BRIGHTON & HOVE
HOMELESS HEALTH
CONFERENCE

Recognising and Responding:

First Aid to Frailty

Arch. JL St Martin in the Fields Frontline Network Partner

Please be aware

We will be discussing case studies that will detail medical emergencies.

If you find any of the discussion upsetting then please feel comfortable to leave the room at any point.

Arch. St Martin in the Fields Frontline Network Partner

Overview

Recognising and responding to emergencies

Seizures
Sepsis
Overdose

Recognising and responding to gradual deterioration

Recognising Frailty Using SBAR and RESTORE2

You hear a loud bang and find Tom, a 44 year old male on the floor of a corridor. His body is stiff, then his arms and legs begin jerking.

You see he has bitten his tongue and is incontinent of urine.

Tom is not known to have epilepsy. He is alcohol dependent, but hasn't had a drink today after his money was stolen.

Seizure

Immediate first aid

STAY

STAY with the person

SAFE

Keep the person **SAFE**

Recovery Position

Call paramedics if

- it's the **first time** someone has had a seizure
- the seizure **lasts longer** than is usual for them
- the seizure **lasts more than 5 minutes**, if you do not know how long their seizures usually last
- the person **does not regain full consciousness**, or has several seizures without regaining consciousness
- the person is seriously **injured** during the seizure

What to communicate…

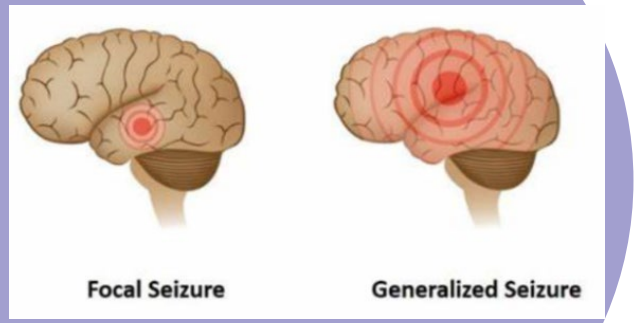
- Any **Triggers** and or warning signs?
- **Timing** -how long did the seizure last?
- **Seizure description** - jerking movement/ incontinence / tongue biting
- **Recovery** -How were they after the seizure?

What is a seizure?

A seizure is a surge of electrical activity in the brain

Seizures can be unpredictable, disruptive and potentially harmful

Type of seizures in alcohol withdrawal



Tonic Phase
Sudden muscle stiffness,
Impaired consciousness

Clonic Phase
Rhythmic jerking

Postictal Phase
Confusion
Tiredness
Improving symptoms
Neurological deficits

Not everyone who has a seizure has epilepsy

Alcohol

- Alcohol withdrawal can lead to seizures 6-72 hours after drinking stops
- Seizure medications may lower alcohol tolerance & alcohol can reduce effectiveness of seizure medication
- Seizures linked to alcohol withdrawal can lead to epilepsy

What is epilepsy?

A lifelong condition affecting the brain, the main symptom is recurrent seizures

Cause: Often unknown, sometimes genetic, a head injury, stroke, brain tumor etc.

Triggers: Missing medication doses, flashing lights, periods, stress, lack of sleep, skipping a meal

Treatment

Medication

Surgery (more for focal seizures)

Epilepsy and homelessness

People who are homeless are at increased risk/higher prevalence (Silva & Marques, 2023).

Seizure frequency increases when a person with epilepsy becomes homeless (Laporte et al, 2006)

Seizures are a common cause of hospital admission amongst homeless (Rosendale et al, 2019)

Inadequately managed (Doran et al, 2021)

Less well controlled in this group because….

- Poor access to healthcare
- Substance misuse – spice, alcohol
- Difficulties taking medications.

What can be done?

Dosset boxes, prompts/reminders to take medications

Support with attending appointments (Free bus pass)

Be mindful of the anxiety related to fear of seizures

Ensure friends, keyworkers and hostel staff are aware

Seizure diary

Carry ID/ Medical alert bracelets

Support to minimise stop substance use

Binge drinking and alcohol withdrawal carry a high risk for seizures

You find Lucy, a 27 year old female on her bed. She has vomited and is unconscious.

Her skin is pale and clammy and she is gurgling. When you check she has Pinpoint pupils.

She was recently discharged from hospital following a 4 week stay.

