Encouraging effective communication between social care services and primary care partners during Out of Hours

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Background

A Review of Primary Care Out of Hours (OOH) Services was commissioned in 2015 in recognition of the challenges being faced in delivering services during the out of hours period. The "Ritchie Report"[1] made numerous recommendations in order for the future service to be "safe, sustainable" and "to enable better joint working".

Regarding the review the then Cabinet Secretary for Health and Sport, Shona Robison MSP, said[2]:-

- "… the time is right to review these services to ensure they continue to deliver sustainable, high quality, safe and effective care"
- "The review will look at core requirements for services at night and the weekends as well as what roles and skills are needed, and where".

In order to progress a number of the recommendations of the Ritchie Report, the Steering Group of the Urgent Care Portfolio and subsequently the Healthcare Improvement Scotland Programme Board, established three working groups to work with complementary terms of reference:-

a. Patient Journey Working Group
b. Care Service Use of GP OOH Collaborative
c. Quality Assurance Network.

The development of a communication tool to support the transfer of information from care settings to NHS 24 during OOH when unplanned events occur was guided by the above governance structure.

The Public Holiday Review[3] was established to:-

- "examine the way by which health and social care services across Scotland are currently provided over public holiday periods
- make recommendations / identify actions for establishing greater resilience of health and social care services over these periods
- take into account the needs and expectations of those who receive and those who deliver services".

The need for the communication tool to support interaction between social care services and NHS 24 was reiterated in the recommendations of this report which identified that "communication between these partners is critical". The report also echoed the need for communication to be "intelligence led - making the most of what we know about our people and their needs".

Methodology

This quality improvement project has been undertaken as part of the wider review of unscheduled care to make improvements as identified in the Richie Report. For the purposes of this study, OOH refers to the 118 hours per week during which access to most GP surgeries are not available (i.e. Monday to Friday 6:00 p.m. to 8:00 a.m. and the 24 hours of Saturday and Sunday).

A feasibility study was undertaken by the Care Inspectorate and Healthcare Improvement Scotland in partnership with care providers and Scottish Care. In August 2017 an ‘Always Event’ took place facilitated by NHS Education Scotland. The outcome was that a quality improvement project was developed in order to contribute to:-

- “improve care services’ confidence in their decision making when the wellbeing of a person in receipt of their care is deemed to require external clinical advice or assistance and
- increase awareness of the importance of the role of the care worker in the continuity of care, health and wellbeing of people in receipt of care at home services”.

By making improvements to the two aspects above this will contribute to a more person centred approach enabling the person experiencing care to receive the right care, at the right time, in the right place.

The quality improvement project has utilised a collaborative and consultative approach, engaging with a number of key stakeholders. Participants at the Always Event identified an opportunity to build on emerging good practice as, during 2017, for example, Erskine care home in Glasgow in partnership with NHS 24 had tested and developed a standard approach for their nursing staff when collating and passing on information to the NHS 24 111 advisor in order to ensure that a better more timely decision making process occurred.

The model uses an ‘SBAR’ approach. Situation-Background-Assessment-Recommendation (SBAR) communication tool is, according to the Institute for Healthcare Improvement[4], “an easy-to-remember, concrete mechanism useful for framing any conversation, especially critical ones, requiring a clinician’s immediate attention and action. It allows for an easy and focused way to set expectations for what will be communicated and how between members of the team, which is essential for developing teamwork and fostering a culture of patient safety”. This tool is used in a variety of health care settings to frame hand over situations, but has not been used widely in the social care sector.

Erskine care home undertook a test of change in one of their care homes in Glasgow to refine the pro-forma for their nursing staff to use to review unexpected situations in the OOH period and subsequently frame conversations with NHS 24 colleagues when appropriate.

In order to test this process within the wider social care environment and explore the impact of using it with other care providers, three care at home and three care homes participated in an initial test of change using the SBAR form developed by Erskine care home as a starting point. These care providers were:-

- Tor-na-Dee care home, Aberdeen
- Marionville Court care home, Edinburgh
- Kingsmill care home Brighterkind, Inverness
- Bluebird Care, Edinburgh
- Sue Ryder, Arbroath
- Highland Home Carers, Inverness.

