. Frazee, Enriquez, Ng and Alter (2014) agreed that abnormal urinalysis results are common in women without infection and Nazarko (2009) claims that half of all women with urinary tract symptoms have urethritis rather than a UTI.

This highlights that inappropriate diagnosis of UTI potentially exposes patients to hazards of antibiotics and contributes to antibiotics resistance. Therefore, routine testing of samples should be discouraged and urinalysis results must be looked at in context with patient symptoms and history.

Benton et al. (2008) specifically discusses asymptomatic bacteriuria within residents in long-term care and evidenced that with increasing level of care, there was a successive increase in asymptomatic bacteriuria prevalence and that treating it can potentially cause more harm than good in long-term care residents. This supports not routinely dip-testing urine and that abnormal urinalysis results without symptoms of UTI is very common. Benton et al. (2008) go on to recommend that if a resident appears ill but there are no symptoms clearly arising from the urinary tract, other sources should be sought for the change in clinical status.

The reliability of the urinalysis dipstick result is commonly thought to be dependent on the method of sample collection. A mid-stream sample of urine was considered to be the gold standard method of collecting a sample. This is where the first part of the urine passed is discarded, however it is not always possible for older adults to provide a mid-stream urine sample due to incontinence, dexterity or capacity to understand the instructions given.

Although prior cleansing of the external genitalia often is recommended, it has no proven benefit (Lifshitz and Kramer 2000, Simerville et al. 2005) and cleansing with antiseptic has been shown to lead to false negatives (PHE, 2017). Frazee et al. (2014) demonstrated that reliable results are not dependent on sample methods and Wilson (2005) also argues that there is no need to cleanse visibly clean genitalia and that catheter specimens are adequate methods for collection. Catheter specimens should always be taken from the sampling port (PHE, 2017).

Urine collection pads are another method that is used when it is impractical to pass urine into a container, however this should be a last resort as artificially elevated leukocyte counts may occur when pad collection is used (PHE, 2017). When using this method, effort should be made to test as soon as possible after the pad is wet with urine (but no faecal soiling). A tip of a sterile syringe should be inserted into the pad to draw urine into the syringe and the urine transferred directly into a sterile sample bottle. If difficulty is experienced in withdrawing urine, the wet fibres may be inserted into the syringe barrel and the urine squeezed directly into the container with the sterile syringe plunger, taking care not to contaminate the specimen.

Delays to testing urine and storage at room temperature allow organisms to multiply, which can give false positive nitrite results (PHE, 2017). If urine is stored in the fridge, it should be allowed to return to room temperature before testing (Wilson, 2005).

It is considered to be best practice is to use computerised urine analysers allow the user to view the result on a small screen and then print a copy for the records. This is more convenient and produces greater accuracy in results (Wilson, 2005). In the care home environment, computerised analysers are not readily available due to budgetary constraints. Manual visual analysis is used widely, meaning there is greater need for thorough training and competencies to ensure users follow the process correctly to avoid user error.

Best Practice guidelines for manual visual urinalysis:

1. Check specimen has been labelled correctly if not testing immediately after collection
2. Test specimen as soon as practicable after collection and no later than 2 hours
3. Allow urine stored in the fridge to return to room temperature
4. Wash hands and apply gloves and apron
5. Note colour, clarity and odour of urine
6. Check expiry date on urinalysis dipsticks container
7. Check urinalysis dipsticks have been stored correctly (in line with manufacturers' instructions) with lid securely fastened
8. Remove one dipstick, taking care to only touch the plastic handle and not the reagent strip, replace the lid on the container immediately
9. Fully immerse the dipstick so that all reagent test pads are covered and remove after approximately 2 seconds
10. Tap the side of the container or on absorbent paper to remove the excess urine
11. Hold dipstick horizontally to prevent contamination of adjacent reagent test pads
12. Use a timer to measure exact time according to manufacturers' instructions, noting that timing can vary between 20 seconds and 2 minutes between individual reagent test pads, depending on the brand
13. Record the results, informing patient/resident, Registered Nurse and GP as appropriate

Delegation

Registered Nurses can delegate this task to unregistered staff (e.g. Care Home Assistant Practitioners (CHAPs)) that have current evidence of training and competence. The nurse can delegate collecting the sample, preforming the urinalysis dipstick test, recording the result in the notes. The nurse would need to interpret the result and write any clinical instructions within the care plan.

