

Evolve Care Group Nursing Needs Funding Assessment

CHC Assessments – Example Assessment Answers in Each Domain of CHC Assessment

Please note: The descriptors under each domain is taken directly from the CHC Assessment

Examples of Low, Medium, High, Severe and Priority written responses on the CHC Assessment

Note with reference to www.caretobedifferent.co.uk for some of the information shared below

Summary of Care Domains in the CHC Assessment

Its not possible to score Priority and Severe in each domain

Care Domain	Priority Need A++	Severe Need A +	High Need A	Medium B	Low C +	No Needs C
Breathing						
Nutrition						
Continence						
Skin [inc Tissue Viability]						
Mobility						
Communication						
Psychological and Emotional Needs						
Cognition						
Behaviour						
Medication						
Altered States of Consciousness						
Other Priority Areas not covered above						
Totals						

CHC Wales – Key Messages

Needs should not be marginalised because they are successfully managed. Well-managed needs are still needs. Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need will this have a bearing on CHC eligibility.

For example, where psychological or similar interventions are successfully addressing behavioural issues, consideration should be given as to the present-day need if that support were withdrawn or no longer available and this should be reflected in the Behaviour domain.

For example, where needs are being managed via medication (whether for behaviour or for physical health needs), it may be more appropriate to reflect this in the Drug Therapies and Medication domain.

Similarly, where someone's skin condition is not aggravated by their incontinence because they are receiving good continence care, it would not be appropriate to weight the skin domain as if the continence care was not being provided.

Section 1. Breathing

As with all other domains, the breathing domain should be used to record needs rather than the underlying condition that may give rise to the needs. For example, an individual may have Chronic Obstructive Pulmonary Disease (COPD), emphysema or recurrent chest infections or another condition giving rise to breathing difficulties, and it is the needs arising from such conditions which should be recorded

No Needs

Mrs. X is not diagnosed with any long-standing respiratory or cardiac condition which would give rise to any breathlessness symptoms.

She is not noted to suffer with any breathing difficulties. She has a history of respiratory tract infections, but none has been noted in the past 6 months. Her chest sounded crackly on the day of assessment, but Mrs. X did not appear short of breath.

Mrs. X presents with NO NEEDS as she has normal breathing and no issues with shortness of breath.

IMPORTANT – Note that Mrs. X is assessed as having ‘No Needs’, despite having a history of chest infections and sounding “crackly” at the assessment. A diagnosis of respiratory tract infections and/or symptoms of chestiness or coughing may not necessarily indicate difficulty in breathing, for the purposes of the DST. If the person recovers following a course of antibiotic treatment, does not suffer shortness of breath and does not require the use of an inhaler, it is unlikely this will impact their assessed level of need in this domain

No Needs

Mr. X has a history of Tuberculosis and it was reported by family that he suffered with variable breathlessness which required him to stop and rest whilst mobilising.

Prior to admission to the care home, Mr. X was mobile with assistance. However, since Mr. X was discharged from hospital, he is no longer able to mobilise and is nursed permanently in bed for his own comfort. There is no evidence to suggest Mr. X suffers with breathlessness during any intervention and thus a level of ‘No Needs’ would be appropriate.

Mr X presents with NO NEEDS as he has normal breathing and no issues with shortness of breath.

IMPORTANT – Mr. X does suffer some shortness of breath when moving around due to a history of Tuberculosis. If the DST had been completed while he lived at home, Mr. X would have been assessed as having a ‘Low’ level of need in this domain. However, since a recent admission to hospital, Mr. X has been unable to mobilise and is nursed permanently in bed. Consequently, he no longer experiences breathlessness and presents with ‘No Needs’ in this domain. This is a good example of how a deterioration in the person’s physical health may sometimes lead to a reduction in their assessed level of need on the DST

Low Needs

Mr. X has a diagnosis of COPD; he takes both a nasal spray (Flixonase 0.005%) and inhalers (Fostair, Ventolin, Tiotropium) throughout a 24-hour period. At this present time, he self-administers the inhalers when indicated by senior care staff at appropriate times.

His condition would appear to be well-managed and he does not present with breathlessness at rest. On occasion, Mr. X would become breathless when mobilising longer distances; however, he now uses a wheelchair which has reduced these symptoms.

