This information has been written in collaboration with a multi-agency team to assist staff to cope effectively with some of the common minor illnesses and conditions that residents might experience. Please be aware that although the content relates to physical conditions, consideration and attention must always be given to residents emotional needs, also remember that a physical illness may make dementia symptoms suddenly worse. Dignity and privacy must be upheld and appropriate information given in order that a resident can make informed choices about their care.

Please refer to the content prior to contacting the District Nurse (DN), General Practitioner (GP), Emergency Care Practitioner (ECP), or Ambulance Service except in an emergency:
Chest pain, suspected stroke – call 999 immediately.

For non urgent conditions, attending the GP surgery would be preferable where appropriate, and arrangements for the resident to do so should be made. However, if a visit from the GP or DN is needed, please try to communicate the names of all residents requiring a visit as early as possible, and at the same time. In this way, multiple phone calls and duplicated visits can be avoided and improve the outcomes for residents as the GP / DN will be better prepared.

DN’s have primary nursing responsibility for those who are registered as Residential clients, even in Nursing Homes. They should be the first point of contact for any such resident with a nursing need. However, in emergency situations it may be necessary for the Nursing Home nurse to deliver First Aid or give other assistance – after which, care of the resident, including a record of the care given should be then communicated to the appropriate person e.g. DN, GP, ECP.

If you need copies of any of the assessment or other forms included in the pack, please contact the relevant service, or the Care Homes Support Team.

If you have any questions regarding this Information Pack, please speak to:
(Insert) District Nurse Team – Tel

Care Homes Support Team Nurse - Tel 0114 305 4109

The information contained herein is for reference use. The content has been provided in good faith by specialist contributors. References contained within are considered to be relevant to that field of practice at the time of printing. Sheffield Teaching Hospitals Foundation Trust, Primary and Community Services Care Group, does not assume responsibility for the ongoing accuracy of the content. The onus is on staff using the document to ensure that practice is current and appropriate to the circumstances at that time. Staff should at all times work within their sphere of capability.
IMPORTANT STATEMENTS

It is intended that the contents of this Information Pack will be used by staff that have a good working knowledge and understanding about:

**Dignity - Consent - Mental Capacity - Safeguarding Adults**

and that any treatment offered and given, is done so with reference to and consideration of the above. Furthermore, that this is recorded in the care plan.

**Dignity in Care** means the kind of care, in any setting, which support and promotes, and does not undermine, a person's self respect regardless of any difference (Social Care Institute for Excellence 2007). In other words, treat someone how you would wish for yourself or your family to be treated.

**Informed Consent – Why consent is crucial.**

1. People have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is central in all forms of health and social care from personal care to major surgery. Seeking consent is also a matter of common courtesy between professional and those for whom they care.

2. Consent is a persons agreement for a professional to deliver care and may be indicated non-verbally (e.g. presenting an arm for the pulse to be taken), orally or in writing. For consent to be valid a person must be competent to make the particular decision, have received sufficient information to give it, and not be acting under duress (Sheffield Teaching Hospitals Foundation Trust (STHFT) Consent to Examination or Treatment). A person’s mental capacity to consent should be considered.

**The Mental Capacity Act** (MCA) provides a legal framework designed to help protect adults aged 16 years and over, who are unable to make decisions including consent, for themselves. The Act is necessary because some adults may be unable to make some or all of their own decisions due to a temporary or permanent disturbance in the way the mind or brain works. This can result from ill health e.g. dementia, stroke or delirium. Such inability to make decisions is known as ‘lack of mental capacity’ – the decisions to be made could be about personal welfare, healthcare or money matters. Staff working in care homes are likely to care for some residents who lack mental capacity, and have a legal duty to ensure that everything done for, or on behalf of, a resident is in the residents’ best interests and is the least restrictive option. A mental capacity assessment is time and decision specific. For instance, someone who lacks capacity for some decisions may be able to make day to day choices. For more information about the Mental Capacity Act see ‘Making Decisions. A guide for people who work in health and social care’ (2007).

**Safeguarding Adults** all adults have the right to live a safe life, free from fear or harm. Organisations that provide services to vulnerable adults have a professional duty of care; this will be included in the home’s Code of Conduct. All organisations in Sheffield work to the Safeguarding Adults Procedures for South Yorkshire, although your own organisation may have its own policy and procedures which are in line with this. For information about Safeguarding Adults, see the ‘South Yorkshire Safeguarding Adults Procedures’. Training enquiries can be directed to Brockwood Training Centre, Tel 0114 2293041.
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**Appendix A**
**Health Protection Agency** - Policy for the Management of Outbreaks of Infectious Diarrhoea and Vomiting in Nursing and Residential Homes

**Appendix B**
**Resuscitation Council (UK) Guidelines – adult basic life support**

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Referral Criteria for Emergency Care Practitioners (ECP)

For non urgent concerns, the first point of contact should always be the GP or GP out of hours, or DN. In an emergency e.g. chest pain or suspected stroke call 999 immediately.

ECPs are able to assess and treat patients at home, or refer on directly to the most appropriate hospital or community speciality, for example the Intermediate Care Teams, District Nurses and Chronic Obstructive Pulmonary Disease (COPD) Nurses.

Use ‘Worried about a Resident’ page 9, to help you decide which service is the most appropriate for a resident in need of attention.

**ECPs will take referrals from care home staff for residents presenting with:**

- Abdominal pains e.g. D&V, constipation, urine retention, gall stones etc
- Any injury that will require suturing, an x-ray, dressings etc. These include lacerations / bites / fractures / foreign bodies etc
- Any muscular skeletal / sprain injuries to the neck, ribs, back and ALL joints
- Catheter problems
- Ear, Nose & Throat problems
- Epistaxis (Nose Bleed)
- Eye problems
- Falls
- Head Injuries (not on Warfarin)
- Headaches including migraines
- Non-specifically unwell residents
- Respiratory problems e.g. chest infections, asthma
- TIAs (Mini Stroke) see FAST guide – page 7
- Urinary Tract Infections (UTI)

**ECP available between the hours of 07.00am – 2.00am every day.**

**ECP contact number – 01924 584939**
The Face, Arm, Speech Test (FAST) can help you recognise the symptoms of a stroke.

**FAST**

- **Facial weakness**
  Can the person smile? Has their mouth or eye drooped?

- **Arm weakness**
  Can the person raise both arms?

- **Speech problems**
  Can the person speak clearly and understand what you say?

- **Time**
  to call 999

**What are the symptoms of stroke?**
- Sudden weakness or numbness of the face, arm or leg on one side of the body
- Sudden loss or blurring of vision, in one or both eyes
- Sudden difficulty speaking or understanding spoken language
- Sudden confusion
- Sudden or severe headache with no apparent cause
- Dizziness, unsteadiness or a sudden fall, especially with any of the other signs

**Why act FAST?**
Stroke is a medical emergency. By calling 999, you can help someone reach hospital quickly and receive the early treatment they need. Prompt action can prevent further damage to the brain and help someone make a full recovery. Delay can result in death or major long-term disabilities, such as paralysis, severe memory loss and communication problems. Ambulance crews use FAST and with hospital staff can act fast to identify and diagnose a stroke quickly.

**If you suspect a stroke, act FAST and call 999**
EARLY ALERT SIGNS

Before requesting advice / support from GP or ECP use this to help you identify your concerns, so you can give appropriate information about your concerns.
For example – Resident has cough and is breathless – list symptoms to help GP or ECP

Not feeling well today?

Restlessness / more restless
Falling / off balance
Coughing
‘Off their legs’
Breathless
Sick
Weak

Confusion / increased confusion
Agitation / increased agitation
Smelly Urine
Uncooperative
Off their food / fluids
Any swelling?

Depressed / can’t be bothered / low mood
<table>
<thead>
<tr>
<th>Worried About A Resident?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>999</strong></td>
</tr>
<tr>
<td><strong>24 hours</strong></td>
</tr>
<tr>
<td><strong>ECP</strong></td>
</tr>
<tr>
<td><strong>07:00 – 02:00</strong></td>
</tr>
<tr>
<td><strong>01924 584939</strong></td>
</tr>
<tr>
<td><strong>GP 24 hours</strong></td>
</tr>
<tr>
<td><strong>Urgent problem</strong></td>
</tr>
<tr>
<td><strong>District Nurse</strong></td>
</tr>
<tr>
<td><strong>08:00 – 17:00</strong></td>
</tr>
</tbody>
</table>

| Chest pain             |
| Choking                |
| Fitting                |
| Severe breathing problems |
| Stroke                 |
| Unconscious            |
| Vomiting blood         |
| *Head Injury – on Warfarin |

* Head injury is defined as any trauma to the head, other than superficial injuries to the face (NICE 2007)

**Minor Injuries:**
- Bites
- Cuts
- Foreign Objects

**NB: ECPs can deal with other medical problems (see Referral Criteria for ECP Page 6) however GP should be contacted first**

<table>
<thead>
<tr>
<th>Falls</th>
<th>Head Injury - not on Warfarin</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Suspected Fractures</td>
</tr>
</tbody>
</table>

| Unwell resident |
| Breathing problems |
| Worsening confusion |
| UTI (dipstick first) |
| Worsening pain |
| Diabetic Emergencies |

**GP Routine problems**
(weekly visits if available)

| General medical concerns |
| Medication concerns |
| On – going medical problems |
| Psychiatric problems |

**Palliative Care**
Residential clients: discuss with DN
Nursing Clients: for queries/referrals contact Elaine Bird (Mon – Fri, 08:00-17:00) @ St Lukes on Tel: 0114 235 7465

**Medicines Management**
Mon - Fri 09:00 - 17:00
305 1983
Please also use your local pharmacy for advice

<table>
<thead>
<tr>
<th>D/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>17:00 – 08:00</td>
</tr>
</tbody>
</table>

**Urgent nursing problems that will not wait until the following day**
Suggestions for managing End of Life in care homes from Admission to Death
(adapted from a document devised by Broomgrove Nursing Home)

Resident Admitted

Nursing Assessment ‘Your Wishes’ Form

GP/Medical Assessment

MDT Discussion

DNACPR Status determined – (if signed in the hospital, good practice recommends this is reviewed by the GP on transfer – see DNACPR form Section 3

- Advanced Care Plan documented
- Determination of prognostic indicators

Communication with relatives - by nurse/ carer / and/or GP

Ongoing Assessment And Review

Referral to Specialist Palliative Care Nurse/District Nurse

Change in condition /MDT Review

Communicate with out of hours service

Communicate/support with Relatives

Pre-emptive prescribing ? Pink Card

Commence End of Life Care Pathway

Well Managed death in the Care/Nursing Home

Nurse Verification of Expected Death & Bereavement support for relatives
Residents with Skin Complaints

New onset of skin complaint (itchiness, redness, eczema, any rash).

Contact GP for advice or review and possibly to prescribe medication

Always ensure that any creams or ointments are stored, applied, and disposed of as prescribed / per manufacturer’s instructions, unless otherwise instructed by Dermatology Team. Write date of opening on tube (see ‘Fingertip Unit Guide’ - Page 12 and ‘Table of Suggested Expiry Dates’ Page 15). Keep creams or ointments in a safe place so that all care staff are able to locate them but residents do not have access, unless they are self administering.

Adhere to ‘Standard Infection Control Precautions’ page 58, when applying creams/ointments (prevents skin irritation to those applying medication and reduces risk of cross-contamination). Assist resident to wash with emollient substitutes (e.g. Diprobase) and gently dry skin prior to each cream or ointment application, unless otherwise directed.

Observe site of cream/ointment application for signs of sensitivity (irritation, redness, raised rash) and if this occurs liaise with GP.

Record any confirmed sensitivity in resident’s records.

Liaise with DN / GP if the treatment has been applied as prescribed and the condition does not improve. When skin complaint resolves stop the medication as prescribed. In some cases this means a gradual weaning; liaise with DN or GP.

NB. Regular review of treatment is required if resident is prescribed steroid ointment and creams
Fingertip units (FTUs) of steroid preparation to apply to specific areas.

Number of fingertip units (FTUs)

<table>
<thead>
<tr>
<th>Age</th>
<th>Face &amp; neck</th>
<th>Arm &amp; hand</th>
<th>Leg &amp; foot</th>
<th>Trunk (front)</th>
<th>Trunk (back) inc. buttocks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>2 1/2</td>
<td>4</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Children:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-6 months</td>
<td>1</td>
<td>1</td>
<td>1 1/2</td>
<td>1</td>
<td>1 1/2</td>
</tr>
<tr>
<td>1-2 years</td>
<td>1 1/2</td>
<td>1 1/2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3-5 years</td>
<td>1 1/2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3 1/2</td>
</tr>
<tr>
<td>6-10 years</td>
<td>2</td>
<td>2 1/2</td>
<td>4 1/2</td>
<td>3 1/2</td>
<td>5</td>
</tr>
</tbody>
</table>

*One adult fingertip unit (FTU) is the amount of ointment or cream expressed from a tube with a standard 5mm diameter nozzle, applied from the distal crease to the tip of the index finger.
**Good Practice Guidance for Care Homes Expiry Dates**

**Definition** – The expiry date is the point in time when a pharmaceutical product is no longer within an acceptable condition to be considered effective. The medication reaches the end of its ‘shelf life’.

Depending on the product, the expiry date may be set as a fixed time
- after manufacture
- after dispensing
- after opening of the manufacturer’s container.

The shelf life of products is determined by either the break down of the active drug or by risk of contamination. Not all drugs deteriorate at the same rate.

**Key points for basic storage guidelines**
- Keep all medication in the original container in which they were dispensed.
- Keep medicines in their original outer packaging, to protect from sunlight.
- All medicines should be stored in a cool (below 25°C) dry place unless refrigeration is required (between 2°C and 8°C)
- The expiry date of products can change once opened.
- Record the date opened and the calculated expiry on the medicine package/label.
- Be vigilant with product expiry dates.
- Store as recommended by manufacturer.

**Examples of different wording of expiry dates**

<table>
<thead>
<tr>
<th>Wording on packaging</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Best before January 2011</td>
<td>Discard 31/12/2010</td>
</tr>
<tr>
<td>Use before end January 2011</td>
<td>Discard 31/01/2011</td>
</tr>
<tr>
<td>Use by January 2011</td>
<td>Discard 31/12/2010</td>
</tr>
<tr>
<td>Discard after January 2011</td>
<td>Discard 31/01/2011</td>
</tr>
<tr>
<td>Expires January 2011</td>
<td>Discard 31/01/2011</td>
</tr>
<tr>
<td>Use within one month of opening</td>
<td>Self explanatory</td>
</tr>
<tr>
<td>Discard 7 days after opening</td>
<td>Self explanatory</td>
</tr>
</tbody>
</table>

Generally speaking solid dose formulations have a longer expiry date than liquid preparations. The manufacturer’s expiry on a container is the unopened expiry date. After opening, the expiry date may be dramatically shortened e.g. risperidone liquid, antibiotic syrups, eye drops, GTN tablets, oramorph liquid, and many ‘specials’. This should be highlighted on the medicine label or container. **It is recommended that medicines dispensed in a MDS are discarded after 8 weeks if they have not been used**

Certain external factors can affect expiry – contact with water, temperature, air or light e.g. antibiotics to be taken as a liquid formulation are stored in the pharmacy as a dry powder which is then reconstituted with water and given a shorter expiry date.

Any product whose appearance suggests it may be unfit for use should be discarded – irrespective of expiry date. If there is any doubt contact the community pharmacy for advice.

**Effects of using expired stock**
- The active drug becomes chemically unstable
- The effectiveness of the drug may change
- The break down of the drug may be toxic and harmful to the patient
- Increased risk of contamination

Resources
- Continuing Professional Pharmacy Education (CPPE) Supporting Care Homes in Medicines Management April 2007.
- Pharmaceutical Journal – How stable are medicines moved from original packs into compliance aids January 2006 Vol 276
- RPSGB Handling Medicines in Social Care Local Pharmaceutical Committee Sheffield
For Care Home Staff

Good Practice 1 – ordering medication

- Check quantities ordered are appropriate for requirement in order to avoid medication waste.
- Do not forget to check medication not routinely stored in the medicines trolley.
- Nominated member of staff to be responsible for ordering with named deputy.
- Request PRN’s in original packs rather than in MDS. (MDS has reduced expiry therefore more frequent prescriptions will be necessary and more medication waste generated).

Good Practice 2 – receiving medication from pharmacy

- Check if there are any specific expiry date instructions e.g. some liquid antibiotics.
- Check the medication is still within its expiry date.

Good practice 3 – storing medication

- Note and act on any specific storage instruction e.g. store in the fridge.
- Rotate stock so the earliest expiry is at the front and therefore going to be used first.
- Check expiry dates of stock monthly.
- Medication is to remain in the container in which it was received – batches must not be mixed.