Interpreting the result

Results should always be looked at in conjunction with symptoms and clinical presentation. According to PHE (2017), the presence of blood, leukocytes and nitrites indicate probable UTI. Negative nitrite and positive leucocytes does not rule in or out UTI and other causes of symptoms are equally likely. The presence of blood and protein, without nitrites or leukocytes would not indicate UTI, but would need investigating further for other diagnosis.

Recording Urinalysis Results

Firstly record symptoms and reason for the test. This makes it clear why urinalysis dipstick testing was carried out. Colour, clarity and odour should also be recorded along with the result of the urinalysis dipstick (Yates, 2016 and Bulloch et al. 2000). Negative results should also be recorded as this shows that UTI has been ruled out as a cause of symptom. Also record who was informed of the result and the resulting plan of care.

Next steps

The decision of whether to send a specimen for culture and sensitivity testing varies considerably among practitioners. The only conclusive diagnostic test for UTI is a full culture and sensitivity test performed by the laboratory, which is time consuming and a drain on NHS resources (McNulty et al. 2008). It is recommended that prescribing on the results of urinalysis and clinical symptoms should be considered as best practice, however GPs have local guidelines to follow and their advice must be sought.

Key Points

1. Urinalysis dipstick testing should only be carried out when indicated by symptoms and not routinely
2. False results can occur if guidelines are not strictly adhered to
3. Sample collection methods do not affect the reliability of the test
4. Specimens do not need to be sent for laboratory testing to confirm diagnosis of UTI
5. A positive result for nitrites and leukocytes without the presence of symptoms often does not need treatment

COPING WITH CARING:
MANAGING DISTRESSED REACTIONS

John Coyle
Resident Experience Support Manager Four Seasons Health Care

Introduction

Following on from Issue Two's excellent article 'Language in Dementia Care' by Kate Swaffer, which highlighted the importance of effective communication in managing the challenges of dementia care, I wanted to focus on the challenges which care givers may face daily within our homes. Often staff may feel that managing care for residents with a distressed reaction is difficult and they have to "get on with it" challenging as it may be, however staff should know that there is always help and assistance available with the resources of Four Seasons Health Care.

Life History

A key element to understanding the person in our care is getting to know about our residents through their life story/ history. This should contain important information about their family background, preferred routines, previous occupations, hobbies and personal preferences. All of this is vital when considering good communication as it helps us to understand the person's needs and assist with consistent care.

This process commences with the initial referral process to the care home and your Home Manager will obtain as much information as possible regarding a person's background and preferences from the pre-admission assessment. For people who may lack capacity or are unable to articulate this information, it can often be obtained from family members and next of kin.

So what help is available to our staff to provide the best care possible when they are challenged with managing distressed reactions whilst providing care?

Distress Reaction

Remember distress can occur at any time, but if often more common during personal care interventions. Care staff should always employ person-centred approaches and communicate clearly and slowly with their resident before an intervention takes place. Often simple things can resolve or nullify distress, for example someone of the same gender providing intimate care or ensuring someone with sight difficulties is wearing their glasses.

For residents who exhibit a behavioural change outside of their normal character, we should consider a possible infection or other forms of acute illness which may be causing the behavioural change. Clinical observations including urinalysis should be routine in this case. For residents with limited communication or a cognitive impairment the cause may be difficult to define. Other causes may be physical ill health, pain, illness and residents may experience physical discomfort, constipation, thirst or inactivity (sitting too long).

General Practitioner Review

When considering recurrent or new episodes of distress, one should always think about when has the resident last seen their GP? Has there been an annual review? Residents might only get referred to their GP when they suffer an infection or acute illness. Medication review is important due to poly pharmacy and the resident may have been commenced recently on new medications due to a hospital admission and discharge. The combination of a lot of medications may have unwanted side effects. It is important to remember that the prescription of behaviour modifying medication for distressed reactions is always a last resort. One thing that is easy to miss in dementia care is pain. Pain management should be reviewed as the resident may be expressing pain as distress.