Section 1. Breathing

Mr. X presents with a LOW level of need as he suffers shortness of breath and a condition (COPD) which may require the use of inhalers or a nebuliser and has no impact on daily living activities.

NOTE – Mr. X uses a wheelchair for longer distances. Were he fully ambulant, this might have the effect of increasing his level of need to MODERATE, as he would present with more frequent or severe bouts of breathlessness and his “daily living activities” would be affected

Low Needs

Mrs. X has no history of breathing problems or shortness of breath. However, she can be observed panting at times; this is related to feelings of anxiety. Mrs. X is encouraged to take slow breaths and is able to settle soon after. Staff monitor her breathing pattern daily and encourage her to sit and relax when she becomes restless or anxious, which appears to be effective.

Mrs. X presents with a LOW level of need as she suffers episodes of breathlessness that readily respond to management and have no impact on daily living activities.

Moderate Needs

Mr. X is wheezy and breathless when exerting himself, for example when he tries to propel himself in his wheelchair. Due to advanced dementia, he needs encouragement to rest and full assistance to use his inhaler. He is not usually breathless at rest but is sometimes observed to be slightly breathless when eating. He needs 1:1 supervision at mealtimes and prompts to take his time.

Mr. X requires Salbutamol inhaler PRN, which staff need to administer for him. He is largely unable to express his needs, even if he is having problems with his breathing.

He has chest infections in the winter months, which impact on his breathing. Antibiotics are prescribed by the GP, usually with good effect.

Mr. X experiences excess saliva in his mouth and has a diagnosis of dysphagia (difficulty swallowing). His fluids are thickened. He experienced a recent aspiration pneumonia, requiring hospital admission and antibiotic therapy.

Mr. X was observed to have noisy breathing today and was experiencing profuse salivation.

Mr. X presents with a MODERATE level of need as he experiences shortness of breath or a condition which may require the use of inhalers or a nebuliser and limit some daily living activities.

NOTE – Mr. X “only” presents with a ‘Moderate’ level of need. However, there is considerable interaction (complexity) between his needs in the domains of Breathing and Nutrition, due to excess saliva and swallowing difficulties which give rise to a high risk of aspiration. Mr. X has already suffered an aspiration pneumonia and is vulnerable to further infection, which would lead to exacerbations of breathlessness and possible complications. He also suffers from dementia and is unable to communicate his needs, meaning he is reliant on staff to monitor his symptoms and administer his inhaler as required. These factors should be carefully considered in the analysis of the four Key Characteristics. This is a good example of why the assessed level of need does not always have to be ‘High’ (or ‘Severe’ or ‘Priority’) to have a considerable impact on the overall assessment, and why the Key Characteristics really are the key to understanding the eligibility criteria.

Section 1. Breathing

Moderate Needs

Mrs. X has a history of bilateral pulmonary embolism and takes anticoagulant therapy daily to prevent further emboli. This has impacted on her breathing.

Mrs X is short of breath on exertion and occasionally at rest. Her lips and fingers can often be blue and her average blood saturations are 95% on room air. When she is feeling breathless, she needs staff to help her to sit upright and provide reassurance.

Community matron and carers report they have witnessed the shortness of breath, especially when moving and eating.

Mrs X presents with a MODERATE level of need as she suffers episodes of breathlessness that do not consistently respond to management and limit some daily living activities

Moderate Needs

Mr. X has a diagnosis of obstructive and central sleep apnoea and has used a CPAP (Continuous Positive Airways Pressure) machine overnight for several years.

He needs staff to fit the mask securely when he goes to bed and ensure the CPAP machine is working correctly. He needs staff to check on him and the machine at regular intervals throughout the night to ensure the mask remains in place. The staff report no problems or concerns with the CPAP machine since admission (6 months).

Mr. X is slightly breathless on exertion; however, there are no nebulisers or inhalers prescribed.

Mr. X presents with a MODERATE level of need as he requires a therapeutic appliance to maintain airflow where he can still spontaneously breathe e.g., CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep

High Needs

Mr. X required a tracheotomy after suffering laryngeal cancer three years ago. He reports no concerns or complications at this time and is largely self-caring. Mr. X is fully cognisant and is aware of the risks associated with his tracheotomy. However, Mr. X does require assistance in caring for his tracheotomy as he is losing dexterity.