These care providers were subsequently joined by:-

- Peacock care home, Livingston
- Dorward House care home, Montrose
- Linlithgow care home, Linlithgow
- Dalvenie Gardens care home, Banchory
- Paramount Care, Aberdeen and Aberdeenshire
- Overnight care at home service, Inverness.

A profile of each care provider is attached at Appendix 1.

In order to make the pro-forma developed by Erskine care home and NHS 24 suitable for the wider care sector it was refined to suit the service provided by each care provider but continued to reflect the SBAR methodology. Each care provider agreed to use the pro-forma over a 4 week period as a communication tool for any unplanned OOH events to determine if a call to an out of hours NHS 24 111 advisor or responder service was necessary and frame any subsequent discussions with a medical practitioner. Using a divergent – convergent approach enabled a number of variations of the pro-forma to be tested and the experiences to be collated, then considered in order for the communication tool to reflect the needs of the care providers.

The initial tests of change took place during the period January to March 2018. They did not occur simultaneously in all care providers due to the short introductory phase, operational timing in the participating social care services / providers and the limited time scale initially allocated for the quality improvement project.

Managers at each social care service / provider briefed staff on the use of the pro-forma and collated completed forms. Members of staff were asked to complete a questionnaire after each event to reflect on their experience. In the care homes a qualified nurse, if present, would review the situation and make a call to an OOH advisor to gain further support if needed. If a nurse was not present this would be undertaken by a team leader or senior carer. For the care at home and supported housing services, carers or senior carers would make a call on behalf of the person experiencing care if necessary.

The initial participating care services / providers collated details of calls made to an OOH service in the period prior to the trial in order that base line data was available. Members of staff who made these calls were asked to complete a questionnaire to capture information relating to their previous experience.

Colleagues leading on other areas of improvement or supporting the spread of good practice in related aspects of health and social care were also engaged with in order to provide a wider perspective to the quality improvement project. In this context the following initiatives are relevant to this area of improvement:-

- Key Information Summary (KIS)[5], which is an extension of the Emergency Care Summary (ECS), are prepared by GPs and are available for 4.4% of the Scottish population. GPs are able to share this with care home providers when an individual commences in their care. The GP's electronic system enables this information to be shared, up to twice a day, with OOH services, Scottish

Ambulance Service and NHS 24 to ensure accurate and up to date information is available
- An Anticipatory Care Plan (ACP) is a person-centred, proactive document which reflects an individual's situation and conditions, which contains choices about their care and place of care. It is estimated that 5-6% of the population could benefit from ACP. The ACP can be used in conjunction with the KIS to ensure that informed decisions relating to the limitations of care are taken into consideration
- NHS Education Scotland (NES) provide learning sessions for junior doctors and nurses in the use of the SBAR process in order for it to be used successfully when the responsibility for care is transferred from one team to another or a review of a deteriorating patient is necessary
- Surrey and Sussex Healthcare NHS Trust are encouraging care homes to use a SBAR communication tool and have developed a training programme to support this
- Four Seasons Health Care, a UK wide social care provider, utilises the SBAR approach for communications in its care homes when staff need to call a NHS 24 111 advisor and has developed training for staff in the use of this communication tool.

Baseline data

The information relating to previous calls provided by the care homes participating in the initial test of change indicated that calls occur approximately 2 to 5 times per month per location to a NHS 24 111 advisor or responder service.

The information provided by the participating care at home services in the initial test of change and supported housing in the initial test of change relating to previous calls indicated that they occur approximately 1 time per month per provider to a NHS 24 111 advisor.

The care at home services visit people experiencing care based on agreed care plans and these can be for specified periods of time. The level of service provision and limited interaction of the care staff with the people experiencing care is reflected in this occurrence level.