Overdose

Immediate first aid

DANGER

Check for **DANGER**

999

Call **999**

AIRWAY

Check **airway** and put in **recovery position**

Immediate first aid

Give Prenoxad Injection or Nyxoid nasal spray

***You will not cause harm giving Naloxone if it isn't an opioid overdose**

Opioid use can lead to death due to the effects of opioids on the part of the brain which regulates breathing.

35% of deaths amongst homeless people were related to drug poisoning. ONS 2021

Those who are using after prolonged abstinence are at higher risk of opioid overdose eg, following detox, a hospital stay, or release from prison.

Demonstration

Open and assemble Prenoxad Injection

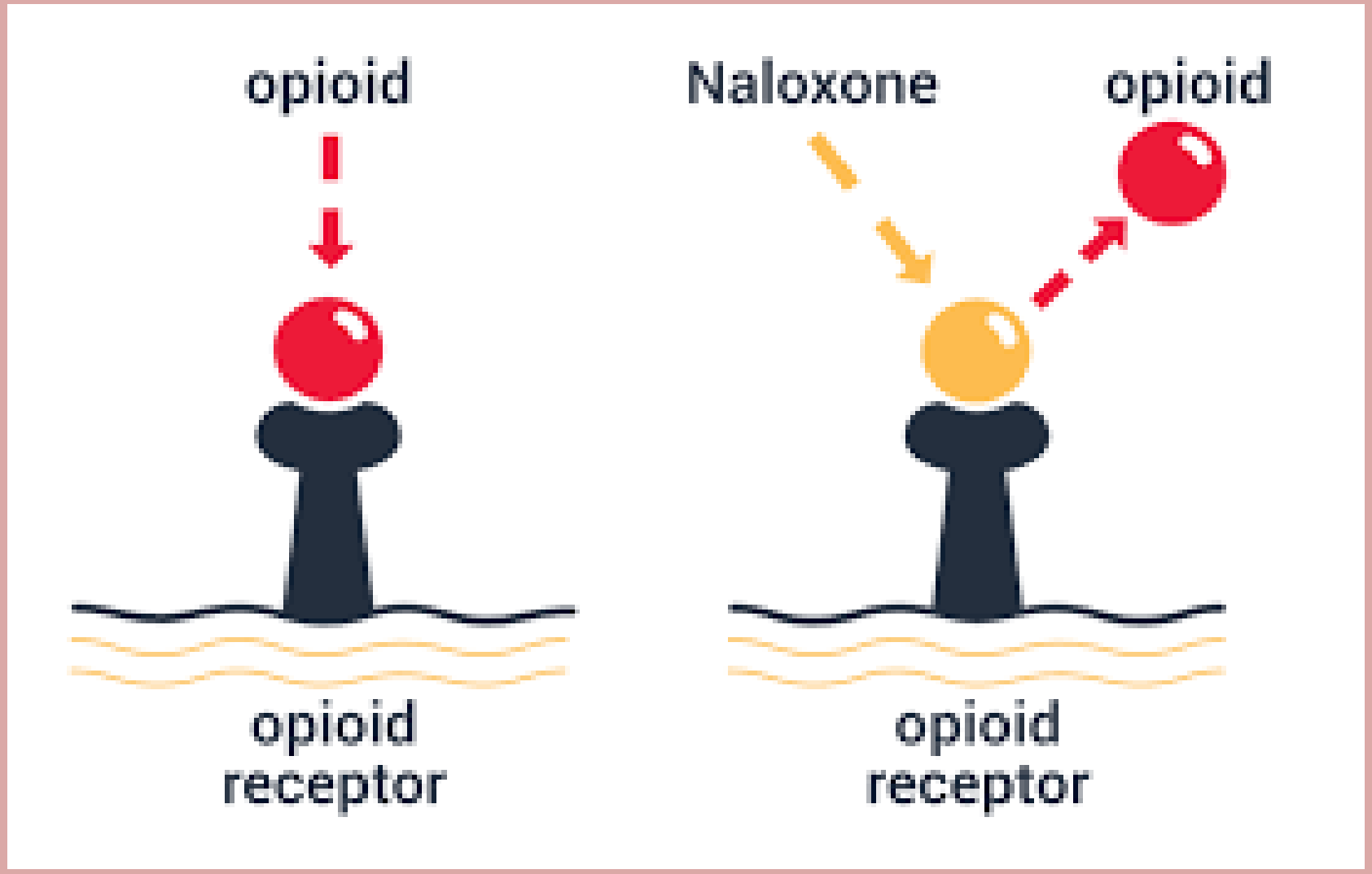
Hold the syringe like a pen

Inject the casualty with the first dose of Prenoxad (0.4ml). The needle should be inserted into the casualty’s outer thigh or upper arm muscle, straight through clothing if required.