Mr. X is able to cough effectively and is usually able to manage any excess secretions himself using a flexible suction catheter. He may sometimes require assistance from staff due to losing dexterity, and will call for help using his buzzer when required. Staff need to help him to clean the tracheotomy tube several times each day to ensure it remains free of blood and mucus. The inner tube needs to be changed regularly and routine suction is required during changes (remove inner tube, suction, insert clean inner tube).

A dry dressing is applied around the tracheotomy site to ensure cleanliness. Mr. X prefers to wear a scarf when he goes into the garden and likes staff to remind him of this.

Mr. X presents with a 'HIGH' level of need as he is able to breathe independently through a tracheotomy that he can manage himself, or with the support of carers or care workers

High Needs

Mrs. X suffers from COAD (chronic obstructive airway disease) and pulmonary hypertension. She is short of breath at rest and on any exertion.

Section 1. Breathing

Mrs. X is prescribed continuous oxygen at the rate of 1 litre per minute to assist her breathing and maintain oxygen saturation levels. Mrs. X is also prescribed Tiotropium Bromide inhaler 1 dose daily.

Mrs. X gets breathless when she is speaking, when she moves around and when she is eating. Mrs. X is unable to mobilise independently due to breathlessness and uses a wheelchair to move around the home. Staff need to make sure she is positioned in an upright position at all times to assist her breathing.

Mrs. X is able to express her needs and so can alert staff to any discomfort or exacerbations of her condition. However, breathlessness can impact on her ability to speak clearly and in full sentences at times.

Mrs. X may benefit from a review of her condition by the Respiratory Team. It would appear her symptoms are not currently well-managed and that her activities of daily living are increasingly affected.

Mrs. X presents with a 'HIGH' level of need as she suffers breathlessness due to a condition which is not responding to treatment and limits all daily living activities

Severe Needs

Mr. X required a tracheotomy after suffering laryngeal cancer three years ago. Mr. X is fully cognisant and is aware of the risks associated with his tracheotomy. However, Mr. X does require assistance in caring for his tracheotomy as he is losing dexterity.

Mr. X experiences copious secretions, worsened by increased immobility and a recent chest infection. He is able to cough, but this is not sufficient to clear secretions and he is at high risk of occlusion. Suction is performed by trained staff using a flexible suction catheter on an as-required basis. Mr. X is able to alert staff to any difficulties using the Nurse Call system but does need care to be delivered immediately and unpredictably.

Staff clean the tracheotomy tube several times each day to ensure it remains free of blood and mucus. The inner tube needs to be changed regularly and routine suction is required during changes (remove inner tube, suction, insert clean inner tube).

A dry dressing is applied around the tracheotomy site to ensure cleanliness.

Mr. X presents with a 'SEVERE' level of need as he has difficulty in breathing, even through a tracheotomy, which requires suction to maintain airway.

NOTE – The difference between the 'HIGH' and 'SEVERE' levels of need arises from the type and frequency of intervention required. While our Mr. X with a 'HIGH' level of need was able to look after his tracheotomy with minimal assistance, this Mr. X requires much more intensive, skilled attention from staff, the need for which is unpredictable. Difficulty in managing secretions mean he is at risk of suffocating, should the tracheotomy tube become occluded. In addition to regular tracheotomy care and cleaning, he requires suction be performed on an as-required, but timely, basis

Section 1. Breathing

Severe Needs

Mrs. X is diagnosed with COAD and type 2 respiratory failure. Her condition is chronic and has required numerous hospital admissions. Mrs. X is nearing the end-stage of the disease progression and has difficulty breathing all the time.

Mrs. X has a Nippy3 ventilator and settings are fixed by the Respiratory Team for non-invasive ventilation via mask from 22.00 to 06.00 and for 4 hours in afternoon. Oxygen is used whilst Mrs. X is on NIV (non-invasive ventilation), as she is now unable to maintain sufficient levels independently.

During the rest of her waking day, Mrs X has oxygen 3L per minute via nasal cannula from oxygen concentrator and is self-ventilating. This is the maximum flowrate that she is able to tolerate. Mrs. X is at risk of hypercapnia; her oxygen saturations are kept between 88 and 92% but low saturations do impact her activities of daily living.