During 2017 the total number of calls made to NHS 24 111 advisors in the regions included in the initial study (Aberdeenshire, Angus, Inverness and Edinburgh) was nearly 185 000, which is more than 15 000 per month.

The initial test of change incorporated services provided to:-

- 194 people experiencing care in a care home settings
- 77 people experiencing care at home and
- 19 people experiencing care in a supported housing environment.

Once the care providers participating in the test of change increased, the improvement project covered a further:-

- 196 people experiencing care in a care home settings

- 208 people experiencing care at home and
- 24 people experiencing care in a supported housing environment.

"Staff are finding this useful but I think I am the one who is seeing the benefit of the information gained. With the information they are recording I am seeing the reasons why the team called, the actions they took and if that was in line with the residents ACP" - Manager of a care home

The latest recorded information identified that in Scotland 34,738 people are experiencing care on a long stay basis in care homes for adults at 31 March 2016[6]. More recent figures are available for those people experiencing care at home services and housing support which indicate 59,640 and 18,940 respectively at 31 March 2017[7].

Test of change

During the initial four week test of change the two services providing care at home did not have the need to contact the OOH. The housing support service called for support on 3 occasions and the participating care homes made a total of 23 calls to an OOH advisor during the test of change period.

Reasons for the calls included, medication queries, seeking advice (possible infection / fall), medical support (catheter / cast removal / GP / ambulance) and medication support (prescription required). Staff, both nurses and care staff, working in care homes indicated that having access to and reviewing supporting information contained in anticipatory care plans and medical records relating to the person experiencing care prior to the call was beneficial, as was having knowledge of the person experiencing care gained by regularly providing care for them. Staff also indicated that using the communication tool enabled them to seek additional support when necessary and that after reviewing the situation, some could be reviewed by the person receiving care's own GP rather than engaging with OOH personnel.

The initial test of change identified that the information relating to the person experiencing care available to care and nursing staff in a care home was significantly greater than that available to carers engaged in the provision of care at home and supported housing. As a consequence, a divergent approach, testing a number of variations of the pro-forma occurred and the experiences converged to establish two different formats of the communication tool for the care providers. The versions of the communication tool are available at appendix 2 (for care homes) and appendix 3 (for care at home and supported housing).

The care providers in the initial test of change stated they were experiencing a benefit by using the communication tool and all continued to use the tool, contributing to the development beyond the test period.

In the subsequent weeks when the additional care providers were participating in the test of change the housing support services sought assistance on 4 occasions, the care homes made 19 calls to an OOH advisor and the care at home services 17 calls. Three care providers did not report any occasions that they had sought additional support during their participation in the later test of change.

Reasons for the request for OOH support varied and included end of life care, falls, breathing difficulties, medication queries and swellings. Staff indicated that using the communication tool enabled them to focus on their observations, reflect on the person experiencing care and their care needs. It enabled staff to review when calls for OOH support were necessary and that after reviewing the situation some instances could wait to be assessed by the persons own GP.

The questionnaires completed by staff indicated that confidence improved by having a structure in place to use when calling a NHS 24 111 advisor or responder service. Comments from staff included:-

- Felt confident on the information giving
- It helps me focus on the person
- Felt confident stating what the client wishes are
- Makes you more aware of your observations
- Was confident to support the family due to GP involvement
- “critically” [the NHS 24 111 advisor] rang back within the hour
- Provides reassurance that you are doing the right thing.

Professionals engaged in the provision of the NHS 24 OOH service were consulted and confirmed that the quality of the calls would improve if the information identified on the communication tool was collated and shared with an OOH advisor and, if subsequently with medical practitioners, this communication tool may support a better outcome for the person experiencing care.

Conclusions

Having a communication tool to assist in collating relevant information regarding the situation and the person experiencing care supports staff when responding to unplanned events during OOH periods.

Having a communication tool that reflects the information available to staff and their varying levels of medical knowledge is beneficial.

Having the communication tool for structuring conversations gives staff greater confidence when speaking to NHS 24 111 advisors and other responder services.