Distress Reaction Monitoring

When considering distress, we need to ensure that we have monitored and recorded any incidents or reactions that have been difficult to manage or when the client has been distressed. This helps us understand what is actually happening, identify triggers, try new approaches and look for patterns. Important things to record include: the date, the time, the location, the staff or people involved, what has happened before the incident or behaviour, what are the facts of the incident and the outcome or the effect and what happened after the incident. Monitoring of incidents coupled with input from family or next of kin will help us understand any patterns of behaviour however we must ensure that behaviour monitoring charts are reviewed after an agreed period of time and are not left to build up in a neat pocket in the care file.

Internal and External Support

An external support service that many are not aware of, is the Behavioural Sciences Specialist referral accessed via the GP. Internally, Four Seasons Health Care also have experienced mental health nurses within the Resident Experience Team that can review individual cases and assist with staff training and the formulation of positive behavioural support plans. Distressed reactions face-to-face training can also be requested internally.

Care Planning

If a person is experiencing distress, a positive behavioural support plan (or care plan) should be devised with as much information as possible from staff, family (and care manager involvement). The plan has to be a multi-disciplinary approach and should include details about a person's daily routine and life pattern. The next of kin should agree the care plan and be involved in progress reports and reviews. The person with dementia does not lose their ability to experience a normal range of emotions such as anger, frustration, depression or happiness and enjoyment. A lot of negative emotions that people with dementia experience are often believed to be because of the disease. Don't let the dementia label deter you from acting – distress is not normal,

Communication

Positive behavioural support plans and teamwork are important in dementia care. To promote positive support and consistent care, colleagues have to be well informed and communicate effectively with each other as well as having a positive approach for the clients. All the good communication points highlighted by Kate Swaffer in the last issue of CNJ are very important and staff should never assume that residents don't understand labelling language because of cognitive impairment. Meaningful activities are also extremely important and a weekly programme of events, no matter how small, involving a hobby or past interest can have a major positive effect on mood and behaviour.

Summary

1. Have a medical assessment GP review and medication review
2. Reassess for Pain using the Abbey Pain Scale or validated instrument to measure pain
3. Complete the Cornell scale for Depression. Review the results of these for positive changes to care and contact GP if required
4. Have a team meeting to communicate a consistent positive approach by all staff and investigate alternative approaches with the life story knowledge and family input
5. Compile a Positive Behavioural Support Plan/ Care plan and communicate to all staff
6. Monitor distress reactions and involve the Behavioural Sciences Team, or other specialist multi-disciplinary teams, for review
7. Review activities and have family involved in meaningful activities
8. Review outcomes of assessments and progress regularly
9. Don't take behaviours personally. Staff should maintain rational detachment and not feel offended
10. Try not to be the trigger or precipitating factor. Know as much as we can about the person we are caring for

CANCER AND AGEING:

AN UPDATE ON CURRENT CONSIDERATIONS IN CARE FOR OLDER PEOPLE

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In the American and British health care systems alike, cancer care and care for older people lack any real connections. Older people typically rely on different processes and health care professionals to receive treatment for cancer than they would for their primary care from a general practitioner even if the cancer is a chronic condition. The divide is so great, at times, that older people may not receive standard of care for diagnosed or even suspected cancers.

Ageism remains a prevalent concern in cancer for care for older people (Lawler, Selby, Aapro, & Duffy, 2014). Most health care professionals acknowledge advancing age as a risk for developing malignancies. Nevertheless, the competencies of health care professionals and the systems and organizations providing health care do not reflect this widely recognized reality. The challenge today facing nurses and any healthcare professional – from nursing assistants to therapists – who work with older people is to reflect on the connection between ageing and cancer and then reflect on their own competencies and the profile of the settings in which they work. The question that naturally arises is about our own preparation to provide care to older people who are more likely than those who are younger to have risk or diagnosis of cancer, possible questions regarding treatment, and perhaps concerns about their overall health and well-being.