Good practice 4 – administering medication

- Check expiry date.
- Record the date opened and the calculated expiry on the medicine package/label where appropriate e.g. creams, eye drops. Some packaging does not allow for the pharmacy label to be placed on the product e.g. eye drops. In these instances the outer packaging will have to be endorsed with the date of opening. It is essential that the product remains in the outer packaging throughout duration of this treatment.
- Highlight any short expiry as a reminder to all staff.
- Any product whose appearance suggests it may be unfit for use should be discarded – irrespective of expiry date. If there is any doubt contact the community pharmacy for advice.

Using creams and ointments

Some products now show an expiry symbol e.g. However, in the care home setting where storage conditions may be variable it is recommended that staff refer to the suggested expiry dates on the following page. There is a lack of robust evidence on generic expiry dates of creams/ointments but that which follows are suggested.

Any product whose appearance suggests it may be unfit for use should be discarded irrespective of expiry date. If there is any doubt contact the community pharmacy for advice.

This information is adapted from The Good Practice Guidance for Care Homes and can seen in full by checking the information provided to you in the ‘green medications folder’
# Table of Suggested Expiry of Products from Date of Opening

<table>
<thead>
<tr>
<th>Formulation and packaging</th>
<th>Suggested expiry after opening unless otherwise stated by manufacturer and still within manufacturer’s expiry date</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tubs of creams / ointments</td>
<td>1 month</td>
<td>The contents are exposed and can become contaminated</td>
</tr>
<tr>
<td>Tubs of creams/ ointment decanted from bulk container</td>
<td>1 month or seek community pharmacy advice</td>
<td>As above, and decanting from bulk container into another container could introduce contamination</td>
</tr>
<tr>
<td>Tubs of cream specially made for individual</td>
<td>Seek community pharmacy advice</td>
<td>Dependant on stability of product</td>
</tr>
<tr>
<td>Tubs of creams/ ointments</td>
<td>3 months</td>
<td>Closed container, contents not openly exposed to environment</td>
</tr>
<tr>
<td>Pump dispenser packs of creams/ ointment</td>
<td>Manufacturer’s expiry</td>
<td>Closed container, contents not openly exposed to environment</td>
</tr>
<tr>
<td>Tablets/ capsules in monitored dosage systems</td>
<td>2 months</td>
<td>No batch number or expiry printed on MDS</td>
</tr>
<tr>
<td>Tablets/ capsules/ liquids decanted into pharmacy bottle</td>
<td>Seek community pharmacy advice</td>
<td>Dependant on stability of product</td>
</tr>
<tr>
<td>Part pack of tablets/ capsules remaining in manufacturer’s blister pack dispensed in pharmacy box/ dispensed in original pack</td>
<td>Manufacturer’s expiry on blister. If no expiry visible contact community pharmacy for advice</td>
<td>Closed container, contents not openly exposed to environment. If no visible expiry there is risk that product may have expired.</td>
</tr>
<tr>
<td>Oral liquids in original container</td>
<td>6 months unless otherwise specified by manufacturer</td>
<td>Exposure of liquid to environment when dose is measured can introduce contamination</td>
</tr>
<tr>
<td>Eye, Ear, Nose drops/ ointments</td>
<td>1 month</td>
<td>Manufacturer’s recommendation</td>
</tr>
<tr>
<td>Inhalers</td>
<td>Manufacturer’s expiry</td>
<td>Closed container, contents not openly exposed to environment</td>
</tr>
<tr>
<td>Insulin</td>
<td>4 weeks for insulin vials and pens unless otherwise stated</td>
<td>The sterile seal has been broken and may be stored outside the fridge</td>
</tr>
</tbody>
</table>
Simple Cuts, Lacerations and Skin Tears

For simple cuts, lacerations and skin tears

If wound is deep, showing fat/muscle, excessive bleeding or possible foreign body: Ring Emergency Care Practitioner (ECP) for advice and treatment.

If resident is diabetic report injury to GP as soon as possible. Observe for deterioration and report as a matter of urgency.

Simple cut, apply: Mepore dressing

Adhering to ‘Standard Infection Control Precautions’, page 58, assess the wound. If necessary, apply pressure, (unless foreign body is suspected) to stop bleeding and follow basic first aid techniques - Cleanse area with water or saline if necessary

Lower leg laceration or skin tear:
Residential Homes to contact DN or ECP service
For Trained Nurses in Nursing Homes:
Normal shaped leg – applying SPIRAL bandaging
- N/A dressing - (e.g. NA Ultra)
- Toe to knee - wool (e.g. Profore 1 or Advasoft)
- Toe to knee - light support bandage (e.g. K Lite) X 2 layers in reverse spiral
Thin leg - As above but only apply one layer of light support bandage and use wool to create a normal leg shape and increase the circumference by using 2 layers of wool

Change dressing as necessary, e.g. if ‘strikethrough’ (leakage seen through dressing) occurs, if resident complains of pain or if area becomes offensive smelling. If none of the above occurs, remove dressing after 3 days and reapply as necessary.

Any wound requiring a dressing refer to DN (Residential clients). Any concerns about deteriorating or non healing wounds refer to Tissue Viability Nurse. Liaise with GP about current Tetanus Immunisation status if wound caused by ‘Dirty’ object or outside in garden.

NB: If the cut is a result of a fall refer to Page 21 and please complete a risk assessment to try and ascertain reason for fall.

Tissue Viability Services run bandaging workshops – phone 3054248 to book a place
PREVENTION OF PRESSURE ULCERS

COMPLETE THE FOLLOWING DOCUMENTATION:-
INITIAL ASSESSMENTS – BODY CHART/MAP, WATERLOW, MUST, CONTINENCE, MOVING & HANDLING

IS RESIDENT AT RISK OF PRESSURE DAMAGE?

YES

IF WATERLOW 10 OR MORE
IMPLEMENT THE FOLLOWING
(INDIVIDUALISE TO RESIDENTS NEEDS)
- CARE PLAN FOR PREVENTION OF PRESSURE ULCERS AND TO ADDRESS THE RISKS IDENTIFIED
- FREQUENCY OF COMPLETING SKIN INTEGRITY CHECK.
- CARE PLAN FOR MANUAL HANDLING
- CONSIDER CARE PLAN FOR NUTRITIONAL SUPPORT
- CONSIDER CARE PLAN FOR CONTINENCE MANAGEMENT

NO
CARE PLAN FOR THE MONITORING OF PRESSURE AREAS
REVIEW MONTHLY OR IF CLIENTS CONDITION CHANGES

DOES THE CLIENT HAVE SKIN DAMAGE? IF SO WHAT IS THE CAUSE?
RESIDENTIAL HOMES REFER TO YOUR DISTRICT NURSING TEAM

PRESSURE
Offload
Positioning
Consider type of cushion/mattress
Wound assessment (if applicable)

MOISTURE
Keep clean / dry
Consider barrier treatment
Review continence assessment

SHEAR/FRICTION
Consider moving & handling procedure
Is the appropriate bed/chair in situ

UNSURE
Refer to:
District Nurse
(If appropriate)
GP
Tissue Viability – Tel: 3054248
SCELS Nurse Advisor – Tel: 2263821
Residents in Pain

**Acute pain** – sudden onset and short duration e.g. caused by trauma or surgery. Signs of acute pain include, sweating, pallor, altered breathing patterns.

**Chronic pain** – long term pain - duration beyond expected time for healing, long-standing functional and psychological impairment. The cause is often chronic and disease related.

**NB. Beware** not all individuals express pain in the expected way and it is important to look for other indicators.

Resident showing signs of pain?

Is this the **first** episode of **this** pain?
Could the pain be due to a recent fall? If ‘yes’ see page 19, Pain Assessment Scales

---

**Pain evaluation tool**
Encourage the resident to describe the type of pain
- Onset
- Pattern
- Duration
- Location
- Intensity

Observe for potential indicators of pain:
- Facial expressions
- Verbal expressions
- Body movements
- Altered interpersonal interactions
- Changes in activity pattern
- Mental status changes
- Physiological changes

See **Pain Assessment Scales**, page 19

Is pain affecting activities of daily living?

Are other factors accompanying pain e.g. depression, anxiety, decreased socialisation?

If on medication for pain relief observe for adverse drug reaction.

Is pain relief being administered as prescribed?

Call Prescriber for advice and assessment of pain relief therapy

---

**Unsure?**
Contact GP, Pharmacist or therapist for clarification

---

NO?
If appropriate refer to homely remedy policy.

---

YES

---

Call Prescriber for advice and assessment for pain relief therapy

---

YES

---

Administer pain relief therapy as prescribed, monitor and record pain control using ‘Pain Evaluation Tool’

---

NO
Pain Assessment Scales

Pain is sometimes difficult to put into words. Pain scales are tools that can help diagnose or measure pain intensity. Choose and record the appropriate pain assessment scale for the patient. It is advised that the same scale is used throughout the patient’s pain management episode. Explain to the resident that this scale will be used to measure their pain. It would be good practice to document if you believe the resident was able to understand this scale.

Visual scales
Each face shows how a person in pain is feeling. The patient can point to the face that best describes their pain

Wong-Baker Faces Pain Rating Scale

![Wong-Baker Faces Pain Rating Scale Diagram](image)

Verbal Scales
This type can be used to describe the degree of discomfort by choosing one of the vertical lines that most corresponds to the intensity of pain

Numerical Scales
This can be used to describe the intensity of discomfort in numbers ranging from 0 to 10

![Numerical Scales Diagram](image)
Ask the resident to point to the area of pain. Use this tool to locate where the pain is and record in the residents care plan.
Falls / Collapse

Is the person conscious?

No

Breathing? Pulse? present

Yes

Are there any injuries?

* Head Injury / Limb Deformity

Bleeding NO

Refer to Simple Cuts, Lacerations & Skin Tears Page 16

Observe for any changes in condition every hour as per home policy ie; limb deformity, skin discolouration, changes in mobility, increased pain (see Resident in Pain; page 18)

Check Baseline Observations # Signs of infection and hydration

Remains stable

DNACPR in place?

YES

Refer to the homes End of Life documentation

NO

Commence basic life support

Refer to the Resus Council Guideline – Appendix B

Do Not Move Them Dial 999

Deteriorating?

Commence Level 2 Assessment

(see Section 5, General & Best Practice Information Resource Folder)

Referral to GP or District Nurse for review of Level 2 Assessment

Review risk assessment & care plan, (see Falls Checklist page 22)

* Head injury is defined as any trauma to the head, other than superficial injuries to the face (NICE 2007)

# Acute infections eg Urine, Chest & Ear, and Dehydration increase the risk of falls
### Falls checklist

(Based on the Sheffield Bone Health pathway, Level 2 Assessment and York and North Yorkshire Falls and Osteoporosis Screening Tool)

<table>
<thead>
<tr>
<th>Falls Risk Identified</th>
<th>Suggested Action / Care Planning Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong> of falls or near-misses as highlighted by - Falls Risk Assessment on admission, monthly and / or as needs and condition change.</td>
<td>Commence the Level 2 Assessment (Sheffield Fall Pathway). Identify any patterns of falls; activity, time, place Formulate a care plan (see rest of checklist for suggestions) Consider Palliative care needs</td>
</tr>
<tr>
<td>Any signs of acute infection? eg ear, chest, UTI</td>
<td>Refer to GP Ensure adequate oral fluid intake</td>
</tr>
<tr>
<td>Any black outs or loss of consciousness before falling?</td>
<td>Refer to GP Consider Specialist Medical review (Hospital or Community)</td>
</tr>
<tr>
<td>Any dizziness before falling, on standing/ turning? BP: Lying 5 min = Standing 1 min = 3 min = Symptomatic on standing / Postural drop noted?</td>
<td>Refer to GP Ensure adequate oral fluid intake Give advice on preparing to sit up / stand up</td>
</tr>
<tr>
<td>Taking four or more medications – and no recent review? Started on any new drugs / dose? Taking drugs associated with increased falls risk?</td>
<td>Refer to GP / Pharmacist for review Refer to Medicines Management for advice and information (See Level 2 Assessment for types of drug)</td>
</tr>
<tr>
<td><strong>Bone Health</strong> General frailty? Any bone fracture since the age of 40? Taking oral steroids or have done previously?</td>
<td>Refer to GP for assessment, investigation &amp; treatment (eg.Calcium &amp; Vit D therapy or bisphosphonates.) Consider use of protective clothing, e.g. Hip Protectors</td>
</tr>
<tr>
<td>**Mental Health / Mental Capacity; Resident has poor confidence or worried about mobility? Any memory problems? Any Anxiety / Depression? Known to Mental Health (MH) Services?</td>
<td>Ensure nurse call system is easily accessed. Consider Assistive Technology; Movement, bed &amp; chair sensors. Reassure &amp; encourage, express confidence in the resident Refer to Therapy services via GP Refer to Mental Health Services via GP Promote person centred occupation &amp; activities</td>
</tr>
<tr>
<td><strong>Vision &amp; Hearing;</strong> Wears glasses? Any change in vision or new glasses? Has eye conditions? Poor hearing? Wears hearing aid(s)?</td>
<td>Check glasses are the correct ones and are clean. Recommend annual vision check. Consider lighting needs (extra light, night light) Check for ear wax. Ref to GP or DN. Check hearing aid works, is clean and fitted correctly. Refer to Audiology / Hearing Services</td>
</tr>
<tr>
<td><strong>Continence:</strong> Is there a problem? Day / Night Constipation? Access to commode / toilet / night light?</td>
<td>See Continence Information Continence assessment; Refer to continence service. Provision of appropriate aids and safe environment</td>
</tr>
<tr>
<td><strong>Hydration &amp; Nutrition;</strong> Any signs of dehydration? Any reduced appetite / intake? Any difficulties eating? eg dentures Any special dietary needs?</td>
<td>See hydration &amp; nutrition guidelines &amp; risk assessments Referral to Doctor, Dietetic Services, Dental Services, S&amp;LT – for swallowing assessment Consider equipment to facilitate eating</td>
</tr>
<tr>
<td><strong>Alcohol:</strong> Alcohol intake linked to falls/falls risk? More than recommended units being consumed?</td>
<td>Refer to GP Consider local specialist support service.</td>
</tr>
<tr>
<td><strong>Feet and Footwear;</strong> Foot problem affecting gait / balance? (eg pain, problematic bunions / toe nails) Unstable, loose, poorly fitting slipper/shoes worn?</td>
<td>Refer to Podiatry / Orthotic services for treatment Give advice re suitable footwear</td>
</tr>
<tr>
<td><strong>Pain</strong> Is pain affecting mobility?</td>
<td>Refer to Doctor for analgesia review See pain assessments</td>
</tr>
<tr>
<td><strong>Gait and Balance</strong> Is there a problem with gait and balance, muscle strength, range of movement? Is mobility aid appropriate &amp; used safely?</td>
<td>Refer to Physiotherapy for assessment via GP Support client with therapy-recommended exercises/equipment Ensure aids are well maintained (ferrules) and correct height Promote physical activity and mobility</td>
</tr>
<tr>
<td><strong>Care Home Hazards</strong> Lighting and Flooring issues? Home Layout compromising safety? Clutter? Equipment safety?</td>
<td>Ensure lighting is consistently good (without glare.) Maximise natural light Avoid changes in flooring colour and texture, avoid patterns Provide good signage and use highlight colours for doors eg toilet doors. Reduce clutter. Tidy equipment, report problems promptly.</td>
</tr>
<tr>
<td><strong>Staffing linked to falls risk?</strong> Monthly analysis of falls; look for patterns associated with staffing numbers, activity &amp; areas</td>
<td>Promote Falls Awareness with staff Consider staffing numbers and allocation Consider client dependency : Staffing Ratio</td>
</tr>
</tbody>
</table>
Simple Coughs and Colds

Check any new medication and side effects e.g. Ramipril or Enalapril

Encourage increased fluid intake, unless usually restricted on medical advice
See ‘Dietitian Information Pack’ - page 65

- Record temperature 4 hourly and monitor
- Give Paracetamol (if prescribed and suitable)
- Encourage deep breathing
- Keep the resident comfortable and rested, either sitting up or lying on their side
- Monitor pressure areas and give care appropriately
- Try to minimise contact with other residents

If Paracetamol is given expect to see a reduction in temperature after 2 hours

NO

- Symptoms persist for longer than 3 or 4 days
- The resident coughs up blood or green sputum
- The resident experiences difficulty breathing
- Temperature is 38.5° or over

If deteriorating significantly contact GP/ECP as a matter of urgency.