Withdraw the needle from the casualty's outer thigh or upper arm muscle and put the syringe (with the needle still attached) back into the 'cradle' in the Prenoxad Injection case.

It will fit into the cradle even with the needle attached

DO NOT ATTEMPT TO REMOVE OR RE-SHEATH THE NEEDLE


opioid
opioid receptor
Naloxone
opioid
opioid receptor

What can be done?

Ensure stock of Naloxone in your workplace and check expiry dates

Training to administer Naloxone and BLS

Encourage not to use alone

Encourage substitute prescribing

Jess is 34 and has had a leg ulcer for the past 2 years. For the last 2 weeks Jess has not had any woundcare from the nursing team.

You see Jess in the lobby of the hostel where she lives, and she looks in pain and is walking with more of a limp. She tells you her leg is more swollen and painful.

Jess looks pale, she tells you she feels hot and cold, has been very tired. She is breathless and appears a bit confused.

Sepsis

Immediate first aid

SEPSIS?

Could this be **SEPSIS ?**

999

Call **999**

MONITOR

Monitor level of response

Call paramedics if

You suspect **SEPSIS**
Fever, confusion, fast breathing, not passing urine.

Not all wound infections lead to sepsis.
Think – would GP appointment or seeing nursing team be appropriate

What to communicate…

Suspected SEPSIS

Chronic wound – or other source of infection; chest, UTI
Symptoms:

- Temperature
- Shivering
- Confusion
- Breathlessness

What is SEPSIS?

Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs.

It occurs when the body's immune system – which normally helps to protect us and fight infection – goes into overdrive. It can lead to shock, multiple organ failure and sometimes death, especially if not recognised early and treated promptly.

Sepsis is indiscriminate: while it primarily affects very young children and older adults, and is also more common in people with underlying health conditions, it can sometimes be triggered in those who are otherwise fit and healthy.

Sepsis always starts with an infection, and can be triggered by any infection including chest infections and UTIs. It is not known why some people develop sepsis in response to these common infections whereas others don't.

What can be done?

Encourage to see GP/nurses before infection or when first signs of infection.

Start/complete antibiotics if have been prescribed.
Vaccinations

Encourage frequent wound care.

Inform – awareness of Sepsis and signs

Question

- Can you define what you think Frailty is?

Definition of Frailty

NHS England describes frailty as a loss of resilience that means people don't bounce back quickly after a physical or mental illness, an accident or other stressful event. Its advice is based on the British Geriatric Society's Fit for Frailty model.

- It has also been defined by the NHS as a group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care.

- World Health Organisation (WHO)Frailty is characterized by multisystem dysregulations, leading to a loss of dynamic homeostasis, reduced physiological reserve and greater vulnerability to subsequent morbidity and mortality.

Question

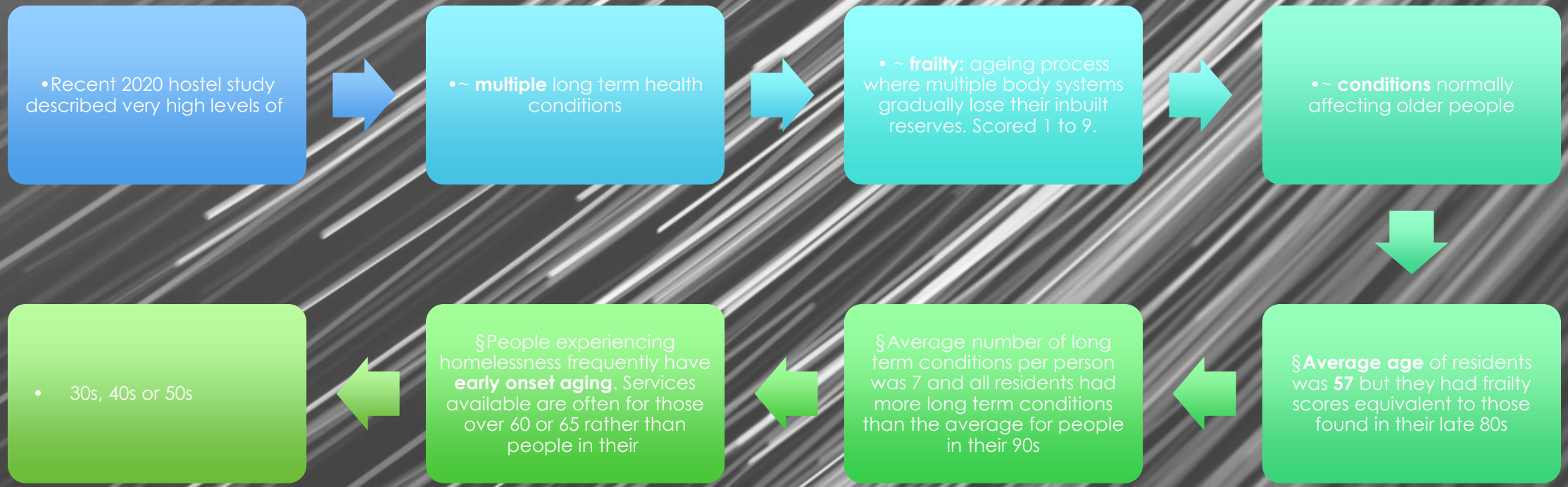
What do you think about these Definitions