Cancer often evokes fears of suffering and death, making people anxious and aversive to talking or perhaps even thinking about the topic. In America, nurses still hear some people whispering about 'the Big C', not wishing to say the word cancer. Paradoxically, the reality of cancer today is far different from what most people believe it to be. True, cancer is still a leading cause of death in most high-income societies like the United Kingdom and the United States (R. L. Siegel, Miller, & Jemal, 2016). However, many cancer deaths trace back to health habits long known to heighten risk of cancer. Tobacco use and coincident alcohol consumption are prime examples.

Current cancer science and specific statistics paint a vividly different picture of this large group of diseases, all called cancer and general distinguished by epigenetic characteristics. Epigenetics, as a science, hold important answers to understanding just how ageing and cancer are connected (Barros & Offenbacher, 2009). Epigenetics is the science that reveals how an individual's genome changes over time through episodic and continuous exposures to a variety of forces in the environment around the person. Experiences of starvation and trauma are situations in which important epigenetic research established that alterations in a person's genome may become permanent and heritable. Changes pass through generations to children and grandchildren. In relation to cancer, epigenetics explains some fundamental relationships. It explains why older people are more likely to be diagnosed with cancer. In the US, median age for diagnosis of cancer is 66 years, regardless of the type of cancer diagnosed (R. Siegel et al., 2012). While the range of median ages for specific cancer sites varies widely, most veer toward older age. Epigenetics shows that, the longer an individual lives, the more exposures to possibly carcinogenetic forces sustained and the greater the chance for modifications in the genome. The science of epigenetics also explains why some people get cancer while others do not, despite having the same behaviours such as tobacco smoking. Some smokers go on to have bladder cancer and not the lung cancer so many expect. Bladder cancer is a malignancy strongly associated with tobacco use. However, because of myths and misunderstandings, few identify it as a risk for smokers as they age. Other people who use tobacco incur cardiovascular disease as they age, without diagnosis of any clinical malignancies.

Epigenetics holds important promise for cancer treatment (Bojang & Ramos, 2014). Increasingly, cancer treatment targets expression of specific genetic markers, lending idea of those biomarkers to the newer treatment option called 'targeted therapies'. In general, targeted therapies aim to destroy cancers by attacking their genetic signatures. The exciting new medication pembrolizumab is a good example of targeted therapy (Kwok, Yau, Chiu, Tse, & Kwong, 2016). Broadly, cancer

treatment options are evolving rapidly. Along with targeted therapies, advances in surgery – primarily in anaesthetic techniques and minimally invasive technologies, in radiotherapy, and in chemo- and bio-therapies, are making treatment more effective and less toxic. As a result, we now speak about chances for cancer cure as well as long-term survivorship. The majority of cancer survivors in the US are over the age of 65 years and many were diagnosed with cancer more than 10 years ago (R. Siegel et al., 2012).

Cancer sits in contrast to other serious conditions common to later life like heart failure and dementia. Cure is possible in cancer but not in heart failure or dementia. Curing or controlling cancer over the long-term among older people requires effective, well-tolerated cancer treatment options. Better understanding of ageing and cancer is shaping cancer treatment and the experience of life with and after cancer for many older people. With increasingly good chances of cure, long-term survivorship, and well-controlled chronic cancer come some challenges for older people, their families, and their nurses. Among the leading concerns for older people living with and after cancer are worries or clinical anxiety related to risk of recurrence and second cancers during survival after an initial diagnosis and self-care in light of side effects of treatment or cancer sequelae (Kagan, 2016). Worries about cancer result in different behaviours among older people. Some may seek out health care more frequently than needed in efforts to quell anxiety while others may distance themselves from fears by avoiding health care encounters and limiting the extent to which they disclose their concerns.