Coughing which is associated with eating/drinking could indicate a swallowing problem. For advice contact Speech & Language Therapy – Tel: 0114 226 2336
Suspected Chest Infection or COPD Flare Up

**Interventions for breathless patients** - if 2 or more chest infections in last year, discuss with GP and ask for referral to Respiratory Team

<table>
<thead>
<tr>
<th>Observation</th>
<th>Intervention</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Too breathless to speak or gasping for breath — could this be anxiety/panic? If YES see box 3</td>
<td><strong>Check Preferred Priorities of Care and GP Medical Care Plan. Dial 999</strong></td>
<td>Immediately</td>
</tr>
</tbody>
</table>
| 2. Early warning signs for chest infection as above                         | 1. Sit resident up or lay them on their side  
2. Check respiratory rate, pulse, temperature and blood pressure if possible – has medication been taken – use Ventolin via Aerochamber applying slow, gentle breaths  
3. Ensure resident can take their respiratory medication if any is prescribed  
After doing 1, 2 and 3, telephone the resident’s GP and ask for a GP visit | Within next half an hour                    |
| 3. Resident is experiencing a chest infection or COPD flare up and has been assessed by their GP or an ECP Anxiety/exercise related? If YES sit with resident, calm and reassure. Assist to use Ventolin where prescribed through Aerochamber. If worsening or not improving after 10mins - Dial 999 | • Make sure the resident takes their medication as prescribed  
• Encourage a sitting up position – if lying down, lying on the side is much better than on the back  
• Encourage fluids – see ‘Fluid Intake Guide’, page 35 for advice  
• Encourage coughing up of sputum  
• Offer the resident small, frequent meals  
• Encourage gentle activity, increasing as the resident improves  
If the resident is not improving after 2 - 3 days of treatment, or is not recovering after 5 days of treatment, take a sputum sample and send to GP - contact the residents GP and ask for a visit. | During each shift for the length of the breathing problem |
Improving and Preventing Dehydration

Is the resident at risk of dehydration?

Refer to 'Dietitian Information Pack' page 65 for contributing signs / indicators, and tips on how to manage.

YES

Start Fluid Intake/Output Chart

NO

Continue to encourage fluids and dietary intake - See 'Fluid Intake Guide' page 37

Has fluid intake improved?

YES

NO

Continue to encourage fluids and record on Intake & Output Chart

Contact GP
Observe for signs of a blocked / leaking catheter:
- no drainage for 2 - 3 hours (the drainage bag should be checked every 2 hours during the day).
- lower abdominal pain / discomfort
- urine leaking out from where the catheter goes into the body (bypassing)

If any of the above signs are present, investigate for all of the possible causes below and act to correct problems straight away. Adhering to ‘Standard Infection Control Precautions’, page 58 check the following;

Kinked catheter tube or catheter bag tube?
- Un-kink the tube. Apply drainage system support products e.g. G-strap. Or is the drainage bag tap open?
- Close tap.

Drainage bag full?
- Empty the drainage bag.

Resident Constipated?
See ‘Suspected Constipation’ Page 48

Resident not drinking?
Encourage the resident to drink more fluids. See ‘Dietitian Information Pack’ page 65 & ‘ Fluid Intake Guide’ Page 37

Urine bag positioned at correct level?
Reposition bag below the bladder (top of drainage bag to be within 30cm of bladder neck), i.e. above the knee

Is the catheter draining now / has the leakage (bypassing) stopped?

YES

Continue to monitor for further problems and document in the resident’s notes.

If catheter is bypassing but the resident is pain-free
Residential client? Apply incontinence pad to keep resident dry and refer to DN service as soon as possible
Nursing Client? Change catheter and go back to top of page, assess as per Community Catheter Guidelines

If any of the following apply:
- resident in pain / discomfort.
- catheter is bypassing and resident is in pain / discomfort.
- resident pain-free but the catheter is not draining and not bypassing.

Document clearly in the resident’s notes
Contact Continence Service, Tel 0114 2716837 for training dates/information

NB.
- Never leave a resident in pain or discomfort.
- Act immediately
- Call for a DN / Evening or Night Nurses / ECP if in any doubt.
Incontinence of Urine

Wherever possible discuss the following with resident:

- seek his/her views as to the cause/problem
- whether he/she needs help to get to the toilet or manage clothing
- whether he/she needs a commode in his/her room
- whether he/she is able to summon help to get to the toilet
- check with resident’s record/colleagues for changes in mobility/health which could affect ability to get to the toilet

Residential clients – discuss with DN
Nursing clients – complete ‘Adult Continence Symptom Profile’ page 38 and ‘Care Home Resident Assessment Form’ page 42
- check for signs of Urinary Tract Infection (see ‘Suspected Urinary Tract Infection’, page 28)

Adhering to ‘Standard Infection Control Precautions’, page 58;
- Use Multistik to test urine – see ‘Using Urine Multistiks’, page 29 and ‘Urinalysis Flowchart’, page 35.
- See also ‘Drugs that may affect Bladder Function’, page 36.


Maintain Fluid Intake/Output via ‘Bladder Diary’, page 40 for 3 days recording each time the resident passes urine/is incontinent of urine

Liaise with GP as necessary

If the problem persists discuss with DN, GP or Continence Nurse (Continence Service Number – Tel 2716837) – see ‘Adult Joint Visit Referral Form’ from the Continence Service page 47
Suspected Urinary Tract Infection (UTI)

Possible signs and symptoms (not all symptoms will be apparent at any one time and some will be absent in the catheterised resident): See also ‘Commonly used drugs that may affect Bladder Function’, page 36.

- Back/loin pain
- Pain/burning on passing urine
- Nausea/vomiting
- Reduced/loss of appetite
- Drowsiness/generally unwell
- Urgency, frequency, nocturia

  Offensive smelling urine
  Darker/cloudy urine
  Unexplained falls
  Raised temperature
  Clammy skin

Unexplained/worsening confusion?
Incontinence/worsening incontinence?
Complete ‘Adult Continence Symptom Profile’, page 38 and follow information.

BE AWARE! Resident may be at increased risk of falls due to infection

‘Adhering to Standard Infection Control Precautions’, page 58
Use Multistik to test urine - see ‘Using Urine Multistiks, page 29 and ‘Urinalysis Flowchart’, page 35.

Encourage/increase oral fluids (unless usually restricted on medical advice)

Maintain Fluid Intake/Output via ‘Bladder Diary’, page 40
Contact GP for advice, informing of ALL symptoms regardless of urinalysis result – discuss result with GP

Monitor temperature, commence temperature chart, give prescribed dose of Paracetamol – refer to MAR sheet, PRN medication or Homely Remedies Policy. Monitor for improvement/deterioration, refer any concerns to GP as antibiotics may be required.

Ensure any medication given to treat UTI is taken as prescribed, continue to monitor temperature, fluid intake/output and condition of resident, discuss as necessary with GP.
Residents who suffer with repeated UTI’s will need to be discussed with GP, and are likely to benefit from referral to Continence Service see ‘Adult Joint Visit Referral Form’, page 47.
### Using Urine Multistiks (Reagent Sticks): Important Information

<table>
<thead>
<tr>
<th><strong>Action</strong></th>
<th><strong>Rationale</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Store reagent sticks in accordance with manufacturer’s instructions. Always check expiry date prior to use.</td>
<td>Test results may be affected by incorrect storage – reliable results are essential to prescribing correct treatment.</td>
</tr>
<tr>
<td>2. Explain and discuss the procedure with the resident.</td>
<td>To ensure that the resident understands the procedure and gives his/her valid consent.</td>
</tr>
<tr>
<td>3. Adhering to ‘Standard Infection Control Precautions’, page 58, obtain clean specimen of fresh urine from resident either by Midstream Specimen of Urine (MSU) if possible, Catheter Specimen of Urine (CSU), or by using ‘Uricol System’ if required page 32</td>
<td>Urine that has been stored deteriorates rapidly and can give false results. Contamination of the specimen can also lead to false results.</td>
</tr>
<tr>
<td>4. Dip the reagent strip into the urine. The strip should be completely immersed in the urine and then removed immediately and tapped against the side of the container.</td>
<td>To remove any excess.</td>
</tr>
<tr>
<td>5. Hold the stick horizontally.</td>
<td>Urine reagent strips should not be held upright when reading them because urine may run from square to square, mixing various reagents.</td>
</tr>
<tr>
<td>6. Wait the required time interval before reading the strip against the colour chart.</td>
<td>The strips must be read at exactly the time interval specified, or the reagents will not have time to react, and inaccuracy may occur.</td>
</tr>
<tr>
<td>7. Follow ‘Urinalysis Flowchart’ page 35 according to result.</td>
<td>For information about how to proceed.</td>
</tr>
<tr>
<td>8. Dispose of sample correctly, and any waste generated in to the appropriate waste stream (Safe management of Healthcare Waste, page 62)</td>
<td>To reduce risk of cross contamination occurring.</td>
</tr>
</tbody>
</table>

Urine which has been ‘dipped’ in this way should not be sent as a laboratory sample as contamination may occur – a fresh specimen must be obtained

Developed by Sue Smelt (CHST) from The Royal Marsden Hospital Manual of Clinical Nursing Procedures, 7th Edition. Edited by Lisa Dougherty and Sara Lister 2008
OBTAINING SPECIMENS OF URINE FROM CARE HOME RESIDENTS

Obtaining a specimen is the first step in determining a diagnosis and treatment (Dougherty and Lister, 2004), and must minimise the risk to others involved with obtaining and handling the specimen. It is also important to reduce the risk of contaminating the sample, to ensure accuracy of results and treatment.

Those who are continent and are able to empty the bladder on request will be required to provide a mid-stream specimen of urine (MSU), Gilbert, (2006). This means that only the middle flow of urine is collected, and bacteria/skin cells will be flushed out with the first flow of urine – this helps to obtain a more accurate laboratory result.

Obtaining MSU’s from care home residents may be a more complex procedure due to issues associated with infirmity, level of understanding and incontinence.

However, it is important that the best possible sample is obtained in order to secure accurate results and the most effective treatment.

The ideal time to obtain a specimen of urine is after bathing, but this may not always be possible. Routine cleansing of the genitals prior to obtaining a specimen appears to make little difference to contamination rates (Leaver 2007, Gilbert 2006).

Adhering to ‘Standard Infection Control Precautions’, page 58 a clean, disposable container e.g. papier mache bowl, should be placed in a commode pan and a sample of urine taken from this, and placed in the urine specimen bottle. It is very important that the inside of the bottle and/or the lid is not contaminated / touched. The cap must be secured tightly, and the specimen accurately and thoroughly labelled. A specimen collected in this way should be described as ‘specimen of urine’ and not MSU.

Alternatively, the Uricol system may be used for residents who are incontinent or unable to provide specimens in the usual manner. This product is not available on prescription, but may be obtained by contacting Redland Healthcare on Tel: 0800 854 052. Information about using the ‘Uricol’ system can be found on page 32.

The container must be labelled with the following information – first and last names, date of birth, NHS number, location, date/time of collection, type of specimen. Failure to provide adequate information may lead to rejection of request by laboratory staff!

See ‘Completed Laboratory Form Example’, page 34.
### Urine Specimen Collection: Important Information

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain and discuss the procedure with the resident ensuring privacy and dignity are upheld while the procedure is being carried out.</td>
<td>To ensure that the resident understands the procedure and gives his/her valid consent.</td>
</tr>
<tr>
<td>2. Adhere to ‘Standard Infection Control Precautions’, page 58, before and after obtaining specimen</td>
<td>Hand cleaning, correct use of Personal Protective Equipment (PPE) and correct disposal of waste greatly reduces the risk of cross-contamination of specimen and others.</td>
</tr>
<tr>
<td>3. A clean, disposable container e.g. papier mache bowl should be placed in a commode pan and a sample of urine taken from this, and placed in the urine specimen bottle. It is very important that the inside of the bottle and/or the lid is not contaminated/touched.</td>
<td>To prevent contamination of specimen.</td>
</tr>
<tr>
<td>4. The cap must be secured tightly, and the specimen accurately and clearly labelled – see pages 30/34. A specimen collected in this way should be described as ‘specimen of urine’ and not MSU.</td>
<td>To prevent leakage during transportation. To ensure accurate and essential information is shared with laboratory staff, and can be given consideration when processing specimen.</td>
</tr>
<tr>
<td>5. Dispose of all waste in the appropriate waste stream – see page 62</td>
<td>To reduce risk of cross contamination</td>
</tr>
<tr>
<td>6. Refrigerate specimen after collection and send to GP within 2 hours. Remember to send lab form with specimen.</td>
<td>To ensure the best possible conditions for accurate laboratory examinations.</td>
</tr>
</tbody>
</table>

**Urine Specimen Collection – URICOL**  
*(the Newcastle Urine Collector): Important Information – How to use the Uricol collection pad to collect a sample of urine.*

‘Standard Infection Control Precautions’, page 58 must be applied, and the procedure needs to take place in an appropriate room e.g. residents own room or en-suite toilet.

<table>
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<td>To ensure that the resident understands the procedure and gives his/her valid consent</td>
</tr>
<tr>
<td>2. Adhere to ‘Standard Infection Control Precautions’, page 58 before and after obtaining specimen</td>
<td>Hand cleaning, correct use of PPE and correct disposal of waste greatly reduces the risk or cross-contamination of specimens and others</td>
</tr>
<tr>
<td>3. The ideal time to obtain a specimen of urine is after bathing/showering but this may not always be possible. However, the genital area and bottom need to be clean prior to using the Uricol system. Do not apply creams/talcum powders after washing and drying</td>
<td>To avoid contamination of specimen Use of these products can reduce pad absorbency and contaminate the sample</td>
</tr>
<tr>
<td>4. Place the Uricol pad accurately over the area where the resident passes urine. This will need to be placed inside the usual incontinence pad.</td>
<td>To effectively collect urine</td>
</tr>
<tr>
<td>5. Leave in place for no longer than 30 minutes, checking at 10 min intervals to see if the pad is wet. If no urine has been passed, you MUST dispose of appropriately and start again with a new pad.</td>
<td>To avoid contamination of specimen</td>
</tr>
<tr>
<td>6. When the pad is wet (this needs to be within the 30 minute period detailed above) remove it. If soiled with faeces discard and begin again from step 1.</td>
<td>To avoid contamination of specimen</td>
</tr>
</tbody>
</table>
7. Lay the pad on a hard, flat surface, wet side up. Take the syringe, place the tip of the pad, at an angle of 45° and pull up the plunger to extract urine from the pad.

To extract urine from pad

8. Hold the tip of the syringe over the open sterile container – press plunger down completely to deposit urine. You may need to repeat Step 7 several more times to obtain enough urine for a sample.

To obtain an adequate specimen

‘Red Top’ container MUST be filled to line.

Take care not to contaminate/ touch the container lid. Avoid dribbling urine down side of container.

‘White Top’ container needs minimum of 5mls urine

9. Replace cap and tighten securely. Accurately and clearly label specimen – see page 31. For guidance on completing the laboratory request form see ‘Completed Lab Form Example’, page 34. Important a specimen collected in this way should be described as a ‘pad urine sample’.

To prevent leakage during transportation

To ensure accurate and essential information is shared with lab staff and can be given consideration to when processing specimen

10. Dispose of all waste in the appropriate waste stream (page 62)

To reduce risk of cross contamination

11. Refrigerate specimen, ensuring it is sent to GP within 2 hours.

To ensure best possible conditions for an accurate laboratory result

Developed by Sue Smelt (CHST) from 'Uricol – The Newcastle Urine collector' by Ontex Healthcare UK Ltd
**COMPLETED LABORATORY FORM EXAMPLE**

The Director is committed to providing a service of the highest quality and is registered with the National Accreditation body. For the current accreditation status of individual departments please see: www.cpa.uk.org

**Microbiology / Virology**

<table>
<thead>
<tr>
<th>Surname:</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forename(s):</td>
<td>ANN</td>
</tr>
</tbody>
</table>

- **Date & Time of Collection:** 01/01/1920
- **Post Code:** S12 3AB
- **Tel:** 01234567

**Microbiology / Virology**

1) M, C and S (micro, culture and sensitivity)

OR

2) Pathogens & Virology

**Antibiotic details:** Metronidazole

**Relevant Clinical Details:**

- 1) Offensive smelling urine
- 2) Diarrhoea for 2 days

**Specimen Type:**

- 1) Urine
- 2) Stool

Please state clearly all patient details, name, DOB, NHS number & phone number

Example of how to fill-in a Microbiology Form

- Please state clearly GP name, address & phone number & ensure form is signed.
- Please state clearly ALL patient details, name, DOB, NHS number & phone number

Please state clearly what tests you want completing

Virology at GP’s request or if an outbreak is suspected

If known biohazard, please indicate

State if patient is currently on or recently had antibiotics

State as much information as possible

Please ensure all the GREY areas are completed and ensure legibility. Failure to do so could lead to your request being delayed or NOT being processed.

See overleaf for further details.