Having access to further relevant information, such as medical history, KIS and ACP’s, is highly beneficial to a professional conversation and supports a comprehensive person centred discussion relating to the individual needing unplanned care.

Support provided by the NHS 24 or responder service varied and included:-

- an ambulance arriving within minutes
- a request to observe and seek further support within specified time scales
- a prescription available at a local pharmacy for collection
- the NHS 24 service was unable to answer the call and the care service determining appropriate action.

The test of change was not able to measure if response times by OOH personnel changed, however, care staff reflecting on their experience indicated that guidance

over the telephone had been helpful and response and outcomes of interaction was in line with the recommendations care staff made during the conversations or better.

The completed communication tool did indicate that care professionals were using their judgement, seeking support after a period of observation when appropriate and that agreed outcomes were escalated when the condition of the person experiencing care deteriorated.

Managers indicated that staff benefitted from having a structure in place to assist with communication.

An unexpected benefit was the use of the communication tool for improving internal communications within care settings for follow up actions, such as ensuring care plans were reviewed and updated expediently after an unexpected event. Care staff have used the tool to aid shift handover and managers for personal development purposes for members of the care team.

"It's a very nice tool for everyone to use to confidently communicate with family members as all the information is in one place" - Manager of a care home.

Care providers who participated in the test of change are keen to continue to make the communication tool available to their staff teams and would like to share the communication tool with fellow managers in other care providers.

The improvement project was time specific and engagement with care providers concluded in June 2018. Should further engagement be determined as appropriate, further resources would need to be identified.

Next steps

- The communication tool has been tested in a number of care homes successfully.
- A good practice guide to support social care staff in the use of the communication tool has been developed (see Appendix 4).

These will be made available for use to support improvement via the Care Inspectorate website and Hub and the Healthcare Improvement Scotland website.

- Further test of change in housing support services and care at home services would provide a valuable extension to the quality improvement project in order to provide a more robust opportunity for the communication tool to be utilised.
- If funding could be identified this would provide a valuable extension to the quality improvement project.

Appendix 1: Services that took part in tests of change

Kingsmill Care Home Brighterkind, based in Inverness, has a 60-bed capacity offering residential, nursing and dementia care.

Marionville Court Care Home, based in Edinburgh, has a 60-bed capacity offering residential, dementia friendly care with the flexibility to cater for high dependency.

Tor-na-Dee Care Home, based on the outskirts of Aberdeen, has capacity for 74 residents and provides residential, respite and nursing care for older people, including individuals with Alzheimer's and other forms of dementia and physical disabilities.

Bluebird Care are providers of tailored care at home services to residents in Glasgow and Edinburgh.

Highland Home Carers, Scotland's largest Employee Owned Company, is a home care provider in the Highlands supporting long term complex care through to support with everyday living, which is tailored to individual requirements.

Sue Ryder are providers of tailored care at home services to residents in Arbroath and the surrounding area.

Peacock nursing home, is situated in Livingston and has accommodation for 80 residents and provider care to older people including those with physical difficulties, mental disability and those with dementia.

Dorward House care home, based in Montrose provides mainstream care, respite facilities, and high dependency care for up to 40 vulnerable older people.

Linlithgow care home, situated within West Lothian, is an 80 bedded care home offering general nursing and dementia nursing care.

Dalvenie Gardens, Banchory is a very sheltered housing complex providing 24 one-bedroom self-contained flats.

Paramount Care, Aberdeen and Aberdeenshire provides tailored care at home to residents across the region.

The **Overnight Care at Home service** was commissioned as a pilot for in Inverness and targets at people requiring short term care at home interventions. The service is a collaboration of providers and is supported by Scottish Care.

Appendix 2: Communication tool for care homes

Do not use in an emergency. In an emergency, call 999.

Communications tool for care homes

Please call from next to the person you are supporting and have their care plan and medication sheet to hand

S — **Situation**

Date __/__/__ Time __:__ I am (your name) ______________________

I am a nurse/senior carer/carer from (name of care home) ______________________

I am concerned about (full name of the person you are supporting) ______________________

I am concerned because (state what your observations are or what the person has told you for example, fallen/very distressed/breathing not right/catheter has come out)

____

Address ______________________

Postcode ______________ Phone Number ______________________

Date of birth (of the person you are supporting) ____/____/____

What are the current circumstances?