Cancer treatment often employs multiple treatment modalities and a huge range of pharmacotherapeutics. As with most drug therapies, side effect profiles vary and include short and long-term effects of which some are not wholly amenable to management. As a result, older people may live for years with symptoms like chronic pain, parenthesis including peripheral neuropathy, and function changes like altered taste and salivary production, all resulting from their cancer treatment and not the cancer per se. These lasting alterations in function may additionally combine with the effects of other age-associated changes or chronic conditions. Think about menopausal symptoms like hot flushes and vasomotor instability or Type 2 diabetes, for example. Respectively, these symptoms are very like the side effects of breast cancer treatments that interrupt oestrogen and progesterone pathways and the side effects of targeted therapies used to treat colorectal and head and neck cancers among others.

Science and treatment are transforming the experience of cancer in later life. Further advances are on the horizon, promising further change and new opportunities and challenges for older people and for nurses and others who care for them. Cancer Nursing journals increasingly publish research reports as well as review articles related to cancer among older people and their care needs. Among the most widely available in the United Kingdom are the European Journal of Oncology Nursing (http://www.ejoncologynursing.com) and Cancer Nursing (http://journals.lww.com/cancernursingonline/Pages/currenttoc.aspx). Seminars in Oncology Nursing (http://www.seminarsoncologynursing.com/), as a topic-focused review journal, routinely includes papers exploring evidence-based nursing care for older people across the trajectory from screening and detection to active treatment and palliative care.

Resources for nurses and others caring for older people to learn about cancer, cancer treatment, and cancer survivorship are available online as well as through professional meetings and conferences. Among well-established online resources are the International Society of Geriatric Oncology (http://siog.org) and the Cancer and Aging Research Group (http://www.mycarg.org/home).

Take a few moments to reflect on your preparation to care for older people living with and after cancer. Then devise a plan to use available resources and advance your knowledge and skills. You will be glad you took the time! While your practice may not now entail care for older people undergoing active cancer treatment, you may see these individuals much more often in the future; increasing your familiarity with their needs to help you to provide much more effective and compassionate care now and in the future.

GUEST BLOG

Louise Morris,
CHAP Project Lead, Four Seasons Health Care

Louise Morris is the national Care Home Assistant Practitioner Project Lead for Four Seasons Health Care. In her blog, she reflects on her nursing journey and the changing landscape of nursing in care homes.

I was invited to attend a service to commemorate the life of Florence Nightingale at Westminster Abbey on 17th May 2017. I felt extremely honoured and proud to be part of that special service and to be part of a group that represented Four Seasons Health Care nurses.

Part of the service involved a procession called the Lamp Party. A lamp that is kept in the Florence Nightingale Chapel at Westminster Abbey was carried by a scholar and followed by a procession of student nurses and midwives from Edinburgh Napier University. When the procession reached the High Altar, the lamp was passed to another two scholars, representing the transmission of knowledge from one nurse to another and highlights the diversity of care given by nurses for the benefit of humanity.

For me, the Lamp Party was a particular special moment during the service and I felt that this represented nursing as a whole and also my personal journey. I took the opportunity to reflect on my career and analyse my thoughts further.

Florence Nightingale became known as "The Lady with Lamp" during her work in the Crimean war, she conducted her night rounds caring for wounded soldiers while holding a lantern. The Lamp has since become a symbol of nursing internationally.

I believe all nurses can identify with The Lamp. Not just the working of nightshifts and supporting the wounded or sick, but in the dark places that nurses find within themselves and their careers. Nursing is not an easy profession – in Florence Nightingale's time there were different challenges to present day nursing, however I would argue that issues of today can be just as challenging in different ways. Often we have to struggle with the ideals of compassion and quality of care, yet manage shortages of funds, shortage of nurses and other challenges of modern nursing.

After 11 years of nursing and while working as a Sister within a large GP practice, I became frustrated and felt I needed a career change. I had completed a degree in Practice

Development and I wanted to use my skills but didn't want to be in the environment where policy didn't meet reality. For example, when your knowledge and experience told you that you needed a particular piece of equipment or treatment to support a patient, but your budget couldn't support it. I was disillusioned and felt I couldn't make the difference that I hoped I could when I started my career. Although we had regular meetings and the issues were aired, things didn't always change. I felt I had no voice.