Being young and Frail is not clearly Identified

Many Definitions refer to older people

This can lead to assumptions that Old people are Frail and Younger People may not have frailty.

Young and Frail and Homeless



How is Frailty Assessed?

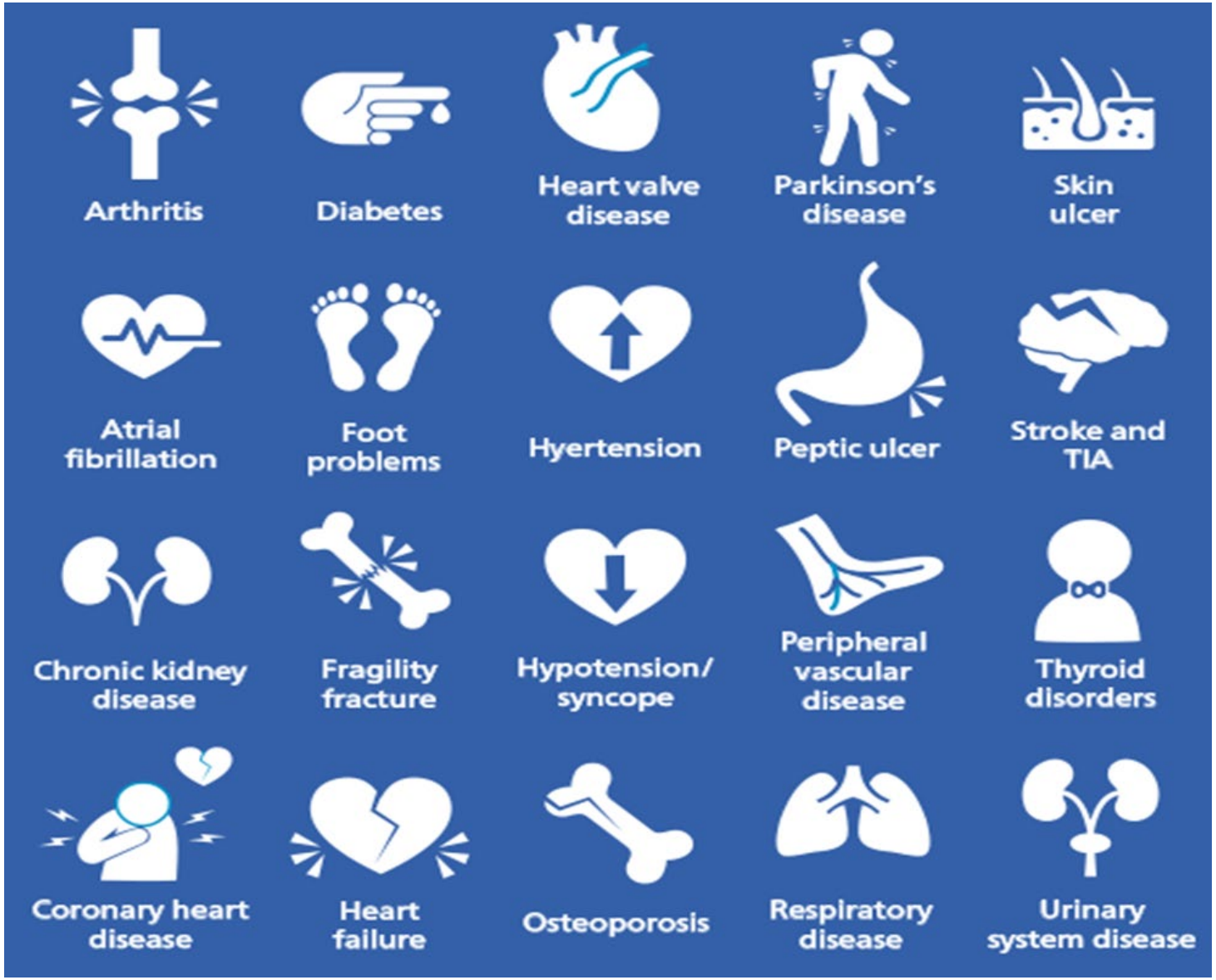
- Using the electronic Frailty Index (eFI) or any other appropriate assessment tool. The eFI uses routine health record data to automatically calculate a score which can identify whether a person in likely to be fit or living with mild, moderate or severe frailty.
- In SCFT we use a screening tool called Rockwood. This is clinician led.
- Proposals to use Edmonton Frailty screening tool. This can be undertaken by both clinicians and non-clinicians with the right training.