B — **Background**

Does this person have a Key Information Summary (KIS)? Yes/No (Does it state anything relevant to this situation in the special notes?) ______________________

This person was last reviewed by medical practitioner on ____/____/____

who stated ______________________

Relevant medical history of this person (including, for example: the person has dementia/sight problems/can get upset with strangers/communication needs/is diabetic/known allergies - have medication sheet to hand)

____

Current medication of this person (have medication sheet to hand)

____

This person has:

- an Anticipatory Care Plan Yes /No (What does it state that is relevant to this situation?)

  ____
- a D.N.A.C.P.R. in place Yes/No
- an AWI or Section 47 treatment plan Yes/No
- a Power of Attorney/Welfare Guardian Yes/No (What does it state that is relevant to this situation?) ______________________

This person's preferred place of care is ______________________

and has lived here since ______. I have known (The name of the person you are supporting)

______________________ for ______ years/months.

What is your assessment of the person?	
A Assessment	What are the symptoms and changes you see in front of you? Has the person's behaviour changed? What has the person told you? Write down everything that you see or the person tells you. (Record what has changed in the last 24 hours. Have they eaten or drank as normal? Do they have a temperature? Are they pale/in pain/struggling to walk/not as responsive as normal?) ____________________ ____________________ ____________________ If appropriate and competent to do so – what are the vital signs? BP _______ time taken __:__ Pulse _______ time taken __:__ Resps _______ time taken __:__ Temp _______ time taken __:__ Other (for example, blood sugar)____________________

Guidance – who might provide support to the current situation?

- Speak to manager or colleague.
- Contact district nurse/pharmacy or other medical professional.
- Contact GP surgery to request visit/call back/appointment.
- If during out of hours – can it wait until surgery is open?
- Out of hours - call 111 advisor/local responder if immediate support or advice is needed.
- 999 this a life threatening situation.

Do you need advice or support?	
R Reccommendation	What do you, or the person needing support, think is needed? (Is advice needed now/call GP tomorrow/nurse needed today/monitor the situation?) ____________________ Date of phone call ___/___/___ and time __:__ To (state service) ____________________ *If you speak to a call handler pass on as much information about the person as you can* Action suggested (ask the call handler to repeat to ensure your understanding) ________________ ____________________ If a practitioner visit is recommended: Time the person arrived __:__ Outcome of the visit? ____________________

Nurse/carer name ____________________ Signature ____________________

Date ___/___/___ Time __:__

Additional notes ____________________

____

____

____

Appendix 3: Communication tool for care at home and supported housing

Do not use in an emergency. In an emergency, call 999.

Communications tool for care at home and supported housing

Please call from next to the person you are supporting and have their care plan to hand

S

Situation

Date __/__/__ Time __:__ I am (your name) ____

I am a senior carer/carer from (name of care provider) ____________________________

I am concerned about (full name of the person you are supporting) ________________________

I am concerned because (state what your observations are for example, fallen/very distressed/ breathing not right/catheter has come out)

____

Address ____________________________________ Postcode _______________

Is a key in a safe place? Yes/No (If Yes and you ring for additional support, tell the call handler)

Phone Number __________ Date of birth (of the person you are supporting) ____/____/____

What are the current circumstances?

B

Background

Current medical history that you are aware of (for example, dementia/sight problems/can get upset with strangers/communication needs/is diabetic/known allergies - what details are in the care plan?)

____

Current medication (If known, what details are in the care plan?) _______________________

____

I have known (The name of the person you are supporting)

____ for _____ years/months.

The following prompts are for use by carers, if the information is available.

They were last reviewed by a medical practitoner on __/__/__ who stated ____________

____ (carer may need to ask for details)

Are you aware that this person has:

- an Anticipatory Care Plan Yes /No/Unknown (What does it state that is relevant to this situation?)