Mrs. X now struggles to eat even small amounts of food and is nutritionally at risk. She cannot speak more than a few words before gasping for breath. She is nursed in bed in an upright position for maximum comfort. She requires regular assistance to change her position and is breathless during such interventions.

Mrs. X has been prescribed numerous inhalers, nebulisers, steroids and diuretics in an attempt to manage her condition. However, these now have limited effect and are only used to promote maximum comfort.

Mrs. X is understandably distressed and frightened by her condition and struggles to sleep for any length of time. She requires much TLC and reassurance from sympathetic staff.

Mrs. X presents with a 'SEVERE' level of need as she demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy.

Severe Needs

Mrs. X is diagnosed with type 2 respiratory failure, COAD and OSA (Obstructive sleep apnoea)/OHS (Obesity Hyperventilation syndrome). Her condition is chronic and has required numerous hospital admissions. Mrs. X requires non-invasive mechanical ventilation overnight and for 2 hours during the day to maintain adequate oxygen levels and removal of Co₂.

Mrs. X has a Nippy 3 ventilator and settings are fixed by the Respiratory Team for non-invasive ventilation via mask from 22.00 to 06.00 and for 3 hours in afternoon. Oxygen is not used whilst Mrs. X is on NIV (non-invasive ventilation).

During the rest of her waking day, Mrs X has oxygen 0.5L per minute via nasal cannula from oxygen concentrator and is self-ventilating.

Mrs. X has tolerated the non-invasive ventilation for a while but struggles to fix mask in place due to her osteoarthritis in her hands. This resulted in admissions to hospital and high dependency treatment. In the 24-hour care setting, Mrs. X is given assistance to place the mask appropriately overnight and maintain a good level of ventilation.

Mrs. X presents with a 'SEVERE' level of need as she has a condition that requires management by a non-invasive device to both stimulate and maintain breathing (bi-level positive airway pressure, or non-invasive ventilation).

NOTE – Mrs. X 2 and 3 would both meet the descriptor for a severe level of need in this domain. However, when we consider the Key Characteristics, Mrs. X 2 presents with significantly more complexity, intensity and unpredictability of need. Her daily living activities are more severely impacted

Section 1. Breathing

by breathlessness and her condition is not responsive despite maximum intervention. Mrs. X 2 and 3 actually require the same type of treatment (non-invasive mechanical ventilation, oxygen therapy via nasal cannula), but the intensity of that treatment, and the demands on the care team, are quite different. This is a good example of why it's important to consider which specific part of the descriptor is met and how the Key Characteristics are affected by the needs described, rather than relying on the fact of an "assessed level of need"

Priority

Mr. X has a complete C4/5 spinal cord injury, sustained in a road traffic accident five years ago. Following a period of rehabilitation at the Spinal Cord Injury Centre, Royal National Orthopaedic Hospital, Mr. X has made a remarkable recovery and now lives at home with a package of care.

Mr. X is tetraplegic, meaning he has no movement or sensation below the level of his injury. He is unable to move his torso, arms, hands, legs or feet.

Due to the nature of his injury, the nerve that activates Mr. X's respiratory muscles has been severed and he is unable to breathe independently. He requires invasive mechanical ventilation via tracheotomy 24-hours a day. Mr. X uses a Nippy 3+ ventilator with settings fixed by the Respiratory Team. The Respiratory Team provides ongoing clinical support including regular monitoring of blood gases.

A second ventilator is always on site for back-up, and a generator is provided in case of mains electricity failure. Mr. X has not required oxygen therapy in the community.

Mr. X is unable to cough making the management of secretions imperative. He is at high risk of occlusion and consequent suffocation. Suction is performed by trained staff using a flexible suction catheter on an as-required basis. Mr. X is unable to alert staff to any difficulties and requires 1:1 skilled nursing care 24-hours a day.

Staff clean the tracheotomy tube several times each day to ensure it remains free of blood and mucus. The inner tube needs to be changed regularly and routine suction is required during changes (remove inner tube, suction, insert clean inner tube). This is a skilled procedure, requiring Mr. X to be disconnected from the ventilator for short periods.