- 34 -

Minor Illnesses & Conditions Information Pack for Sheffield Care Homes – 2012
**URINALYSIS FLOWCHART**

Possible signs and symptoms (not all will be apparent at any one time)
- Back/loin pain
- Pain/burning on passing urine
- Nausea/vomiting
- Reduced/loss of appetite
- Drowsyness/generally unwell
- Urgency, frequency, nocturia

Unexplained/worsening confusion? Incontinence/worsening incontinence?
Complete ‘Adult Continence Symptom Profile’, page 38 and follow information


BE AWARE! Resident may be at increased risk of falls due to infection

**Nitrites**
- Negative
  - Not necessary to send a sample to the lab. Contact GP for advice informing of all symptoms/tests
  - Consider other sites/causes of infection
  - Repeat Multistik test if symptoms persist or increase

**Positive**
- Obtain and send MSU or CSU to the lab following information on pages 31/34
- Ensure lab form is correctly completed, see ‘example’ page 34
- Do symptoms require immediate treatment as resident is displaying some of above Signs and Symptoms?
  - Yes
    - Refer to GP and follow ‘Suspected Urinary Tract Infection’ page 28 for management advice
  - No
    - Await results from sample and follow ‘Suspected Urinary Tract Infection’ page 28 for management advice

**ANTIBIOTIC STEWARDSHIP**
Consider past medical history of infection e.g. MRSA, *Clostridium difficile* when treating with antibiotics. Discuss with nurse/GP

### Nitrites, Leucocytes, Blood, Protein

**Drugs that may affect Bladder Function**, page 36 and **Fluid Intake Guide**, page 37

*NB if positive for Glucose refer to GP*
## COMMONLY USED DRUGS THAT MAY AFFECT BLADDER FUNCTION

<table>
<thead>
<tr>
<th>DRUG</th>
<th>USE</th>
<th>EFFECT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol</strong></td>
<td>Diuretic</td>
<td></td>
</tr>
<tr>
<td><strong>Drugs with Antimuscarinic properties</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orphenadrine</td>
<td>Drug induced Parkinsonism</td>
<td>Voiding difficulties</td>
</tr>
<tr>
<td>Trihexyphenidyl (benzhexol)</td>
<td>Nausea, hypersalivation</td>
<td></td>
</tr>
<tr>
<td>Hyoscyamine hydrobromide</td>
<td>Gastro intestinal spasm</td>
<td></td>
</tr>
<tr>
<td>Hyoscyamine butylbromide</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sedating Antihistamines</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.g. chlorphenamine, promethazine</td>
<td>Allergies, hay fever, rashes, travel sickness</td>
<td>Voiding difficulties - reduced awareness of desire to void</td>
</tr>
<tr>
<td><strong>Tricyclic Antidepressants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.g. amitriptyline, imipramine</td>
<td>Depression, neuropathic pain, incontinence</td>
<td>Voiding difficulties</td>
</tr>
<tr>
<td><strong>Calcium Channel Blockers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(smooth muscle relaxants)</td>
<td>Angina, hypertension</td>
<td>Nocturia, increased frequency</td>
</tr>
<tr>
<td>e.g. nifedipine, amlodipine</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diuretics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Loop Diuretics</strong></td>
<td>Hypertension, pulmonary oedema, heart failure</td>
<td>Urinary urgency and frequency Urge incontinence</td>
</tr>
<tr>
<td>Furosemide, bumetanide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-amilofruse</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Thiazides and other diuretics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bendroflumethiazide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indapamide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metolazone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amiloride</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spironolactone</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CNS drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Antipsychotics</strong></td>
<td>Schizophrenia and related psychotic illness; nausea, vomiting; agitation anxiety</td>
<td>Voiding difficulties, decreased awareness</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>Sedation and anxiety</td>
<td>Decreased awareness, impaired mobility</td>
</tr>
<tr>
<td>Promazine</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Benzodiazepines</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nitrazepam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temazepam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorazepam</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non Benzodiazepine Hypnotics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zopiclone</td>
<td>Sedation</td>
<td>As above</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Sedation</td>
<td>As above</td>
</tr>
<tr>
<td>Amylobarbitone</td>
<td>Sedation</td>
<td>As above</td>
</tr>
<tr>
<td><strong>Chloral derivatives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.g. chloral hydrate</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Antidepressants</strong></td>
<td>Depression</td>
<td>Frequency</td>
</tr>
<tr>
<td>Tricyclic antidepressants (see above)</td>
<td>Depression</td>
<td>Voiding difficulties</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>Bipolar disorder</td>
<td>Diuresis</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Antimanic drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lithium</td>
<td>Dementia</td>
<td>Relaxes bladder: incontinence</td>
</tr>
<tr>
<td><strong>Drugs for Dementia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.g. donepezil, rivastigmine</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Opiate analgesics</strong></td>
<td>Pain control, drug abuse</td>
<td>Bladder sphincter spasm causing difficulty in micturition and urge incontinence, constipation</td>
</tr>
<tr>
<td>e.g. diamorphine, morphine, fentanyl, codeine, co-codamol</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Xanthines</strong></td>
<td>COPD</td>
<td>Increased diuresis, aggravates detrusor instability causing urge incontinence</td>
</tr>
<tr>
<td>Theophylline, aminophylline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caffeine (in tea/coffee)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Fluid Intake Guide to determine suggested volume intake per 24 hours

REFERENCE:

<table>
<thead>
<tr>
<th>PATIENT’S WEIGHT</th>
<th>MLS</th>
<th>FLUID Ounces</th>
<th>PINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stones KGS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 38</td>
<td>1,190</td>
<td>42</td>
<td>2.1</td>
</tr>
<tr>
<td>7 45</td>
<td>1,275</td>
<td>49</td>
<td>2.5</td>
</tr>
<tr>
<td>8 51</td>
<td>1,446</td>
<td>56</td>
<td>2.75</td>
</tr>
<tr>
<td>9 57</td>
<td>1,786</td>
<td>63</td>
<td>3.1</td>
</tr>
<tr>
<td>10 64</td>
<td>1,981</td>
<td>70</td>
<td>3.5</td>
</tr>
<tr>
<td>11 70</td>
<td>2,179</td>
<td>77</td>
<td>3.75</td>
</tr>
<tr>
<td>12 76</td>
<td>2,377</td>
<td>84</td>
<td>4.2</td>
</tr>
<tr>
<td>13 83</td>
<td>2,575</td>
<td>91</td>
<td>4.5</td>
</tr>
<tr>
<td>14 89</td>
<td>2,773</td>
<td>98</td>
<td>4.9</td>
</tr>
</tbody>
</table>

This matrix is to be used as a guideline and broadly it is suggested that patients fall within a margin of error of +/- 10% - the guideline applies to body frame and gross obesity should not be taken as a guide for increasing fluid. Activity levels should be taken into account.

NB: during times of ill health and periods of hot weather, or in the very warm care home environment, residents are likely to need increased fluids unless restricted on medical advice.

See Dietitians Information Pack, page 65, for tips about increasing fluid intake.
<table>
<thead>
<tr>
<th>Symptom/Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient have a permanent/intermittent urinary catheter (urethral/ suprapubic)</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient have a stoma (colostomy/ileostomy/urostomy)</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient leak when pressure is exerted on the abdomen i.e. whilst hoisting/ transferring from sitting to standing, laughing, coughing or sneeze</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient only ever leak a little urine</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient always know when they have leaked</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient have a sudden strong urge to pass urine and have to go quickly</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient leak moderate or large amounts of urine before they reach the toilet</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient pass urine frequently</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient have to get up at night to pass urine at least twice</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient have a sudden strong urge to pass urine and have to go quickly</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient leak moderate or large amounts of urine before they reach the toilet</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient only ever leak a little urine</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient always know when they have leaked</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Is the patient aware of the need to empty their bladder</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient frequently have urinary tract infections</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient have to push or strain to pass urine</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient’s urine flow stop and start several times</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Is the patient’s urine stream is weak and slow</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Do you think that the patient has not completely emptied their bladder after going to the toilet</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient leak a few drops of urine just after I have passed urine</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient exhibit signs of pain on passing urine</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient sometimes have blood in the urine</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Can the patient control the passage of wind</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient often pass loose stool</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient leak liquid or solid stool on to their underwear without prior warning</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient have to strain to pass a stool</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient feel a sudden strong urge to pass a stool and have to go quickly</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>When the patient gets a strong urge to pass a stool do they make it to the toilet in time</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Does the patient often not pass a stool for several days</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Is the patient’s stool very hard</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Is there ever any blood/mucus in the stool</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Has the patient’s bowel habits changed over the last 2 months</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Are there any visual signs of rectal prolapse</td>
<td></td>
<td>□</td>
</tr>
</tbody>
</table>
Adult Continence Guidelines:  
Continence Advisory Service  Tel: 0114 271 6852

If ANY symptoms are ticked follow guidelines in white box first then follow the guidelines for each coloured box that has 1 or more ticks (more than 1 box may have ticks)

### URGENCY/URGE INCONTINENCE

1. Follow Urgency/Urge incontinence leaflet, encourage patient/staff to follow advice
2. Assess fluid intake/output via bladder diary for 3 days. observe fluid advice leaflet.
3. Refer to CAS for assessment for possible anti-cholinergic therapy

Provide pads if required  Consider referral to Link Nurse or CAS for joint home visit

### NEUROPATHIC/OUTFLOW OBSTRUCTION

1. Refer to CAS for Bladder scan. Provide pads if required
2. Pain with voiding? Do dip test: if positive do MSU and refer to GP; if no infection present refer to GP and CAS, for joint management.
3. Blood in urine? Refer to G.P immediately

### Bowels

1. Maintain bowel habit diary.
2. If faecal impaction suspected refer to GP and CAS for joint management
3. If passive faecal incontinence suspected refer to CAS for joint management and follow Bowel Care Leaflet + Urgency/Urge Incontinence Leaflet + if able encourage pelvic floor exercises
4. If constipation suspected or rectum is full/partially full follow Constipation guidelines:
   a. Assess dietary/fluid intake: encourage high fibre diet and water intake (fluid matrix chart)
   b. Encourage gentle exercise – immobility makes constipation worse.
   c. Use laxatives, suppositories and enemas as prescribed
5. If rectal prolapse seen refer to GP
6. If any change in bowel habit or blood/mucus in stool refer to GP
7. Provide pads if required
8. Consider referral to CAS for further nursing support

---

Performed urinalysis. If positive, take MSU and send to Microbiology for MC&S

Observe:

- Skin condition: if red use an appropriate barrier cream/spray i.e cavilon, sorbaderm
- If vaginal or rectal prolapse seen at rest/cough refer to GP.
- If the patient is able to tighten pelvic floor muscles: see if lift and puckering can be seen. If patient can be taught exercises, teach/encourage pelvic floor exercises as per leaflet.

1. Note catheter details in catheter care diary/follow care pathway. Any problems? Refer to CAS
2. Note stoma care needs in plan of care and refer to Stoma team

---

STRESS URINARY INCONTINENCE

Observe genital area, if patient cooperative and can understand ask patient to tighten pelvic floor muscles:

- If upward and inward puckering seen then give Pelvic Floor Exercise Leaflet and encourage daily pelvic floor exercises; teach patient to tighten pelvic floor muscles quickly before they sneeze, cough, lift etc to prevent leakage.
- If lift not observed: or cannot be initiated by patient then commence assessment for products/consider referral to continence link nurse within the home and/or continence nurse specialist (CAS)

Please note: Severe leakage is 4 or more times per day (assessed by Bladder Diary).

Only provide pads for severe leakage.
BLADDER DIARY – Continence Advisory Service

It is important that you fill in this form to help us to understand the problems you are having with your bladder.

The white box is for the amount you drink. Record how much you drink in the white box nearest to the time you had your drink. Do this by measuring the fluid in your glass and mug by using a jug and recording this in millilitres. **Glass =** [Mug =]

The grey box is for you to measure when you pass urine. Best practice is to measure the volume but if you are unable to do this put an **X** in the grey box nearest to the time you went to the toilet.

If you are wet, please put damp = **D**, wet = **W** or saturated = **S** in the blue box at the time you leaked. Please record even small wets.

**URGE** write a U in the wet column when you feel a strong urge that is difficult to ignore.

**Please note down the following on your chart overleaf:**

When did you go to bed and get up? Indicate the time in the box at the bottom of the page.

When did you change your pad? Indicate with Pad or (P) in the Wet column.

How did you get to the toilet? Indicate in the comments space at the bottom of the page.

**Example:**

<table>
<thead>
<tr>
<th></th>
<th>Day 1</th>
<th></th>
<th></th>
<th>Day 2</th>
<th></th>
<th></th>
<th>Day 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time</strong></td>
<td>In</td>
<td>Out</td>
<td>Wet</td>
<td>In</td>
<td>Out</td>
<td>Wet</td>
<td>In</td>
<td>Out</td>
</tr>
<tr>
<td>7.00</td>
<td>200ml</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>300mls</td>
</tr>
<tr>
<td>8.00</td>
<td>200ml</td>
<td>100mls</td>
<td>Pad</td>
<td>200ml</td>
<td></td>
<td></td>
<td>100ml</td>
<td></td>
</tr>
<tr>
<td>9.00</td>
<td>200ml</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>Wet</td>
<td></td>
<td>W</td>
</tr>
</tbody>
</table>
### Continence Advisory Service - Bladder diary

**Name**………………………………...**DOB**……………………**NHS no**……………………

<table>
<thead>
<tr>
<th></th>
<th><strong>Start Date:</strong></th>
<th><strong>Day 1</strong></th>
<th><strong>Day 2</strong></th>
<th><strong>Day 3</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>In</td>
<td>Out</td>
<td>Wet</td>
<td>In</td>
</tr>
<tr>
<td>7.00 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.00</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9.00</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.00 noon</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.00 pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.00</td>
<td></td>
<td></td>
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<tr>
<td>3.00</td>
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<tr>
<td>4.00</td>
<td></td>
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</tr>
<tr>
<td>5.00</td>
<td></td>
<td></td>
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<tr>
<td>6.00</td>
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<td>7.00</td>
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<td>8.00</td>
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<td>9.00</td>
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<tr>
<td>10.00</td>
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<tr>
<td>11.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.00 midnight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.00 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.00</td>
<td></td>
<td></td>
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<td>Time to bed</td>
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</table>

**Comments**

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Minor Illnesses & Conditions Information Pack for Sheffield Care Homes – 2012 - 41 -
| **Sheffield’s Integrated Continence Services**  
<table>
<thead>
<tr>
<th>- Adult continence assessment form for Care Home residents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRINT:</strong></td>
</tr>
<tr>
<td>Mr, Miss, Mrs, other <em>(please circle)</em></td>
</tr>
<tr>
<td><strong>Patient’s first name</strong></td>
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<tr>
<td><strong>Surname</strong></td>
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<td><strong>DOB</strong></td>
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<td><strong>NHS Number</strong></td>
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<td><strong>Address</strong></td>
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<td><strong>POST CODE</strong></td>
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<tr>
<td><strong>TELEPHONE</strong></td>
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<tr>
<td><strong>District Nurse Base</strong> <em>(If applicable)</em></td>
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<tr>
<td><strong>GP Surgery</strong></td>
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<td><strong>Next of Kin</strong></td>
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<td><strong>Name</strong></td>
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<td><strong>Address</strong></td>
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<td><strong>Tel No</strong></td>
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<tr>
<td><strong>How often do they visit?</strong></td>
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<tr>
<td><strong>Any other family support?</strong></td>
</tr>
<tr>
<td><strong>What are the patient’s medical problems?</strong></td>
</tr>
<tr>
<td><strong>If diabetic is their diabetes well controlled</strong></td>
</tr>
<tr>
<td><strong>ALLERGIES</strong></td>
</tr>
<tr>
<td><strong>What are the patient’s continence symptoms?</strong></td>
</tr>
<tr>
<td><strong>About treatment: what are you doing to improve the symptoms prior to ordering pads?</strong></td>
</tr>
</tbody>
</table>

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Minor Illnesses & Conditions Information Pack for Sheffield Care Homes – 2012 - 42 -
<table>
<thead>
<tr>
<th>Urinalysis results</th>
<th>Result</th>
<th>Initial</th>
<th>Date</th>
<th>Result</th>
<th>Initial</th>
<th>Date</th>
<th>Result</th>
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<tbody>
<tr>
<td>GLUCOSE</td>
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<td>LEUCOCYTES</td>
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</table>

Document reason if not able to do urinalysis (consider using uricol urine collection system)

Document colour, clarity, odour:

**GUIDELINES**

<table>
<thead>
<tr>
<th>Date</th>
<th>Initial</th>
<th>VARIANCE FROM GUIDELINES AND REASON / COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

How many drinks ______ cups/mugs of fluid per 24 hours. What type of fluid.
Weighs _____ stones/kg
document any recent weight loss (intentional/unintentional)

If patient drinks volumes outside parameters of fluid guidelines, document what they should be drinking.

Document normal dietary intake e.g. breakfast, lunch, tea and fibre intake.

Bowel habits.
Document Bristol stool form.
Frequency, volume and straining.