  ____

- a D.N.A.C.P.R. in place Yes/No/Unknown
- an AWI or Section 47 treatment plan Yes/No/Unknown
- a Power of Attorney/Welfare Guardian Yes/No/Unknown (What does it state that is relevant to this situation?) ____

This person's preferred place of care is (if known) ______________________________

What is your assessment of the person?	
A Assessment	What are the symptoms and changes you see in front of you? Has the person's behaviour changed? Write down everything that you see. (Record what has changed in the last 24 hours. Have they eaten or drank as normal? Do they have a temperature? Are they pale/in pain/ struggling to walk/not as responsive as normal? What is on the log sheet?) ____ ____ ____ I (or the person needing support) think the problem is ____________________ OR, I don't know what the problem is but I am really worried.

Guidance – who might provide support to the current situation?

- Speak to manager, colleague or OHH support.
- Contact district nurse/pharmacy or other allied professional.
- Contact GP surgery to request visit/call back/appointment.
- If during out of hours – can it wait until surgery is open?
- Out of hours - call 111 advisor/local responder if immediate support or advice is needed.
- 999 this a life threatening situation.

Do you need advice or support?	
R Reccommendation	What do you think is needed? (call 999/NHS 111? GP/nurse needed today?) ____________ ____ Date of phone call ___/___/___ and time __:__ To (state service) ______________________________ *Pass on to the call handler as much information about the person as you can.* **If appropriate, the carer needs to make it clear to the call handler that - you will not be there when they call back or a practitioner attends - the phone number they should call back on if different to the one the call was made from.** Action suggested (ask the call handler to repeat to ensure your understanding) ____________ ____ If a practitioner visit is recommended: Time the person arrived (if known) __:__ Outcome of the visit? (if known) ____________________________

Carer's name ____________________ Signature ____________________

Date ___/___/___ Time __:__

Additional notes ____________________________________

____

____

____

Appendix 4: Communication guide for care managers

Good practice communication guide for managers

When the person comes into your care

Ensure that you and the care team:

- fully understand their care needs
- get to know them
- always keep the person you are caring for at the centre of everything you do.

Request a copy of the key information summary (KIS) from the person's GP and ensure that you receive an updated version when any changes take place.

Be aware if the KIS contains a 'do not resuscitate' or other special requirements – make sure the care team are aware.

If the person experiencing care has recently moved home, encourage them to register with the local GP practice as soon as possible. Keep the details of their old address to hand until this has happened and all records have been transferred.

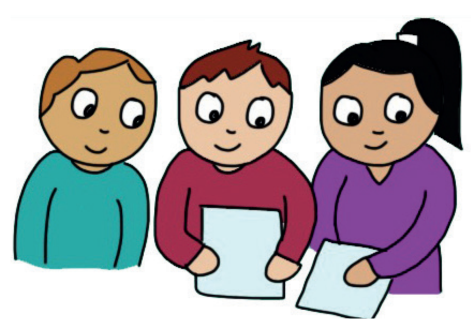
Consider each person you are supporting and introduce the concept of an anticipatory care plan (ACP) to ensure that their future care wishes can be discussed and written down.

Lots of information can be found on the HUB, ihub and NHS websites to help you with this.

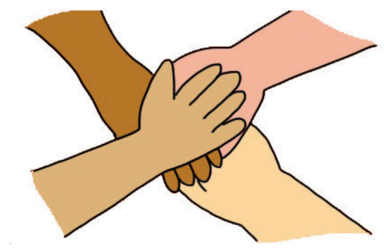
Ensure that staff handovers include information on any changes to the person.

Ensure that all carers are aware of any specific health matters for everyone they are supporting and that they receive relevant information and training to ensure that the care provided is personalised to their needs.

Ensure all staff know where all records are for all people in your care.