Mr. X requires 24-hour skilled care, the nature of which is unusual outside an acute (hospital) environment. The use of invasive ventilation in a domiciliary setting requires expert staff, with the ability to troubleshoot issues with the equipment and the patient's symptoms, and ongoing clinical support. The risk to Mr. X should complications occur are immediate and critical.

Mr. X presents with a 'Priority' level of need as he is unable to breathe independently, requires invasive mechanical ventilation.

Section 2. Nutrition Domain

Nutrition – Food and Drink: Individuals at risk of malnutrition, dehydration and/or aspiration should either have an existing assessment of these needs or have had one carried out as part of the assessment process with any management and risk factors supported by a management plan. Where an individual has significant weight loss or gain, professional judgement should be used to consider what the trajectory of weight loss or gain is telling us about the individual's nutritional status

Low Needs

Mrs. X eats independently and has a normal diet and fluids. Her appetite is good.

She does not have any swallowing problems and her risk of choking is low.

Mrs. X has lost 6.5kg since April 2021; however, she is above normal weight, and the weight loss may be due to the fact that she had recently been prescribed diuretics (March 2021) so her limbs are less oedematous than they were previously.

Weight history

December 2020 – 81.3kg

January 2021 – 81.3kg

February 2021 – 79.2kg

March 2021 – 77.4kg

April 2021 – 74.8kg BMI 26

Mrs. X has several missing teeth and does not have dentures. However, this does not appear to affect her dietary intake.

Mrs. X presents with NO NEEDS as she is able to take adequate food and drink by mouth to meet all nutritional requirements

Low Needs

Mr. X has a poor appetite. He has a normal, soft consistency diet and normal fluids and is fed and given drinks by carers. Fluids need to be encouraged.

There is no evidence that Mr. X has any swallowing difficulties and there are no reported episodes of choking.

Mr. X was referred to the GP on 22.02.2020 due to loss of appetite, low BMI (17) and a MUST score of 4. Ensure Compact food supplements were prescribed 3 x per day and a referral was made to the Dietician. Mr. X was reviewed by the Dietician on 5.09.19 and 17.10.19; BMI now 19 MUST score 1 – the advice was to continue with food supplements and a fortified diet, milky drinks and snacks between meals.

Weight history 2020

On admission 6.2.20 – 42.3kg (BMI 17)

April 45.3kg

May 46kg

June 49.5kg

August 49.4kg

Section 2. Nutrition Domain

July 50.6kg BMI = 21

September 49.6kg

October 48.3kg

November 50.6 kg

Dec 51.6kg

Since his admission to the home in February 2020, Mr. X has gained 9.3kg in weight. (1.5 stones). Mr. X is now fed by carers due to declining cognition; however, he appears to enjoy his meals, which he will typically finish within 15-20 minutes. Mr. X's weight has steadily increased since admission to the home and is now within the normal range. His BMI has increased to 21 and the Dietician reviewed him on 5th December 2020 and decreased his food supplements to x 2 per day. Mr. X will be reviewed again in January 2021 with a view to reducing the supplements to 1 per day and then discontinue.

Mr. X presents with a LOW level of need as he is able to take food and drink by mouth but requires additional/supplementary feeding.

NOTE – Mr. X has a history of weight loss and low BMI, which might suggest his nutritional status is at risk ('high' level of need). However, at the time of assessment, he has gained a significant amount of weight and his BMI is within the healthy range. The Dietician has reduced the prescription of supplements, with a view to discharge in the near future. To that extent, Mr. X is no longer considered "nutritionally at risk"

Moderate Needs

Weight History

October 2020 – 64.5kg

November – 63.8kg

December – 64.1kg

January 2021 – 62.5kg

February – 63kg

Mr. X has a normal consistency diet with normal thickness fluids. There is no evidence that he has any difficulty swallowing (dysphagia) and he is not assessed as being at risk of aspiration.

Mr. X's weight is currently stable. However, he has a history of significant weight loss (2019) and was under the care of the Dietician until June 2020. Mr. X has now been discharged by the Dietetics department, but his diet is fortified with additional calories to ensure he maintains his weight.