I left nursing at this point in 2013 and went into teaching Health and Social Care. Looking back this seems an unusual choice given that I felt so uninspired, yet I was in a formative position in students' lives where I had the opportunity to inspire, coach and mould them into our nurses, midwives, carers and social workers of the future. In hindsight, it was just what I needed to re-ignite that Lamp of Light in me and I was able to find my voice and passion for nursing again. By teaching others the foundation values of care, I was able to find my own. I developed a skill for teaching academic subjects in a vocational way to an audience that did not always consider themselves to be academic.

During this time, I was asked to be involved in a project that brought me into teaching within Social Care. My teaching work took me into care homes and learned so much from the carers and nurses that I met. They had so much compassion for their residents and were making a difference to their lives on a daily basis. The residents depended on them to brighten their day as well as meeting their care needs with skill. The passing of knowledge from one to another was very apparent in this environment, they learned from me and equally, I learned from them. My perception of social care changed during this time.

When an opportunity came up to work at Four Seasons Health Care, I took it. I soon was working within a role that allowed me to coach, nurture and mould our future Care Home Assistant Practitioners (CHAPs). I am now able to influence policy changes and lead on wider projects and really make a difference.

I believe that the CHAP Project is part of the solution to the national shortage of nurses that we have. CHAPs are making a difference to our services by supporting and assisting our residents, using their skills, compassion and experience to benefit both the nurses and the residents. CHAPs are not a replacement of nurses but an enhancement to what we already have. Nursing as an all graduate profession is a concept of modern nursing – and one I fully agree with, however I don't believe that those without degrees cannot nurse. Within the short history of the profession, we have had Registered Nurses that have not been degree qualified (Enrolled Nurses or Diploma trained nurses) that have equally cared for patients and residents to an excellent standard. The change to an all graduate profession has meant that we have missed an opportunity to train those with good values but without the academic entry level qualification to be nurses. When we are faced with a national shortage of registered nurses, this has presented an opportunity to bring in another tier to the nursing structure and this is where, in Four Seasons Health Care, the CHAP role sits.

Registered Nurses are leaders of the profession, their specialist skills cannot and should not be replaced, however he more minor and less complex duties that a nurse working in the care home sector traditionally carried out can safely be delegated to competent CHAPs.

Nursing is evolving – by training CHAPs well to assist nurses, we are adapting to pressures, challenges and shortages in a proactive and innovative way that enhances resident experience. The passing of knowledge from one nurse to another, as was symbolised in the Lamp Party, is not just the clinical knowledge, but how to cope with the complexities of modern nursing and adapt to meet the needs of residents and patients in safe and dynamic ways.

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Useful Links: Coping with caring: Managing distressed reactions

Meeting needs and reducing distress Guidance on the prevention and management of clinically related challenging behaviours NHS

http://www.reducingdistress.co.uk/reducingdistress/guidance/understanding-challenging-behaviour/

Advice on the Management of When Required Medicines to Service Users Displayed In Distressed Reactions RQIA 2015

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Care Awards

Celebrating those who are Making A Difference

Back due to popular demand!

After the success of the 2016 Four Seasons Care Awards we are back again and this time it will be bigger and better.

Who would you like to see as your 2017 Four Seasons Champions?

Our care awards are your opportunity to recognise those in our homes who are passionate and committed to providing special experiences for our residents every day.

Nominating is easy! Simply complete the form on the home's iPad or go to www.fshc.co.uk

NURSES' FORUM

nurses forum

Don't forget to take a look at the resources and comments regarding best practice that colleagues across the organisation are sharing.

The Nurses Forum belongs to you and will grow and thrive with your energy and input. The intention is to keep you Informed, Educated and Entertained!

You don't have to do anything because as a member of the Four Seasons nursing community you are automatically enrolled. Just log in to SOAR and select the nurses' forum button.

It couldn't be easier!

Your Forum is designed to:

- Keep you up to date with nursing news at FSHC
- Find your online Care Home Nursing Journal
- Let you join in or post discussions on nursing-related issues
- Help you with your CPD portfolio
- Support your revalidation process
- Let you chat with colleagues in real time in our Nurses' Chatroom
- Keep you updated on what's happening in your area
- Allow you to join Q&A sessions with nursing specialists
- Provide links to great external sites such as Nursing Times