Has a Bladder and/or Bowel Diary been completed.
If not document reason.

Document pressure area, genital area visual observation/skin assessment findings (reason for non-consent obtained)
## GUIDELINES

<table>
<thead>
<tr>
<th>Current medication</th>
<th>Date</th>
<th>Initial</th>
<th>VARIANCE FROM GUIDELINES AND REASON / COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the counter</td>
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<tr>
<td>Breathing: smoking status COPD/asthma. Oxygen.</td>
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<tr>
<td>Pain needs: has the patient expressed any pain, how well is the pain controlled.</td>
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<tr>
<td>Sleep and rest needs: any problems sleeping, where do they sleep? Any sleep medication administered at night</td>
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<tr>
<td>Personal needs: do they require any support with washing and dressing?</td>
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<tr>
<td>Communication: Hearing aid/glasses. Can they express their wishes?</td>
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<tr>
<td>Document any mobility, dexterity problems. Any moving and handling needs. Document any history of falls in the last 6 months</td>
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<tr>
<td>Home environment: are there any issues within the home that affect the patient</td>
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<tr>
<td>Social needs: any cultural needs.</td>
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<td>GUIDELINES</td>
<td>Date</td>
<td>Initial</td>
<td>VARIANCE FROM GUIDELINES AND REASON / COMMENTS</td>
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<td>---------------------------------------------------------------------------</td>
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<tr>
<td>Document information leaflet given as indicated continence guidelines. To either patient or relative</td>
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<tr>
<td>Document type of pad previously purchased and how many used or other product e.g. sheath, catheter etc.</td>
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<tr>
<td>Document type of pad product requested to trial. Document sitting hip and waist measurements.</td>
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<td>Note: pads must not be ordered unless products have been tried and found to be appropriate.</td>
</tr>
<tr>
<td>Document that assessing nurse has informed patient/carer that their details may be passed on.</td>
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</table>

Provide mail order information if quantities requested are over the daily allowance to relatives.

Observations: BP _______ Pulse _______ Respiration _______ Temp _______.

Blood glucose level: _____________________________

Referred on to: _______________________________________________________________________________

_____________________________________________________________________________________________

TO BE COMPLETED BY ALL STAFF USING THE PATHWAY

SIGN TO CONFIRM THAT YOU HAVE MET ALL STANDARDS OR RECORDED VARIANCES

<table>
<thead>
<tr>
<th>FULL NAME</th>
<th>DESIGNATION</th>
<th>INITIALS</th>
<th>SIGN</th>
<th>DATE</th>
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</table>
**ADULT JOINT VISIT REFERRAL FORM**

<table>
<thead>
<tr>
<th>Surname</th>
<th>Title</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Forename(s)</th>
<th>DOB</th>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Telephone No:</th>
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<thead>
<tr>
<th>GP Name and Base</th>
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<thead>
<tr>
<th>Telephone No.</th>
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**Referral Made By**

<table>
<thead>
<tr>
<th>Place of Work</th>
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<tr>
<th>Telephone No.</th>
<th>Mobile:</th>
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<th>Base Fax No.</th>
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**Relevant Information**

<table>
<thead>
<tr>
<th>Continence Details</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Current Medication and Diagnosis</th>
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</table>

Please fax full continence assessment with this referral
Suspected Constipation

‘Normal’ bowel actions can vary between 3 times daily to 3 times weekly, and should resemble Stages 3 - 4 on ‘The Bristol Stool Chart’, see page 55. Bowel habits should be monitored and documented as routine.

<table>
<thead>
<tr>
<th>Question</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the resident vomiting, in severe pain or passing blood or mucous from the rectum?</td>
<td>Contact GP</td>
</tr>
<tr>
<td>New episode of altered bowel habit for any reason? Changes to usual diet/fluid intake?</td>
<td>See ‘Medicines associated with Constipation’, page 54</td>
</tr>
<tr>
<td>Are laxatives/enemas being taken as prescribed?</td>
<td>Doctor to review medication</td>
</tr>
<tr>
<td>Still problematic after 2-3 days? Contact GP or DN for bowel care assessment/management</td>
<td></td>
</tr>
</tbody>
</table>

Action required:
- Increase fluids unless usually restricted on medical advice, see ‘Dietitian Information Pack’ page 65, and ‘Fluid Intake Guide’ page 37
- Encourage mobility/independence if appropriate
- Increase fruit and fibre – see ‘Fibre Scoring Sheet’, page 53 and ‘What Is Constipation?’ page 51
- Commence ‘Stool Chart’ page 56 for one week, and complete ‘Adult Continence Symptom Profile’, page 38
- Refer residential client to DN team
- Nursing home nurse perform Digital Rectal Examination and act accordingly

NB – loose stools, and/or smearing of underwear with faeces can be a sign of constipation which can result in ‘overflow’. If in doubt refer to DN, GP or Continence Service (Tel 271 6837) Use the ‘Bristol Stool Chart’ as a guide, page 55

Contact the Continence Service, Tel: 0114 271 6837 for training dates/information
DIARRHOEA AND / OR VOMITING

Diarrhoea (see ‘Bristol Stool Chart’, page 55) and vomiting often occur together, but may appear separately. All cases of diarrhoea and/or vomiting should be regarded as infectious, until confirmed / disproved by Microbiology results. Refer immediately to: ‘Infection Prevention & Control Contact Information for Care Homes in Sheffield’ – page 50

Is the resident complaining of:
- Frequent and loose stools?
- Generally unwell?
- Abdominal pain?
- Temperature?
Not all symptoms will be apparent at any one time.

Could the diarrhoea be related to:
- medication – e.g. antibiotics
- existing conditions e.g. irritable bowel syndrome
- change of diet

Obtain and send specimen giving full details see page 34

Refer to Infection Prevention & Control Contact Information Sheet – page 50
Try to minimise spread of infection by:
- Adherence to ‘Standard Infection Control Precautions’, page 58 - obtain ‘faeces specimen’ using information page 57
- Commence Intake/Output Chart (via ‘Bladder Diary’ page 40 ) and food chart
- Commence ‘Stool Chart’, page 56
- Offer small amounts of clear fluids at frequent intervals. Start with sips of fluid, and when symptoms subside slowly increase the quantity
- Seek advice if resident is diabetic, i.e. about diet and insulin or medication administration
- Give oral care every 4-6hrs
- Once resident feels able to eat offer small amounts of bland foods e.g. bread, pasta etc

Phone GP for advice

NO

YES

Is the resident complaining of:
- Blood/mucous in their stools?
- Vomiting blood?
- Acute abdominal pain?

Contact GP and request visit as a matter of urgency.

Is the resident complaining of:
- Frequent and loose stools?
- Generally unwell?
- Abdominal pain?
- Temperature?
Not all symptoms will be apparent at any one time.

Could the diarrhoea be related to:
- medication – e.g. antibiotics
- existing conditions e.g. irritable bowel syndrome
- change of diet

Obtain and send specimen giving full details see page 34

Refer to Infection Prevention & Control Contact Information Sheet – page 50
Try to minimise spread of infection by:
- Adherence to ‘Standard Infection Control Precautions’, page 58
- Follow advice in ‘Health Protection Unit Policy for Management of Outbreaks of Infectious Diarrhoea and Vomiting in Nursing and Residential Homes’, Appendix A

In addition:
Keep resident comfortable, and exclude from group activities until symptom free for 48 hours.
Monitor carefully for signs of dehydration – see ‘Dietitian Information Pack’, page 65 (Urine Specific gravity above 1.020 may indicate this).

Monitor residents, staff and visitors for signs and symptoms - REMEMBER the definition of an OUTBREAK is 2 or more persons affected.
If you suspect a resident / patient has an infection: (refer to Minor Illnesses and Conditions Information Pack to help you)

The GP will be the first point of contact.

For more information about training and education on Infection Prevention and Control contact:
Care Homes Support Team: 0114 3054109

<table>
<thead>
<tr>
<th>Resident’s status</th>
<th>Type of info/Time of day</th>
<th>In hours routine advice - for example: Mon–Fri 0900 – 1700</th>
<th>In hours outbreak management and support *</th>
<th>Out of hours outbreak management and support *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>If infection is suspected contact patient’s own GP</td>
<td>South Yorkshire Health Protection Unit (SYHPU) - 0114 2428850</td>
<td>SYHPU – 0114 2428850</td>
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<td>If additional information is required contact the Care Homes Support Team 0114 3054109</td>
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<tr>
<td>Residential</td>
<td>If infection is suspected contact patient’s own GP</td>
<td>SYHPU – 0114 2428850</td>
<td>SYHPU – 0114 2428850</td>
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<tr>
<td></td>
<td>If additional information is required contact the Care Homes Support Team 0114 3054109</td>
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</tr>
<tr>
<td>Patients in Intermediate Care beds</td>
<td>If infection is suspected contact the patient’s GP (or this may be the GP responsible for Intermediate Care Beds). For additional advice or information contact the Community Infection Prevention &amp; Control Team on 0114 226 1971.</td>
<td>Community Services Intermediate Care Modern Matron 0114 2261972. Please also inform the SYHPU of the outbreak, as a matter of courtesy should they be required to provide advice out of hours.</td>
<td>SYHPU – 0114 2428850</td>
<td></td>
</tr>
</tbody>
</table>

* Please also refer to Minor illnesses & Conditions Information Pack, HPA DVD, HPA CD, Home Policies/Procedures etc
What is constipation?

A person is constipated when they pass stool less than 3 times per week, or if there is often a need to strain to pass stool (usually hard stool).

Constipation is not harmful in itself, but it can be very uncomfortable, and as a result of chronic (long-term) constipation, you may develop one or more of the following conditions:

- Haemorrhoids (piles) – small swollen blood vessels in the back passage, which can bleed occasionally
- Fissure – split in the back passage which may bleed and or / is painful when passing stool
- Rectal prolapse – the lining of the rectum falls down through the back passage

Some factors may make constipation worse:

- lack of fibre in diet
- poor fluid intake
- certain medications (ask your nurse)
- poor bowel habits (for example straining)
- shift work
- immobility
- change of diet/environment
- ignoring the need to open your bowels
- emotional upsets

When should I seek medical advice?

Constipation is a common problem and most bowel disorders are minor, but some are more serious.

Always seek advice from your doctor when:

- you have a sudden and unexplained change in bowel habit that lasts for more than a few weeks and does not return to normal.
- you bleed from the back passage
- you have unexplained weight loss
- you feel very tired
What can I do about it?

• You can talk about your problem. Don’t be embarrassed – remember, doctors, nurses and physiotherapists are trained to deal with such problems.

• Take PRIDE in your bowels!
  P  Privacy and space will help you to relax. Try not to strain, and don’t sit on the toilet for long periods.
  R  Regularity is important, but don’t worry if you’re not one of those people who empty their bowel every day.
  I  Ignore your bowels at your peril! If you put off opening your bowels too often you can make yourself constipated.
  D  Do some exercise. Regular exercise can help your bowel to work better
  E  Eat and drink properly. Have regular meals, with plenty of fibre (fruit and veg), and drink lots of water.

• If you take medication, check with your pharmacist or doctor whether these could be affecting your bowel habit.

Where to get more information?
Your local General Practitioner, Health visitor, or district nurse.
# FIBRE SCORING SHEET

Rate your diet for fibre

Pick the foods you eat at home and find your score:

<table>
<thead>
<tr>
<th>SCORE</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Write your score here</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOOD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BREAD</td>
<td>White</td>
<td>Brown</td>
<td>Wholemeal/Granary</td>
<td></td>
</tr>
<tr>
<td>BREAKFAST CEREAL</td>
<td>Rarely or never eat or eat sugar coated cereal e.g. Frosties</td>
<td>Corn Flakes Rice Krispies Cheerios Special K</td>
<td>Bran Flakes Weetabix Shredded Wheat Muesli Shreddies</td>
<td></td>
</tr>
<tr>
<td>POTATOES PASTA RICE</td>
<td>Rarely or never eat</td>
<td>Eat potatoes, white rice or pasta most days</td>
<td>Eat potatoes in jackets, brown rice or pasta most days</td>
<td></td>
</tr>
<tr>
<td>PULSES BEANS NUTS</td>
<td>Rarely or never eat</td>
<td>Once a week or less</td>
<td>Three times a week or more</td>
<td></td>
</tr>
<tr>
<td>VEGETABLES ALL KINDS OTHER THAN PULSES, POTATOES AND BEANS</td>
<td>Less than once a week</td>
<td>1 – 3 times per week</td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>FRUIT ALL KINDS</td>
<td>Less than once a week</td>
<td>1 – 3 times per week</td>
<td>Daily</td>
<td></td>
</tr>
</tbody>
</table>

**YOUR TOTAL SCORE:**

### Score Guide

- 0 – 12: Increase your fibre
- 13 – 17: Good
- 18: Excellent
## Medicines associated with constipation

<table>
<thead>
<tr>
<th>Aluminium antacids</th>
<th>Calcium supplements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aluminium hydroxide</td>
<td>Calcium salts (BNF 9.5.1.1)</td>
</tr>
<tr>
<td></td>
<td>Calcium with vitamin D</td>
</tr>
<tr>
<td></td>
<td>e.g. Adcal-D3®</td>
</tr>
</tbody>
</table>

### Anti-muscarinics
- Hyoscine
- Oxybutynin
- Tolterodine
- Solifenacin
- Trospium

### Inhaled Anti-muscarinics
- Ipratropium bromide
- Tiotropium

### Anti-epileptics
- Carbamazepine
- Gabapentin
- Pregabalin

### Anti-depressants
- Amitriptyline
- Imipramine
- Nortriptyline
- Lofepramine
- Venlafaxine
- Fluoxetine
- Citalopram
- Sertraline

### Proton Pump Inhibitors
- Lansoprazole
- Omeprazole

### Anti-Parkinson
- Orphenadrine
- Trihexyphenidyl (benzhexol)
- Procyclidine

### Antipsychotics
- Chlorpromazine
- Haloperidol (less likely)
- Perphenazine (less likely)
- Promazine
- Trifluoperazine (less likely)
- Risperidone

### Diuretics
- Bendroflumethiazide
- Indapamide
- Co-amilofruse
- Furosemide
- Bumetanide
- Amiloride
- Spironolactone
- Co-amilozide

### Calcium Channel Blocker
- Verapamil

### Iron tablets
- Ferrous sulphate
- Ferrous fumarate
- Ferrous gluconate

### Opiates
- Morphine
- Buprenorphine
- Codeine
- Co-codamol
- Dihydrocodeine
- Fentanyl
- Methadone
- Tramadol

### Bone metabolism
- Alendronate
- Risedronate
## Bristol Stool Chart

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>Separate hard lumps, like nuts (hard to pass)</td>
</tr>
<tr>
<td>Type 2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>Type 3</td>
<td>Like a sausage but with cracks on its surface</td>
</tr>
<tr>
<td>Type 4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>Type 5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>Type 6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>Type 7</td>
<td>Watery, no solid pieces. Entirely Liquid</td>
</tr>
</tbody>
</table>

Developed by Heaton & Lewis at the University of Bristol (1997)
Date ........................................
Patient’s name.................................................................
NHS number................................................................. Ward or department.........................................................

## STOOL CHART

<table>
<thead>
<tr>
<th>Time</th>
<th>Bristol stool chart type</th>
<th>Volume</th>
<th>Blood present?</th>
<th>Mucus present?</th>
<th>Pain?</th>
</tr>
</thead>
<tbody>
<tr>
<td>01:00</td>
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<td>02:00</td>
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<td>23:00</td>
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<tr>
<td>24:00</td>
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<td></td>
</tr>
</tbody>
</table>
Faeces Specimen Collection - Important Information

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain and discuss the procedure with the resident ensuring privacy and dignity are upheld while the procedure is being carried out.</td>
<td>To ensure that the resident understands the procedure and gives his/her valid consent.</td>
</tr>
<tr>
<td>2. Adhere to ‘Standard Infection Control Precautions’, page 58 before and after obtaining specimen.</td>
<td>Hand cleaning, correct use of PPE, and correct disposal of waste greatly reduces the risk of cross contamination, of specimen and others.</td>
</tr>
<tr>
<td>3. On completion of procedure, place specimens in appropriate, correctly labelled containers – refer to ‘Completed Laboratory Form Example’, page 34.</td>
<td>To ensure accurate and essential information is shared with laboratory staff, and can be considered when processing specimen.</td>
</tr>
<tr>
<td>4. If possible, ask the resident to empty bowels into a clinically clean bedpan/commode pan or disposable container placed in bottom of either of these.</td>
<td>To avoid unnecessary contamination.</td>
</tr>
<tr>
<td>5. Scoop enough stool to fill a third of the specimen container using the spoon, incorporated in the specimen container, secure the lid.</td>
<td>To obtain a usable amount of specimen. To prevent contamination.</td>
</tr>
<tr>
<td>6. Examine the specimen for such features as colour, consistency odour, blood, mucous etc and record your observations. Refer to ‘Bristol Stool Chart’, page 55.</td>
<td>To establish a ‘base’ and monitor for improvement/deterioration.</td>
</tr>
<tr>
<td>7. Disposal of all waste in the appropriate waste stream (page 62)</td>
<td>To reduce risk of cross contamination</td>
</tr>
<tr>
<td>8. Send specimen to GP within 2 hours, with the completed request form.</td>
<td>To ensure the best possible conditions for any laboratory examinations</td>
</tr>
</tbody>
</table>

Adapted by Sue Smelt (CHST) from the Royal Marsden Hospital Manual of Clinical Nursing Procedures
Date 2008
Standard Infection Control Precautions

Adhering to standard infection control precautions is a fundamental component of safe practice. It is also a legal requirement, as described in The Health and Social Care Act 2008, Code of Practice for health and adult social care on the prevention and control of infections and related guidance (Department of Health 2010). Furthermore, this aspect of care is being assessed by the regulator, the Care Quality Commission.