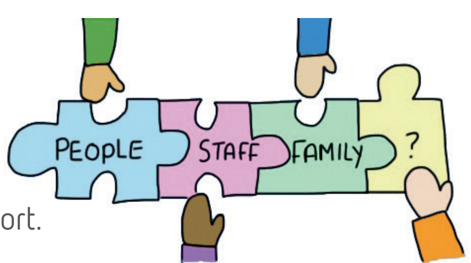
Who else can provide support?



Ensure you are aware of the people that matter to the person coming into your service. This can include friends, next of kin, welfare guardian or other contact. Ensure these details are available to the carer.

If the person is still living in their own home, do they have friends or neighbours who are able to provide support to them? Ensure these details are up to date and available to carers.

Who could you contact to get support?



It is helpful to have a policy to guide carers.
Line managers, colleagues, responder services, GPs, district nurses, and pharmacy, 999 and the NHS24 111 services are there to provide support.

What happens if a person needs unplanned support?

Have a phone available for carers to use with the person they are supporting.

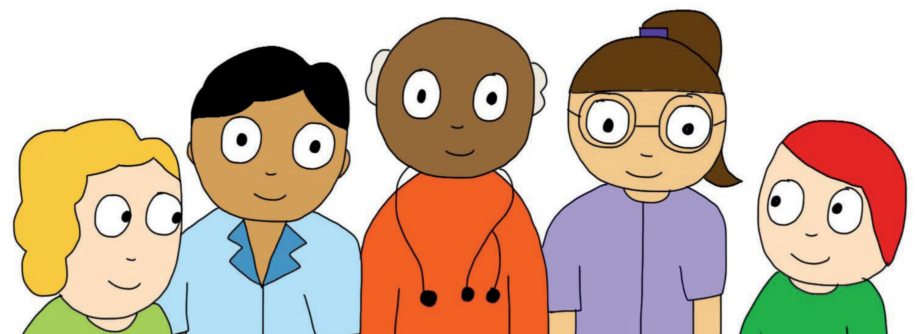
It is helpful to have a protocol in place should a carer arrive at a person's house and encounter an unplanned event that they need to deal with.

It is helpful to have staff trained to deal with unexpected situations.

Make sure your staff teams know what to do when an unplanned event occurs.

What happens if a carer is delayed?

It is helpful to have a procedure for informing people who are due to receive a visit of any delay.



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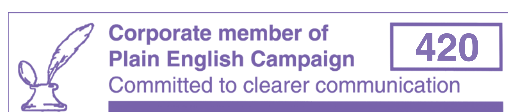

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Appendix 5: Communication guide for carers

Good practice communication guide
for carers

When a person come in to your care

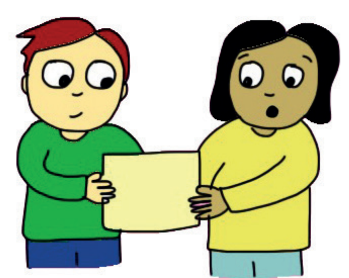
When a person comes into your care, ensure that you fully understand their care needs.

Get to know the person so that you can notice any changes.

Be aware of any specialised requirements to ensure that the care is personalised.

Always keep the person you are caring for at the centre of everything you do.

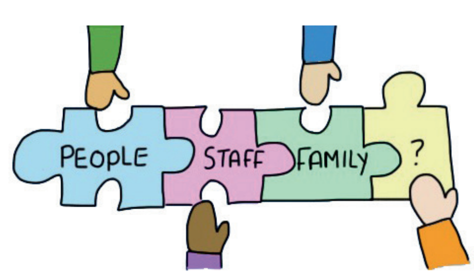
If the person has recently moved home, encourage them to register with the local GP practice as soon as possible. Keep the details of their old address to hand until this has happened.



Check if the person's GP has provided a copy of their key information summary (KIS).

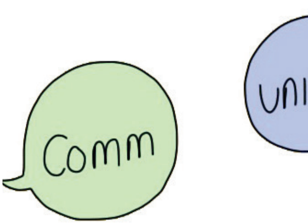
Be aware if the KIS contains a 'do not resuscitate' and other special requirements.