What increases your likelihood of Frailty and what can we look out for/monitor?

The signs and symptoms that increase the likelihood of frailty include:

- Dizziness
- •polypharmacy
- •dyspnoea (difficult or laboured breathing)
- •sleep disturbance
- •falls
- •urinary incontinence
- •memory and cognitive problems
- •weight loss and anorexia
- •Chronic substance misuse

The disease states that increase the likelihood of frailty include:



Disabilities likely to increase Frailty

- Vision/Blindness
- Activity Limitation
- Housebound
- Social Vulnerabilty
- Requirement for Care
- Hearing loss
- Mobility and Transfer Problems

Abnormal test Results

- Anaemia and haematinic deficiency

What happens after screening has taken place or needs highlighted as a concern?

- Qualified practitioner such as nurses, occupational therapists and physiotherapists within our team at SCFT will come and further assess the patient. Some GPs surgery's/PCN's have access to Frailty teams in the community.
- Plans put in place to try and support the patient to stabilise their needs: Respite Bed or wrap around support in the community
- With the right support Frailty can be reversible

The Importance of Identifying Frailty

- •There are lots of reasons that it is important to recognise that someone is living with frailty. These include:
- •prompting early decision making and collaboration with services and care providers
- •reducing the risk of **deconditioning**, unnecessary hospitalisation, inappropriate treatment and hospital related harm
- •identifying persons who require **anticipatory care planning**
- •reducing rates of readmission and unsuccessful discharge attempts from hospital
- •supporting a 'getting it right first time' approach by identifying people suitable for community intervention and if required 'same day' emergency care
- •identifying the demand and capacity needs required to support the management of frailty in the community and in hospitals

Remember the 6 M's

- Why Frailty "Matters"
- Mobility
- Medicines
- Malnutrition
- Mind
- Multi-Complexity

Future Plans

- Use of Edmonton Frailty Tool as a screening tool
- collaborative working with ASC to provide carer support
- Being involved in any re-design of accommodation in the city to support those patients with multi-complex needs and Frailty
- Looking at more integration from Mainstream Health Services around respite beds and/or intermediate care
- Challenging policy to identify long-term chronic addiction as a Long term chronic condition that has an impact on a persons resilience and increased likelihood of becoming frail due to poor mobility, malnutrition, incontinence, poor skin/foot health and social isolation

References

- Why Frailty Matters Week 2022 - What is frailty and why does it matter? with Catherine Evans, Nurse Consultant Palliative
  - slides
  - webinar
- NHS England: Frailty elearning programme for healthcare
- British Geriatric Society frailty hub (resources and signposting)
  - MDTea podcasts on frailty and frailty assessment
    - frailty
    - frailty scores
- Edmonton Frail Scale (EFS)
- Cross Sectional Observational Study on Frailty and Homeless Populations in two hostels in London


SEEKING
HUMAN
KINDNESS

Get your message across

Resident Name: **Time/Date:**

Raise the Alert within the hostel e.g. to a keyworker or manager.

Report your concerns to a Hostel Nurse, GP, 111, 999 **using the SBARD Structured Communication Tool below.**

S	**Situation** e.g. what's happened? How are they?
B	**Background** e.g. what is their usual presentation, how have they changed?
A	**Assessment** e.g. what have you observed / done?
R	**Recommendation** 'I need you to...'
D	**Decision** what have you agreed? (including any Treatment Escalation Plan & further observations)

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

RESTORE2 mini

Recognise Early Soft Signs, Take Observations, Respond, Escalate

Ask the resident – how are you today?

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

A **shivery fever**— feel hot or cold to touch. Increasing

breathlessness or chestiness, looks grey or pale.