These precautions should be applied at all times, for all staff and all residents. The key principles are:

1.0 Hand hygiene - is the adoption of an effective hand decontamination (cleaning) technique prior to contact with a resident/client and between clean & dirty tasks. Alcohol handrub for hand decontamination should be provided in areas which do not have ready access to a wash hand basin or where rapid decontamination of physically clean hands is required. To help healthcare staff understand the precise moments when they need to clean their hands and why, the National Patient Safety Agency endorses the World Health Organisation ‘Your Five Moments for Hand Hygiene’, see page 61.

1.1 ‘Methods of Hand Hygiene’: see poster, page 63 for correct methods of cleaning hands

i) Alcohol handrub - is the recommended product in all routine patient care situations when hands are visibly clean. However it must not be used when any of the following apply:
   - Hands are visibly dirty or soiled
   - There is an outbreak of Norovirus, Clostridium difficile or other diarrhoeal illness
   - The resident/client is experiencing vomiting and/or diarrhoea
   - There has been direct hand contact with bodily fluids ie: if gloves have forgotten to be worn

ii) Hand washing – is by using liquid soap and running water. Wet hands prior to applying the soap and ensure all areas are washed thoroughly. Rinse the soap off completely under running water to remove all residual soap and dry hands thoroughly using disposable paper towels, see page 63 for correct technique.

1.2 Broken skin – cuts and abrasions on the hands and forearms of staff should be covered with a waterproof dressing at all times. Staff who have moist lesions on their hands such as eczema or psoriasis should contact their GP and inform their manager.

2.0 Personal Protective Equipment (PPE)

PPE is required if there is the possibility of direct contact with blood and body fluids. PPE includes single use disposable gloves, disposable plastic apron and eye protection, which must be disposed of in the most appropriate waste stream, see ‘Safe Management of Healthcare Waste’ page 62.
The use of gloves is not an alternative to effective hand hygiene, which should be carried out before applying and following glove removal. Disposable gloves are single use items and must be discarded appropriately after each use or procedure.

3.0 Sharps Management – used needles, blades and other sharp instruments must be placed immediately into a rigid sharps container which conforms to British and European Standards. Never re-sheath, bend or break needles. Discard used needle and syringe as one item directly into the sharps bin. Ensure bins are correctly assembled and that the relevant documentation is completed on the label on the front of the bin. Never fill a sharps container above the ‘fill line’ and always use the temporary closure mechanism located on the lid when not in use. Ensure that the bin is securely locked before disposal and ensure documentation is completed – see poster, page 64. It is recommended that ‘staff who may have direct contact with patient’s blood or blood stained body fluids or with patient’s body tissues should be immunised against Hepatitis B’ (Department of Health 2006). Criterion 10 in the Health & Social Care Act requires registered providers to ensure that care workers are ‘protected from exposure to infections that can be caught at work and risk assessment undertaken regarding same – see ‘Immunisation against infectious disease (‘The Green Book’) DOH, 2006.

4.0 Spillages – In some settings, management of spillages will be compromised by the presence of items such as carpets and fabric upholstery. Spillages must be cleaned up safely and as soon as possible, as they are a potential source of infection to others. Appropriate PPE should always be worn when dealing with spillages and the area kept well ventilated. All used items and materials should be discarded in the appropriate waste stream (see 5.0) and hand washing performed after dealing with any type of spillage. Always refer to COSHH regulations for safe handling of any products.

4.1 A number of companies produce spillage kits which are designed to help staff manage a range of spillages. The kits can be purchased to effectively deal with a range of substances including blood, urine and vomit. Additionally they contain all the items required to undertake the cleaning procedure such as disposable gloves, aprons, scoop, waste bag etc.

4.2 Blood spillage - should be treated with a chlorine containing product, mixed to a concentration of 10,000 parts per million e.g: Milton tablets 2% - always check product information for mixing details.

Vomit / urine spillage – as above with chlorine product in a concentration of 1,000 parts per million.

NB – Using chlorine on urine/vomit spills may cause a chemical reaction resulting in the release of chlorine vapour, which is a toxic fume. Ensure the area is well ventilated e.g. open the room window.

4.3 The use of chlorine solutions on carpets and fabrics can cause damage beyond repair, therefore use of chlorine in such circumstances must be avoided (always check manufacturers cleaning instructions). In these cases soak up as much of the spillage as possible using kitchen/paper roll and discard appropriately (5.0). Clean the area with hot water and detergent, followed by drying with paper towels. During next refurbishment, consider replacing carpets and fabrics with items that will withstand cleaning with chlorine based products, of up to 10,000 parts per million.

5.0 Healthcare waste management – In Sheffield Primary and Community Services Care Group, waste is now segregated into the new colour-coded waste streams which are, household (black), offensive (yellow with black stripe – known as a tiger bag), infectious (orange) and body parts (yellow). Please refer to your Waste Contractor for guidance on current waste disposal for your place of work (ie: the company who collects your waste from your premises.) It is the responsibility of the healthcare worker to dispose of any waste in the appropriate stream. Wastes bags should never be more than two thirds full and must be securely tied. Waste bags from different streams should not be stored together, as cross-contamination can occur, see poster, page 62.

6.0 Linen – The provision of clean linen is a fundamental requirement of care. Incorrect handling, laundering and storage of linen can pose an infection hazard. All dirty and used linen must be handled with care and appropriate PPE worn by the healthcare worker. Linen should be removed from a resident’s/ client’s bed with care, avoiding the creation of dust and placed into the appropriate colour-coded category.
Linen should be divided into basic categories such as:
- used linen/clothing
- heavily soiled/infected linen
- clothing/heat-labile (heat labile linen includes any fabric that the normal heat disinfection process and high temperatures could damage - check the manufacturer’s washing instructions).

An alginate bag is a bag used for heavily soiled or infected linen. The bag dissolves away when in contact with water. Very wet linen can start the dissolving process from the inside, therefore, the colour-coded alginate bag should be placed inside the appropriate colour-coded plastic bag before placing into the colour coded cotton laundry sack. This is to prevent cross-contamination of linen and to protect the healthcare worker and the laundry personnel during transportation and the laundering process.

7.0 Medical devices & equipment – ensure all equipment is decontaminated following the manufacturers guidelines. For normal cleaning use a suitable detergent mixed with hot water or a detergent wipe. For equipment or devices used on a resident with a known risk of infection, or when the contaminant is a body fluid e.g. vomit, ensure that detergent cleaning is followed by disinfection with a chlorine containing product prepared to a concentration of 1,000 parts per million. If contaminated with visible blood, clean with detergent followed by a chlorine containing product mixed to 10,000 parts per million.

8.0 References:
Department of Health (2006) Immunisation against infectious diseases

9.0 Related Health Policies:
Standard Infection Control Precautions
Healthcare waste management
Personal Protective Equipment
Blood and body fluid spillage management
Safe disposal of sharps and management of contaminated injuries
Decontamination of medical devices and equipment

Authors: Katie Grayson, Diane Allender, Nikki Littlewood and Sue Smelt
Date: January 2012
Next review: January 2014

For Further information about auditing IP&C practices in your home see the Infection Prevention Society Quality Improvement Tool Care Setting Process Improvement Tool: Care Homes (2011)
1. **BEFORE PATIENT CONTACT**

   **WHEN?** Clean your hands before touching a patient when approaching him/her
   **WHY?** To protect the patient against harmful germs carried on your hands

2. **BEFORE AN ASEPTIC TASK**

   **WHEN?** Clean your hands immediately before any aseptic task
   **WHY?** To protect the patient against harmful germs, including the patient’s own, from entering his/her body

3. **AFTER BODY FLUID EXPOSURE RISK**

   **WHEN?** Clean your hands immediately after an exposure risk to body fluids (and after glove removal)
   **WHY?** To protect yourself and the healthcare environment from harmful patient germs

4. **AFTER PATIENT CONTACT**

   **WHEN?** Clean your hands after touching a patient and his/her immediate surroundings when leaving the patient’s side
   **WHY?** To protect yourself and the healthcare environment from harmful patient germs

5. **AFTER CONTACT WITH PATIENT SURROUNDINGS**

   **WHEN?** Clean your hands after touching any object or furniture in the patient’s immediate surroundings when leaving – even if the patient has not been touched
   **WHY?** To protect yourself and the healthcare environment from harmful patient germs

Adapted from WHO World Alliance for Patient Safety 2006
Safe Management of Healthcare Waste (General).

- San Pro, Nappy & non Infectious Clinical Waste
- Medically Assessed as Infectious Waste (Including heavily blood soiled dressings)
- Offensive Waste collection (Yellow & Black Striped Bag)
- Infectious Waste collection (Orange Bag)
- Household Waste (Including paper towels, gloves etc)
- Household Waste collection (Black Bag)
How to handwash?
WITH SOAP AND WATER
0. Wet hands with water
1. Apply enough soap to cover all hand surfaces
2. Rub hand with water
3. Use soap to wash from指尖 to wrist
4. Rub water on all surfaces
5. Dry hands