Consider each person and introduce the concept of an anticipatory care plan (ACP) to ensure that their wishes can be considered.



What happens if the person needs additional support?

- who will provide this?
- who is there for them and when?
- ensure you are aware of the person's next of kin, welfare guardian or other contact and that details are available.



Ensure you know where all records are for all people experiencing care.

Ensure daily logs and handovers give accurate information on changes to the person experiencing care.

Try to ensure that you are aware of all health matters for everyone you are supporting and that you receive relevant information and training.

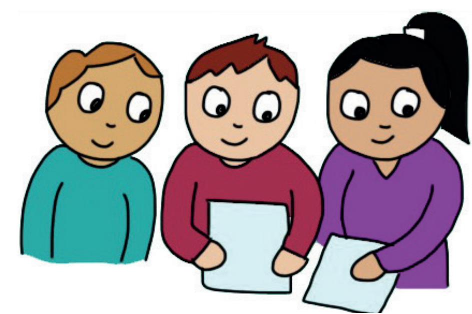
Lots of information can be found on the HUB, ihub and NHS websites.

Ensure that all care plans are reviewed regularly and are available at all times.

As a carer:

- do you know what to do if you encounter an unplanned event?
- are you trained to deal with unexpected situations?

When an unplanned event happens, consider what may be needed for example, emergency services, NHS 24 111 advisor, or local services during 'normal' hours.

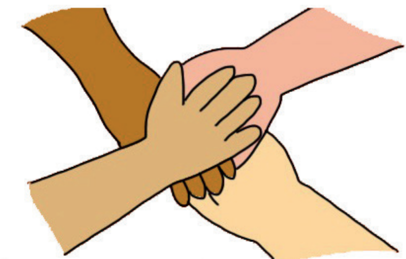


Use the communication tool to:

- listen carefully and record what the person tells you about their symptoms if they are not well.
- gather together all the relevant information you have access to about this person and then, with the person if possible, decide what support they need and from who.

If it is urgent – call 999.

Whenever possible, make a call for support with the person you are supporting.

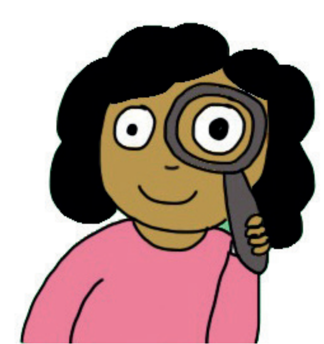


Give as much information about the person to the responder or call handler as you can.

Help the person to speak to the call handler if possible.

Things to look out for

How does the person look today? Tired? Unwell? In pain?
More confused? What are they saying to you?



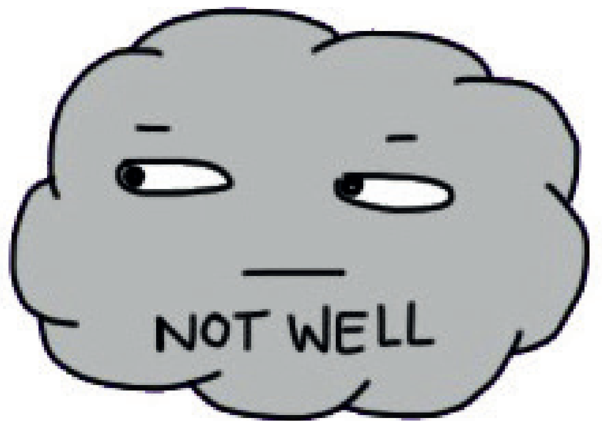
Are they eating and drinking as normal? Dehydrated? Losing weight?

Are there changes in toilet habits? Smelly urine? Constipated or diarrhoea?

Is mobility as normal?

Check documentation – what is it telling you? Anything condition specific?

If you are concerned – seek support.



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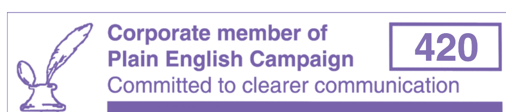

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Appendix 6: References

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