Change in usual drinking / diet habits.

Weight loss

`Can't pee` or **`no pee`**, change in pee appearance

Diarrhea, vomiting, dehydration

Reduced mobility—**`Off Legs`/** less coordinated, falls, walking change in gait.

Change in their **smell.**

Facial injuries

Complaining of feelin unwell /dizziness/light headiness/ visual disturbance

New or increased confusion/agitation/ anxiety/ pain/ vacant look (vacancy).

Changes to substance/alcohol use or effects of use.

Emotional or behavioural changes.

Changes in skin—rec rashes on neck /arms or popping marks.

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

SBAR

NHS
University Hospitals Sussex
NHS Foundation Trust

Are you worried that a patient is deteriorating?

Use this tool to aid your referral to a Doctor, CCOT, Physiotherapist etc.

Medical / Anaesthetic / Obstetric Emergency or Cardiac Arrest? Dial 2222.

S — SITUATION

Referrers Name : Recepients Name and Bleep:	Patients Name or Label
Date & Time of Referral:	Patients Hospital Number or Label
Site (please circle): RSCH / PRH / Worthing / SRH /Other: Ward/ Area / Department :	Patients Date of Birth or Label
Reason for Referral:	NEWS Score :

B — BACKGROUND

Reason for Admission :	Date of Admission :
Significant History and Allergies :	Treatment Escalation Plan?

A — ASSESSMENT

Airway	Clear ☐	Obstructed (stridor, choking) Call for help — Anaesthetic Support +/- MET		
Breathing	Respiratory Rate	o2 Saturation %	o2 Therapy (Venturi? Humidified o2?)	NIV ☐ Intubated ☐
Circulation	Heart Rate	Blood Pressure	Passing Urine? Y / N / Not sure	
Disability	Alert Voice New Confusion Pain Unconscious (circle)	Blood Sugar	Pain /10	
Exposure	Temperature	Swelling ☐	Rash ☐	Drains ☐ Lines ☐

R — RECOMMENDATION

I think the problem is... Or I don't know what the problem is but I am concerned ☐

- I would like an urgent review of this patient ☐
- I would like a non-urgent review of this patient ☐
- I would like advice over the telephone about this patient ☐
- **Whilst I'm waiting for a review is there anything else I should do?** (Document advice overleaf)

I have already (i.e. given o2, taken bloods, VBG, placed urinary catheter, ECG, etc.) ...

1. 5.
2. 6.
3. 7.
4. 8.

Whilst waiting for a review is there anything else I should do?

1.
2.
3.
4.
5.
6.

SBAR responder should document their review in the patients notes.

This document should be filed in the patients notes.

CCOT Bleep RSCH: 8495 / PRH 6331

SRH: 6342 / Worthing: 1428

NHS
University Hospitals Sussex
NHS Foundation Trust

Version 2.2. SBAR Form. University Hospitals Sussex NHS Foundation Trust: Critical Care Outreach Team LMc

Get your message across

Resident Name: **Time/Date:**

Raise the Alert within the hostel e.g. to a keyworker or manager.

Report your concerns to a Hostel Nurse, GP, 111, 999 **using the SBARD Structured Communication Tool below.**

S	**Situation** e.g. what's happened? How are they?
B	**Background** e.g. what is their usual presentation, how have they changed?
A	**Assessment** e.g. what have you observed / done?
R	**Recommendation** 'I need you to...'
D	**Decision** what have you agreed? (including any Treatment Escalation Plan & further observations)

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

RESTORE2 mini

Recognise Early Soft Signs, Take Observations, Respond, Escalate

Ask the resident – how are you today?

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

A **shivery fever**— feel hot or cold to touch. Increasing

breathlessness or chestiness, looks grey or pale.

Change in usual drinking / diet habits.

Weight loss

`Can't pee` or **`no pee`**, change in pee appearance

Diarrhea, vomiting, dehydration

Reduced mobility—**`Off Legs`/** less coordinated, falls, walking change in gait.

Change in their **smell.**

Facial injuries

Complaining of feelin unwell /dizziness/light headiness/ visual disturbance

New or increased confusion/agitation/ anxiety/ pain/ vacant look (vacancy).

Changes to substance/alcohol use or effects of use.

Emotional or behavioural changes.

Changes in skin—rec rashes on neck /arms or popping marks.

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

Thank you

Any Questions?

Arch.

St Martin in the Fields Frontline Network Partner

Arch.

St Martin in the Fields Frontline Network Partner