How to handrub?
WITH ALCOHOL HANDBRUB
1a. ```
```

Hand cleaning techniques

Rub hands palm to palm
Rub each thumb clasped in opposite hand
Rub tips of fingers in opposite palm
Rub with palm of fingers on fingertips
Rub with palm of fingers on the palm
Rub back of each hand with the palm of other hand
Rub hands palm to palm once dry, your hands are safe

Adapted from WHO Global Alliance for Patient Safety 2006

Minor Illnesses & Conditions Information Pack for Sheffield Care Homes – 2012
WASTE DISPOSAL POLICY

SHARPS
Contaminated with Cytotoxic/cytostatic waste

Complete identification label prior to disposal

Store separately. Arrange collection according to local policy

SHARPS
Contaminated with medicinal waste (NOT cytotoxic/cytostatic)

Complete identification label prior to disposal

Store separately. Arrange collection according to local policy

CLINICAL WASTE

Ensure bags are securely tagged and labelled with point of origin

DOMESTIC WASTE

www.daniels.co.uk
Dietitian’s Information Pack

Hydration Information
Constipation Management
Dementia: Feeding Tips

Adapted from Sheffield Teaching Hospitals NHS Trust
Original produced by Sheffield Dietitians August 2004
Hydration Information

Identification

Is the resident dehydrated or at risk of becoming so?

Normal fluid requirements are about **8 cups** of non-alcoholic fluids a day – **note** - alcohol and caffeinated drinks can be dehydrating!

Fluid dehydration is common among older people.

**Look for common signs:**

- Thirst
- Eyes appear sunken
- Loss of strength
- Onset of apathy
- Swallowing food can be difficult
- Dry skin because perspiration secretion is reduced and the skin loses its turgor
- Saliva production is reduced to make the mouth and tongue dry and uncomfortable
- Clarity of speech may be affected due to dry mucous membranes
- Dizziness
- Decreased urine output
- Constipation
- Confusion-change in mental state

**Other contributing factors or indicators are:**

- UTI in past 30 days
- Weight loss - 2 to 3 lb in last 7 days
- Vomiting or diarrhoea or loose stools
- Over last 3 days, beverages offered but not consumed, or large volume remaining
- Fever
- Recent increase or addition of diuretics
Is the resident suffering the following consequences?

- Decreased ability and mobility
- Predisposition to falls and infections
- Faecal impaction

Try to identify the cause of risk of dehydration, for the resident for example:

- Lack of sense of thirst
- Short-term memory problems
- Increasing difficulty with physically feeding self and decreased ability to access own fluids
- Fear of incontinence
- Ability to access toilet or commode
- Recent change in mobility
- Recent additional medication, diuretics or laxatives
- Unnecessary restriction of fluid
- Hot weather and regular exposure to sunlight
Hydration management: Fluid content of foods:

Aim for 6 - 8 cups per day being at least 200mls - some of this could be provided by the foods eaten (see guidelines below).

Soup bowl – 200mls (1 cup)

Stews, casseroles, gravy (1/4 cup – 50mls)

Ice cream, yogurt, trifles (1/4 cup – 50mls)

Milk puddings (1/2 cup – 100mls)

Custard (1/2 cup – 100mls)

Monitor residents fluid intake over the next 24 hours if no improvement within this time; - Alert GP and community nursing team (if appropriate) if management plan does not improve fluid input.
Hydration Management Plan

- Identify residents’ preferences for beverages
- Make sure this beverage is available at scheduled time, within reach and in an appropriate cup
- Provide assistance to those who need help
- Include family and friends in the plan
- Include toileting routine
- Encourage foods with high fluid content (especially if the patient regularly refuses drinks but will eat food). These include soup, stews and casseroles, tinned fruit in juice and cream, ice cream, yogurt, milk puddings, trifles. Add extra gravy, sauces, or custard where possible.
- If the resident prefers sucking items to drinking fluids in order to refresh the mouth, use ice cubes (made from water or squash). Use orange slices, lemon segments or chopped apple soaked in fruit juice.
- Set a routine. Aim for a minimum of 6 drinks (preferably 8 drinks) a day. Encourage drinks at these times:
  - Before breakfast or early morning
  - Between meals (mid morning and mid afternoon)
  - Bedtime (= 4)
  - Cold beverages during the meal and additional starter of fruit juice at each meal (small glass) (= 1 - 2 drinks)
- Make cold beverages more interesting by adding fruit to fruit juices (fruit punch) and chill with ice cubes (especially if resident is a slow drinker).
- Use nourishing fluids. For example milkshakes made by kitchen staff and stored for a day in fridge in dining room if poor food intake as well.
Constipation Management

Is the resident’s food and fluid intake poor?

**Fluid**

Is resident drinking 8 cups of non-alcoholic fluid? If no, refer to hydration management and encourage an increase in drinks and fluid containing foods.

Is resident eating enough fibre foods? Use the diet quality checklist.

**Foods**

Encourage residents to choose high fibre foods as outlined below.

**Breakfast**

Grapefruit or prunes
Porridge, Weetabix – add dried fruit, stewed fruit or prunes
Wholemeal bread or toast

**Main Meal**

Choose vegetables, potatoes with meal
Fruit based dessert using fresh, stewed or dried fruit
Milk pudding – add chopped fresh fruit, stewed or dried fruit made available for particular dining rooms
Mashed banana and mix with custard
Serve fruit with jelly, ice cream or yogurts

**Evening Meal**

Wholemeal bread
Fruit based dessert with fresh, stewed or dried fruit

**Snacks**

Offer fruit, dried fruit, wholemeal bread or toast as Snacks
Dementia: Feeding Tips

- Minimise distractions (such as television, radio) at meal times
- Take into account that some individuals eat better alone than in groups
- Do not fill glasses and cups to the top but allow room for shaking as a person moves the glass or cup to their mouth
- Give out only 1 course at a time
- If the resident has difficulty using normal utensils, try modified ones and may need the help of the Occupational Therapist – discuss Referral with GP
- Have essential items only on the table, condiments should be offered then removed
- Plan the menu to suit the resident’s level of eating (for example, they may need bite size chunks)
- Ensure that portion sizes are appropriate to the individual resident
- Avoid mixed textures of foods
- Ensure food is served at the correct temperature and that hot food, for example, is not too hot
- If resident has difficulty sitting for long periods offer finger foods in handy carry bags to eat on the move
APPENDIX A
South Yorkshire Health Protection Unit

Policy for the Management of Outbreaks of Infectious Diarrhoea and Vomiting in Nursing and Residential Homes

Issued August 2007
Revised June 2010
Revision date 2012
Introduction

This policy is designed to be used in conjunction with the “Infection Control Guidance for Care Homes” (Department of Health 2006) and “Guidelines on Infection control in schools and other childcare settings”. (Health protection Agency 2010). This policy reflects both of these guidelines. It is important that all establishments base their own policies and procedures for local practice on these documents, which also include further information on infection control.

Infectious diarrhoea and vomiting occurs frequently in the community. Infections may be airborne, foodborne, transmitted by direct contact from person to person or may spread through the air to contaminate the environment. Prompt and effective measures are needed to control the spread of infection between patients/residents, staff and visitors.

Outbreaks of viral gastro-enteritis, such as those caused by Norovirus, are the most common, but, infections may also be caused by bacteria, such as Campylobacter or Salmonella.

If the outbreak is suspected to be food related the local Environmental Health Officers will undertake a joint investigation with the Health Protection team.

Outbreak Definition

An outbreak of infectious diarrhoea and vomiting should be suspected when unexplained diarrhoea and/or vomiting affects two or more patients/residents or members of staff within a 48 hour period.

Typical features of viral gastro enteritis are:

1. Vomiting
2. Diarrhoea (see Bristol Stool Chart for stool recognition)
3. Duration of 24 - 48 hours
4. Rapid spread from person to person

Typical features of other gastro enteritis (food, water) are:

1. Vomiting
2. Diarrhoea (see Bristol Stool Chart for stool recognition)
3. Duration variable
4. Point source outbreak

Mode of Spread:

1. Airborne, leading to gross environmental contamination
2. Person to person via the faecal-oral route
3. Foodborne/waterborne via contaminated food and drink
Effective Control of the Outbreak:

It is worth noting that infection can be spread to and within any establishment very easily. By using Infection control policies and procedures and notifying promptly a suspected outbreak, the necessary action can be taken which will minimise the spread of infection. This will prove to be cost effective and may result in avoidable admissions to hospital:

1. Early reporting to the Environmental Health Department, South Yorkshire H.P.U. and the PCT Infection Control Nurse (if there are PCT beds), of diarrhoea and vomiting in either patients or staff when there are two or more cases.
2. The Consultant Communicable Disease (CCDC) or the Community Infection Control Nurse (CICN) will require daily reports on the progress of the outbreak and will provide advice accordingly.
3. In certain circumstances it may be necessary to hold outbreak meetings.
4. These meetings will be arranged at the discretion of the CCDC.
5. Faecal samples from affected staff and residents must be obtained as soon as possible.
6. Increase cleaning and drying of toilet facilities, especially communal facilities/areas.
7. Strict compliance with infection control measures.

Management of an outbreak of diarrhoea and vomiting:

Immediate action of the Duty Manager:

1. Report the outbreak to:
   a) The local Environmental Health Department.
   b) South Yorkshire Health Protection Unit.

2. Discuss cases involved in the outbreak with the patients/residents General Practitioner(s) to ascertain whether or not symptoms could be attributed to underlying medical conditions and to agree on the collection of specimens.

3. The following details should be recorded:
   a) The names of cases
   b) Nature, date and time of onset of symptoms for each individual case
   c) Food/drink items in common/menus
   d) The names of symptomatic staff and information on their symptoms (noting those who are food handlers)
   e) Any movement of patients outside building i.e. out-patients, day trips etc during last 7 days
   f) Intermittent staff/agency staff i.e. hairdressers, chiropodists, nurses etc.

4. Arrange collection of faecal specimens from all those symptomatic as soon as possible after the onset of symptoms (in some areas the faecal containers will be provided by the Environmental Health Offices otherwise they will be via the GP)

5. Implement infection control measures
Infection Control Measures:

Segregation/Isolation/Exclusion

1. **Segregation**
   a) Segregation is necessary in an outbreak where a large group of people use the building. It is important that where possible the asymptomatic and symptomatic people are kept strictly apart (known as cohort nursing).
   b) Staff should be specifically designated to work in one area, this will help reduce the transmission of the causative organisms and stop the spread of the outbreak.
   c) No one should be admitted/transferred/discharged during the outbreak.
   d) Symptomatic patients/residents may be nursed together within a designated area if sufficient individual rooms are not available.

2. **Isolation**
   a) Symptomatic patients/residents should be nursed in isolation in their own rooms, or cohort nursed as above.
   b) Symptomatic patients/residents should, where possible, have sole use of designated lavatory facilities.

3. **Exclusion**
   a) If a Nursing/Residential home is responsible for running day care facilities these will need to be cancelled until 48 hours after the last person/patient recovers.
   b) During the outbreak no new patients/residents, including Day Care patients/residents, should be admitted and no transfers made unless absolutely necessary.
   c) If admissions are absolutely necessary the patient/resident and/or their family/carers should be informed that they are being admitted to an area in which there is, or has recently been, an outbreak of diarrhoea and vomiting.
   d) When the transfer of a patient/resident is absolutely necessary the establishment receiving the patient/resident must be informed that the patient/resident has recently been in an outbreak area.
   e) The home should remain closed to admissions for 48 hours following the recovery of the last symptomatic case.
   f) Advice should be sought from Environmental Health Officers if the home supplies meals on wheels or outreach workers; these services may need to be discontinued for the duration of the outbreak

4. **Staff Issues**
   a) Any staff member (including bank and agency staff) with symptoms of diarrhoea and/or vomiting should be sent home immediately.
   b) Stool specimens should be obtained from all symptomatic members of staff.
   c) **It is vital that any symptomatic staff member does not return to work until 48 hours AFTER normal bowel habits have returned.**
   d) If staff are admitted to hospital they should inform the hospital that they have been working in an area in which there is, or has recently been, an outbreak of diarrhoea and vomiting.
Bank Nursing staff should inform their main employer that they have been working in an area in which there is, or has recently been, an outbreak of diarrhoea and vomiting.

4. **Cleaning**

Thorough cleaning of the entire building/home is essential, and is especially important if people have vomited in public areas (e.g. lounges), including tables, handrails and TV remotes. Cleaning the toilets/changing mats, door/toilet handles and any other areas where symptomatic people have been is vital. It is very important that the cleaning regime is carried out using clean cloths, mops and hot water and a chlorine based solution in communal areas. Local policies should detail which cleaning detergents and chemicals should be used and the appropriate cleaning frequencies

a) A chlorine based solution, correctly diluted and used in accordance with the manufacturers instructions, should be used for cleaning hard surfaces.

b) For carpets and soft furnishings, body fluids/waste, e.g. faeces and vomit, should be removed and the area cleaned using a liquid detergent and the carpet steam cleaned.

c) All bed linen, curtains etc. should be washed using the hot cycle of a washing machine where possible.

d) Clothing should be washed in a washing machine at the hottest setting that the fabric will tolerate.

e) Disposable plastic aprons and gloves should be worn when caring for isolated patients/residents /infected

f) Gloves and aprons must be single patient use only

g) Gloves and aprons must be discarded into a clinical waste bag

h) Staff should change their uniforms daily, before working in other establishments and before going home.

An explanation regarding the outbreak and the risk of infection should be offered to visitors, with the advice that they wash their hands on leaving the patient's/resident's room. They may also be advised that visiting is restricted until the outbreak is over.

5. **Hand Washing**

a) Is vital to prevent person to person transmission and frequent hand hygiene must be actively encouraged.

b) Liquid soap and paper towels should be easily accessed by staff.

c) Alcohol hand gel is recommended to be used in outbreak situations as a further measure to prevent person to person spread, in addition to handwashing

d) Handwashing should occur:

- at the start and end of clinical duties
- before and after all patient contact and care procedures
- before putting gloves on
- following removal of gloves
- when hands are visibly soiled
- immediately after hands have been contaminated with body fluids/waste
- before serving or preparing food
- after visiting the lavatory
6. **Handwashing Technique (see page 80)**

   a) Wet both hands thoroughly before applying soap to the hands. Follow the technique outlined below for 20-30 seconds.
   b) Pay particular attention to the thumbs, fingertips, and between the fingers.
   c) Hands should be thoroughly rinsed with running water.
   d) Care should be taken to dry the hands thoroughly using disposable paper towels.
   e) Hand cream may be applied to the hands at the completion of nursing duties to prevent the skin drying and cracking.

**Duty of Care**

The owner/manager has a duty of care to protect their staff and residents. Policies and procedures should be evident, which are adhered to, preventing as appropriate any spread of disease. An occupational health policy must also be present and adhered to.
## Bristol Stool Chart

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>Type 1</td>
<td>Separate hard lumps, like nuts (hard to pass)</td>
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<tr>
<td>Type 2</td>
<td>Sausage-shaped but lumpy</td>
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<tr>
<td>Type 3</td>
<td>Like a sausage but with cracks on its surface</td>
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<tr>
<td>Type 4</td>
<td>Like a sausage or snake, smooth and soft</td>
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<tr>
<td>Type 5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
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<tr>
<td>Type 6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
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<tr>
<td>Type 7</td>
<td>Watery, no solid pieces. Entirely Liquid</td>
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</table>
D & V OUTBREAK – MANAGEMENT CHECKLIST

Date Completed:  
Checklist Completed By (Print Name):  
Name and telephone number of Institution:  
Type of Institution:  
Name of Manager:  

HISTORY OF OUTBREAK:

ACTION TAKEN BY INSTITUTION (eg Isolation time, handwashing etc):

ADVICE GIVEN RE: FURTHER ACTION REQUIRED:

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<tr>
<th>Prevention</th>
<th>Yes</th>
<th>No</th>
<th>Comments:</th>
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<tbody>
<tr>
<td>☑ Alcohol gel advised and contact details given</td>
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<tr>
<td>☑ Monitor that staff deploy handwashing effectively</td>
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<tr>
<td>☑ Liquid soap and paper towels available</td>
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<td>☑ Deep clean, i.e daily cleaning with a chlorine based solution (especially handles and taps).</td>
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<td>☑ Steam clean carpets/furniture needed</td>
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<td>☑ Protective clothing available (i.e gloves &amp; aprons)</td>
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<tr>
<td>☑ Appropriate disposal of waste available</td>
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<tr>
<td>☑ Infected linen segregated and use of dissolvable bags</td>
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<td>☑ Dedicated toilet facilities/commodes</td>
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<td>☑ D &amp; V Guidance faxed/posted</td>
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<td>☑ List of cases – separate for staff and clients</td>
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<td>☑ Visitors – to be informed and restricted</td>
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<td>☑ Admissions, discharges and transfers suspended</td>
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<td>☑ Any attached daycare/residential facilities, if so, segregate</td>
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<td>☑ Deploy 48º rule for ill clients and staff</td>
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<td>☑ Deploy care staff to dedicated areas if possible (restrict food handling if possible)</td>
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<td>☑ Check if staff work elsewhere (restrict) and that all staff are well (including agency). Exclude if unwell (see above)</td>
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<td>☑ Inform EHOs</td>
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<td>☑ Specimen collection agreed by EHOs</td>
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APPENDIX B
Introduction
This chapter contains the guidelines for out-of-hospital, single rescuer, adult basic life support (BLS). Like the other guidelines in this publication, it is based on the document

2010 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations (CoSTR), which was published in October 2010. Basic life support refers to maintaining airway patency and supporting breathing and the circulation without the use of equipment other than a protective device.

It is important that those who may be present at the scene of a cardiac arrest, particularly lay bystanders, should have learnt the appropriate resuscitation skills and be able to put them into practice. Simplification of the BLS sequence continues to be a feature of these guidelines, but, in addition, there is now advice on who should be taught what skills, particularly chest-compression-only or chest compression and ventilation. Within this advice, allowance has been made for the rescuer who is unable or unwilling to perform rescue breathing, and for those who are untrained and receive telephone advice from the ambulance service.

Guidelines 2000 introduced the concept of checking for ‘signs of a circulation’. This change was made because of the evidence that relying on a check of the carotid pulse to diagnose cardiac arrest is unreliable and time-consuming, mainly, but not exclusively, when attempted by non-healthcare professionals. Subsequent studies have shown that checking for breathing is also prone to error, particularly as agonal gasps are often misdiagnosed as normal breathing. In Guidelines 2010 the absence of normal breathing continues to be the main sign of cardiac arrest in a non-responsive victim. Once cardiopulmonary resuscitation (CPR) has started, it is now recommended that the rescuer should only stop CPR if the victim shows signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully, as well as breathing normally.

Guideline changes
It is well documented that interruptions in chest compression are common and are associated with a reduced chance of survival. The ‘perfect’ solution is to deliver continuous compressions whilst giving ventilations independently. This is possible when the victim has an advanced airway in place, and is discussed in the adult advanced life support (ALS) chapter. Compression-only CPR is another way to increase the number of compressions given and will, by definition, eliminate pauses. It is effective for a limited period only (probably less than 5 min) and is not recommended as the standard management of out-of-hospital cardiac arrest.

It is also known that chest compressions, both in hospital and outside, are often undertaken with insufficient depth and at the wrong rate.
The following changes in the BLS guidelines have been made to reflect the importance placed on chest compression, particularly good quality compressions, and to attempt to reduce the number and duration of pauses in chest compression:

1. When obtaining help, ask for an automated external defibrillator (AED), if one is available.
2. Compress the chest to a depth of 5-6 cm and at a rate of 100-120 min\(^{-1}\).
3. Give each rescue breath over 1 s rather than 2 s.
4. Do not stop to check the victim or discontinue CPR unless the victim starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starts to breathe normally.
5. Teach CPR to laypeople with an emphasis on chest compression, but include ventilation as the standard, particularly for those with a duty of care.

In addition, advice has been added on the use of oxygen, and how to manage a victim who regurgitates stomach contents during resuscitation.

**Adult basic life support algorithm**

```
<table>
<thead>
<tr>
<th>UNRESPONSIVE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shout for help</td>
</tr>
<tr>
<td>Open airway</td>
</tr>
<tr>
<td>NOT BREATHING NORMALLY</td>
</tr>
<tr>
<td>Call 999</td>
</tr>
<tr>
<td>30 chest compressions</td>
</tr>
<tr>
<td>2 rescue breaths 30 compressions</td>
</tr>
</tbody>
</table>
```
Adult basic life support sequence

Basic life support consists of the following sequence of actions:

1. **Make sure the victim, any bystanders, and you are safe.**
2. **Check the victim for a response.**
   - Gently shake his shoulders and ask loudly, ‘Are you all right?’

3A. **If he responds:**
   - Leave him in the position in which you find him provided there is no further danger.
   - Try to find out what is wrong with him and get help if needed.
   - Reassess him regularly.

3B. **If he does not respond:**
   - Shout for help.
   - Turn the victim onto his back and then open the airway using head tilt and chin lift
     - Place your hand on his forehead and gently tilt his head back.
     - With your fingertips under the point of the victim's chin, lift the chin to open the airway.

4. **Keeping the airway open, look, listen, and feel for normal breathing.**
   - Look for chest movement.
   - Listen at the victim's mouth for breath sounds. Feel for air on your cheek.

In the first few minutes after cardiac arrest, a victim may be barely breathing, or taking infrequent, noisy, gasps. This is often termed agonal breathing and must not be confused with normal breathing.

Look, listen, and feel for **no more** than 10 s to determine if the victim is breathing normally. If you have any doubt whether breathing is normal, act as if it is **not** normal.

5A. **If he is breathing normally:**
   - Turn him into the recovery position (see below).
   - Summon help from the ambulance service by mobile phone. If this is not possible, send a bystander. Leave the victim only if no other way of obtaining help is possible.
   - Continue to assess that breathing remains normal. If there is any doubt about the presence of normal breathing, start CPR (5B).

5B. **If he is not breathing normally:**
   - Ask someone to call for an ambulance and bring an AED if available. If you are on your own, use your mobile phone to call for an ambulance. Leave the victim only when no other option exists for getting help.
   - Start chest compression as follows:
     - Kneel by the side of the victim.
     - Place the heel of one hand in the centre of the victim’s chest (which is the lower half of the victim's sternum (breastbone)).
     - Place the heel of your other hand on top of the first hand.
     - Interlock the fingers of your hands and ensure that pressure is not applied over the victim’s ribs. Do not apply any pressure over the upper abdomen or the bottom end of the sternum.
     - Position yourself vertically above the victim’s chest and, with your arms straight, press down on the sternum 5 - 6 cm.
     - After each compression, release all the pressure on the chest without losing contact between your hands and the sternum. Repeat at a rate of 100 - 120 min⁻¹.
     - Compression and release should take an equal amount of time.
If the initial rescue breath of each sequence does not make the chest rise as in normal breathing, then, before your next attempt:

- Check the victim's mouth and remove any visible obstruction.
- Recheck that there is adequate head tilt and chin lift.
- Do not attempt more than two breaths each time before returning to chest compressions.

If there is more than one rescuer present, another should take over CPR about every 1-2 min to prevent fatigue. Ensure the minimum of delay during the changeover of rescuers, and do not interrupt chest compressions.

6A. Combine chest compression with rescue breaths:

- After 30 compressions open the airway again using head tilt and chin lift.
- Pinch the soft part of the victim’s nose closed, using the index finger and thumb of your hand on his forehead.
- Allow his mouth to open, but maintain chin lift.
- Take a normal breath and place your lips around his mouth, making sure that you have a good seal.
- Blow steadily into his mouth whilst watching for his chest to rise; take about one second to make his chest rise as in normal breathing; this is an effective rescue breath.
- Maintaining head tilt and chin lift, take your mouth away from the victim and watch for his chest to fall as air comes out.
- Take another normal breath and blow into the victim’s mouth once more to give a total of two effective rescue breaths. The two breaths should not take more than 5 s. Then return your hands without delay to the correct position on the sternum and give a further 30 chest compressions.
- Continue with chest compressions and rescue breaths in a ratio of 30:2.
- Stop to recheck the victim only if he starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starts to breathe normally; otherwise **do not interrupt resuscitation**.

6B. Compression-only CPR

- If you are not trained to, or are unwilling to give rescue breaths, give chest compressions only.
- If chest compressions only are given, these should be continuous at a rate of 100 - 120 min⁻¹.
- Stop to recheck the victim only if he starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starts to breathe normally; otherwise **do not interrupt resuscitation**.

7. Continue resuscitation until:

- qualified help arrives and takes over,
- the victim starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starts to breathe normally, OR
- you become exhausted.
Further points related to basic life support

Risks to the rescuer and victim
The safety of both the rescuer and victim are paramount during a resuscitation attempt. There have been few incidents of rescuers suffering adverse effects from undertaking CPR, with only isolated reports of infections such as tuberculosis (TB) and severe acute respiratory distress syndrome (SARS). Transmission of HIV during CPR has never been reported.

There have been no human studies to address the effectiveness of barrier devices during CPR; however, laboratory studies have shown that certain filters, or barrier devices with one-way valves, prevent transmission of oral bacteria from the victim to the rescuer during mouth-to-mouth ventilation. Rescuers should take appropriate safety precautions where feasible, especially if the victim is known to have a serious infection.

Initial rescue breaths
During the first few minutes after non-asphyxial cardiac arrest the blood oxygen content remains high. Therefore, ventilation is less important than chest compression at this time.

It is well recognised that skill acquisition and retention are aided by simplification of the BLS sequence of actions. It is also recognised that rescuers are frequently unwilling to carry out mouth-to-mouth ventilation for a variety of reasons, including fear of infection and distaste for the procedure. For these reasons, and to emphasise the priority of chest compressions, it is recommended that, in adults, CPR should start with chest compressions rather than initial ventilations.

Jaw thrust
The jaw thrust technique is not recommended for lay rescuers because it is difficult to learn and perform. Therefore, the lay rescuer should open the airway using a head-tilt-chin-lift manoeuvre for both injured and non-injured victims.

Agonal gasps
Agonal gasps are present in up to 40% of cardiac arrest victims. Therefore laypeople should be taught to begin CPR if the victim is unconscious (unresponsive) and not breathing normally. It should be emphasised during training that agonal gasps occur commonly in the first few minutes after sudden cardiac arrest; they are an indication for starting CPR immediately and should not be confused with normal breathing.

Use of oxygen during basic life support
There is no evidence that oxygen administration is of benefit during basic life support in the majority of cases of cardiac arrest before healthcare professionals are available with equipment to secure the airway. Its use may lead to interruption in chest compressions, and is not recommended, except in cases of drowning (see below).

Mouth-to-nose ventilation
Mouth-to-nose ventilation is an effective alternative to mouth-to-mouth ventilation. It may be considered if the victim's mouth is seriously injured or cannot be opened, if the rescuer is assisting a victim in the water, or if a mouth-to-mouth seal is difficult to achieve.
Mouth-to-tracheostomy ventilation

Mouth-to-tracheostomy ventilation may be used for a victim with a tracheostomy tube or tracheal stoma who requires rescue breathing.

Bag-mask ventilation

Considerable practice and skill are required to use a bag and mask for ventilation. The lone rescuer has to be able to open the airway with a jaw thrust whilst simultaneously holding the mask to the victim's face. It is a technique that is appropriate only for lay rescuers who work in highly specialised areas, such as where there is a risk of cyanide poisoning or exposure to other toxic agents. There are other specific circumstances in which non-healthcare providers receive extended training in first aid, which could include training, and retraining, in the use of bag-mask ventilation. The same strict training that applies to healthcare professionals should be followed and the two-person technique is preferable.

Chest compression

In most circumstances it will be possible to identify the correct hand position for chest compression without removing the victim's clothes. If in any doubt, remove outer clothing.

Each time compressions are resumed on an adult, the rescuer should place his hands on the lower half of the sternum. It is recommended that this location be taught in a simple way, such as 'place the heel of your hand in the centre of the chest with the other hand on top.' This teaching should be accompanied by a demonstration of placing the hands on the lower half of the sternum. Use of the internipple line as a landmark for hand placement is not reliable.

Performing chest compression:

- a. Compress the chest at a rate of 100-120 min⁻¹.
- b. Each time compressions are resumed, place your hands without delay 'in the centre of the chest' (see above).
- c. Pay attention to achieving the full compression depth of 5-6 cm (for an adult).
- d. Allow the chest to recoil completely after each compression.
- e. Take approximately the same amount of time for compression and relaxation.
- f. Minimise interruptions in chest compression.
- g. Do not rely on a palpable carotid or femoral pulse as a gauge of effective arterial flow.
- h. ‘Compression rate’ refers to the speed at which compressions are given, not the total number delivered in each minute. The number delivered is determined not only by the rate, but also by the number of interruptions to open the airway, deliver rescue breaths, and allow AED analysis.

Compression-only CPR

Studies have shown that compression-only CPR may be as effective as combined ventilation and compression in the first few minutes after non-asphyxial arrest. However, chest compression combined with rescue breaths is the method of choice for CPR by trained lay rescuers and professionals and should be the basis for lay-rescuer education. Lay rescuers who are unable or unwilling to provide rescue breaths, should be encouraged to give chest compressions alone. When advising untrained laypeople by telephone, ambulance dispatchers should give instruction on compression-only CPR. 18, 19, 19a
Resuscitation Council (UK)

Regurgitation during CPR

Regurgitation of stomach contents is common during CPR, particularly in victims of drowning. If regurgitation occurs:

- Turn the victim away from you.
- Keep him on his side and prevent him from toppling on to his front.
- Ensure that his head is turned towards the floor and his mouth is open and at the lowest point, thus allowing vomit to drain away.
- Clear any residual debris from his mouth with your fingers; and immediately turn him on to his back, re-establish an airway, and continue rescue breathing and chest compressions at the recommended rate.

Teaching CPR

Compression-only CPR has potential advantages over chest compression and ventilation, particularly when the rescuer is an untrained or partially-trained layperson. However, there are situations where combining chest compressions with ventilation is better, for example in children, asphyxial arrests, and prolonged arrests. Therefore, CPR should remain standard care for healthcare professionals and the preferred target for laypeople, the emphasis always being on minimal interruption in compressions.

A simple, education-based approach is recommended:

- Ideally, full CPR skills should be taught to all citizens.
- Initial or limited-time training should always include chest compression.
- Subsequent training (which may follow immediately or at a later date) should include ventilation as well as chest compression.

CPR training for citizens should be promoted, but untrained lay people should be encouraged to give chest compressions only, when possible and appropriate with telephone advice from an ambulance dispatcher.

Those laypeople with a duty of care, such as first aid workers, lifeguards, and child minders, should be taught chest compression and ventilation.

Over-the-head CPR

Over-the-head CPR for a single rescuer and straddle CPR for two rescuers may be considered for resuscitation in confined spaces.
Resuscitation Council (UK)

Recovery position

There are several variations of the recovery position, each with its own advantages. No single position is perfect for all victims. The position should be stable, near a true lateral position with the head dependent, and with no pressure on the chest to impair breathing.

The RC(UK) recommends the following sequence of actions to place a victim in the recovery position:

- Remove the victim’s glasses, if present.
- Kneel beside the victim and make sure that both his legs are straight.
- Place the arm nearest to you out at right angles to his body, elbow bent with the hand palm-up.
- Bring the far arm across the chest, and hold the back of the hand against the victim’s cheek nearest to you.
- With your other hand, grasp the far leg just above the knee and pull it up, keeping the foot on the ground.
- Keeping his hand pressed against his cheek, pull on the far leg to roll the victim towards you on to his side.
- Adjust the upper leg so that both the hip and knee are bent at right angles.
- Tilt the head back to make sure that the airway remains open.
- If necessary, adjust the hand under the cheek to keep the head tilted and facing downwards to allow liquid material to drain from the mouth.
- Check breathing regularly.

If the victim has to be kept in the recovery position for more than 30 min turn him to the opposite side to relieve the pressure on the lower arm.

Choking

Recognition

Because recognition of choking (airway obstruction by a foreign body) is the key to successful outcome, it is important not to confuse this emergency with fainting, heart attack, seizure, or other conditions that may cause sudden respiratory distress, cyanosis, or loss of consciousness.

Foreign bodies may cause either mild or severe airway obstruction. The signs and symptoms enabling differentiation between mild and severe airway obstruction are summarised in the table below. It is important to ask the conscious victim ‘Are you choking?’

<table>
<thead>
<tr>
<th>General signs of choking</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Attack occurs while eating</td>
<td></td>
</tr>
<tr>
<td>Victim may clutch his neck</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signs of severe airway obstruction</th>
<th>Signs of mild airway obstruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response to question ‘Are you choking?’</td>
<td>Response to question ‘Are you choking?’</td>
</tr>
<tr>
<td>▪ Victim unable to speak</td>
<td>▪ Victim speaks and answers yes</td>
</tr>
<tr>
<td>▪ Victim may respond by nodding</td>
<td></td>
</tr>
<tr>
<td>Other signs</td>
<td>Other signs</td>
</tr>
<tr>
<td>▪ Victim unable to breathe</td>
<td>▪ Victim is able to speak, cough, and breathe</td>
</tr>
<tr>
<td>▪ Breathing sounds wheezy</td>
<td></td>
</tr>
<tr>
<td>▪ Attempts at coughing are silent</td>
<td></td>
</tr>
<tr>
<td>▪ Victim may be unconscious</td>
<td></td>
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</tbody>
</table>
Resuscitation Council (UK)

Adult choking treatment algorithm

Sequence for the treatment of adult choking
(This sequence is also suitable for use in children over the age of 1 year)

1. If the victim shows signs of mild airway obstruction:
Encourage him to continue coughing, but do nothing else.

2. If the victim shows signs of severe airway obstruction and is conscious:
   - Give up to five back blows.
     - Stand to the side and slightly behind the victim.
     - Support the chest with one hand and lean the victim well forwards so that when the obstructing object is dislodged it comes out of the mouth rather than goes further down the airway.
     - Give up to five sharp blows between the shoulder blades with the heel of your other hand.
Check to see if each back blow has relieved the airway obstruction. The aim is to relieve the obstruction with each blow rather than necessarily to give all five.

If five back blows fail to relieve the airway obstruction give up to five abdominal thrusts.

- Stand behind the victim and put both arms round the upper part of his abdomen.
- Lean the victim forwards.
- Clench your fist and place it between the umbilicus (navel) and the bottom end of the sternum (breastbone).
- Grasp this hand with your other hand and pull sharply inwards and upwards.
- Repeat up to five times.

If the obstruction is still not relieved, continue alternating five back blows with five abdominal thrusts.

3. If the victim becomes unconscious:

- Support the victim carefully to the ground.
- Call an ambulance immediately.
- Begin CPR (from 5B of the adult BLS sequence). Healthcare providers, trained and experienced in feeling for a carotid pulse, should initiate chest compressions even if a pulse is present in the unconscious choking victim.

Following successful treatment for choking, foreign material may nevertheless remain in the upper or lower respiratory tract and cause complications later. Victims with a persistent cough, difficulty swallowing, or with the sensation of an object being still stuck in the throat should therefore be referred for an immediate medical opinion.

Resuscitation of children and victims of drowning

Both ventilation and compression are important for victims of cardiac arrest when the oxygen stores become depleted: about 2 - 4 min after collapse from ventricular fibrillation (VF), and immediately after collapse for victims of asphyxial arrest. Previous guidelines tried to take into account the difference in causation, and recommended that victims of identifiable asphyxia (drowning; trauma; intoxication) and children should receive 1 min of CPR before the lone rescuer left the victim to get help. But most cases of sudden cardiac arrest out of hospital occur in adults and are of cardiac origin due to VF (even though many of these will have changed to a non-shockable rhythm by the time of the first rhythm analysis). These additional recommendations, therefore, added to the complexity of the guidelines whilst applying to only a minority of victims.

Many children do not receive resuscitation because potential rescuers fear causing harm. This fear is understood; it is far better to sue the adult BLS sequence for resuscitation of a child than to do nothing. For ease of training and retention, laypeople
Resuscitation Council (UK)

should be taught to use the adult sequence for children who are not responsive and not breathing normally, with the single modification that the chest should be compressed by one third of its depth. However, the following minor modifications to the adult sequence will make it even more suitable for use in children:

- Give 5 initial rescue breaths before starting chest compressions (adult BLS sequence of actions 5B).
- If you are on your own, perform CPR for 1 min before going for help.
- Compress the chest by one third of its depth. Use two fingers for an infant under 1 year; use one or two hands for a child over 1 year as needed to achieve an adequate depth of compression.

The same modifications of five initial breaths, and 1 min of CPR by the lone rescuer before getting help, may improve outcome for victims of drowning. This modification should be taught only to those who have a specific duty of care to potential drowning victims (e.g., lifeguards). If supplemental oxygen is available, and can be brought to the victim and used without interruption in CPR (e.g., by attaching to a resuscitation face mask), it may be of benefit.

Drowning is easily identified. It can be difficult, on the other hand, for a layperson to recognise when trauma or intoxication has caused cardiorespiratory arrest. If either cause is suspected the victim should be managed according to the standard BLS protocol.
## ABBREVIATIONS USED IN THIS PACK

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>BP</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>CHST</td>
<td>Care Homes Support Team</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CSU</td>
<td>Catheter Specimen of Urine</td>
</tr>
<tr>
<td>D&amp;V</td>
<td>Diarrhoea and Vomiting</td>
</tr>
<tr>
<td>DN</td>
<td>District Nurse</td>
</tr>
<tr>
<td>DNACPR</td>
<td>Do not attempt cardio-pulmonary resuscitation</td>
</tr>
<tr>
<td>ECP</td>
<td>Emergency Care Practitioner</td>
</tr>
<tr>
<td>ENT</td>
<td>Ear, Nose and Throat</td>
</tr>
<tr>
<td>FAST</td>
<td>Face, Arm, Speech, Time to phone 999</td>
</tr>
<tr>
<td>FTU</td>
<td>Finger Tip Unit</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GTN</td>
<td>Glyceryl Trinitrate</td>
</tr>
<tr>
<td>MAR</td>
<td>Medicines Administration Record</td>
</tr>
<tr>
<td>MC and S</td>
<td>Microscopy, Culture and Sensitivity</td>
</tr>
<tr>
<td>MDS</td>
<td>Monitored Dosage System</td>
</tr>
<tr>
<td>MRSA</td>
<td>Meticillin Resistant Staphylococcus Aureus</td>
</tr>
<tr>
<td>MSU</td>
<td>Midstream Specimen of Urine</td>
</tr>
<tr>
<td>NA</td>
<td>Non Adherent</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
</tr>
<tr>
<td>NSF</td>
<td>National Service Framework</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>PEG</td>
<td>Percutaneous Enteroscopic Gastrostomy</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
</tr>
<tr>
<td>PRN</td>
<td>As Required</td>
</tr>
<tr>
<td>SCHBPG</td>
<td>Sheffield Care Homes Best Practice Group</td>
</tr>
<tr>
<td>TIA</td>
<td>Transient Ischaemic Attack</td>
</tr>
<tr>
<td>UTI</td>
<td>Urinary Tract Infection</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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</table>
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The following specialists have contributed to the content of this Information Pack

Diane Allender  Infection Prevention and Control Nurse
Shirley Budd  Continence Lead
Debbie Butterworth  Respiratory Nurse Specialist
Sarah Church  Senior Dietitian
Paul Finner  Biomedical Scientist
Michelle Gibson  Specialist Nurse Older People
Katie Grayson  Infection Prevention & Control Nurse
Kath Hodges  Specialist Nurse Older People
Brenda King  Nurse Consultant Tissue Viability
Helena Lee  Specialist Nurse Older People
Paula MacDonald  Senior Sister Dermatology Out Patients
Debbie Oliver  Elderly Care Pharmacist
Christine Oxley  Specialist Nurse Older People
Christian Richmond  Team Leader Emergency Care Practitioner
Sue Smelt  Specialist Nurse Older People
Joy Smith  Medicines Standards Officer
Hilde Storkes  Medicines Governance Pharmacist
Steve Vessey  Specialist Nurse Older People
Jackie Wainwright  Adult Safeguarding Lead
Lorraine Woodcock  Lead Public Health Development Nurse Stroke/Older People
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Uricol – The Newcastle Urine Collector. Ontex Healthcare UK Ltd

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