Mr. X is severely cognitively impaired and is unable to feed himself. He needs to be fed by one member of staff to ensure adequate daily nutritional intake. Mr. X is compliant with feeding but requires much encouragement to eat and drink adequate amounts. Typically, Mr. X takes between 40 and 60 minutes to finish a meal.

Mr. X presents with a MODERATE level of need as he needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed.

Moderate Needs

Mrs. X is nil-by-mouth and all her nutritional requirements are met via PEG (percutaneous endoscopic gastronomy). She is under the care of the dietician, who reviews her regime on a regular basis.

Section 2. Nutrition Domain

1000mls of Jevity feed and 1000mls of water are administered over a 12-hour period, between the hours of 7am and 7pm, per the instruction of the dietician.

Mrs. X needs to be positioned at a 45-degree angle for the duration of the feed and for 45-minutes pre-and post-feeding, to reduce the risk of choking and aspiration.

Mrs. X drools saliva from her affected side and her mouth becomes dry easily. Carers perform oral hygiene to prevent the build-up of mucous and plaque in her mouth.

Mrs. X is assessed as being at a high risk of choking. However, she is nil-by-mouth and has been discharged by the SaLT (Speech & Language Therapy) Team.

Mrs. X's son reported that on one occasion, when he visited his mother, he found her lying flat and she was choking. The senior nurse stated that Mrs. X had used the remote control for the bed and had inadvertently lowered the head of the bed. The nurse confirmed that the remote has now been removed from Mrs. X's reach and that staff check on her every 15 minutes while the feed is running.

Mrs. X's weight is stable, and she appears to be well nourished and hydrated.

Weight history:

31.07.2020 – 64.8kg, BMI = 23

30.08.2020 – 65.8kg

15.09.2020 – 65.8kg, BMI = 24.1

MUST score = 0

Mrs X presents with a MODERATE level of need as she is unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG

NOTE – Many people would consider Mrs. X to have a 'HIGH' level of need as she is diagnosed with dysphagia (swallowing difficulty and associated risk of choking). However, Mrs. X does not take **any** nutrition or hydration orally and receives all her food and fluids via PEG. Consequently, her risk of choking and aspiration is drastically reduced, and she does not require skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway ('high' level of need).

High

Mrs. X is under the care of Speech and Language Therapy to periodically assess and review her swallow. She is noted to have moderate oropharyngeal dysphagia and is assessed by SaLT as being at a high risk of aspiration. She has a delayed swallow and a tendency to pocket food in her mouth. Mrs. X also requires the input of the dietician to ensure she is getting the right nutrients.

Mrs. X has a recent history of chest infections and was admitted to hospital for treatment of aspiration pneumonia in January of this year. She remains at very high risk of further infection.

Mrs. X has frontotemporal dementia (also known as Pick's disease). Mrs. X has the variant that includes FTD associated with motor neurone disease, which impacts on her muscles. This causes poor muscle control and poor swallow. In 2016, when the condition took rapid hold, she was unable to eat and drink at all. Mrs. X has an advanced directive confirming she does not wish to be fitted with a PEG.

Mrs. X requires a pureed diet and stage 3 thickened fluids. Despite these adjustments, Mrs. X continues to cough and choke on food and fluids. This occurs 2-3 times a week. In the event of choking, staff are required to clear the airway manually and to assist Mrs. X to cough. Suctioning has been required on two occasions since admission to the home, as Mrs. X was unable to clear her airway with maximum staff assistance.

Section 2. Nutrition Domain

Mrs. X is unable to feed herself. Carers need to feed her food and fluids from a spoon or syringe. She is unable to tolerate the use of a beaker. It is difficult to coax Mrs. X to open her mouth for feeds at times. She clamps her mouth shut and requires lots of encouragement. Feeding is time consuming, and usually takes 40-60 minutes per meal, 3 times daily with a carer on a 1:1 basis. Mrs. X needs thickened fluids to be given on a spoon throughout the day on a 1:1 basis by a carer.

Due to poor cognition and communication, Mrs. X is unable to indicate her requirements for food or fluids. Carers need to monitor and record her intake. Carers need to identify foods that make her cough and to eliminate these from her diet. Mrs. X is not mobile and needs to be hoisted by 2 carers into a chair for meals to ensure she is in an upright position to minimise the risk of aspiration. After meals she needs to be hoisted back to chair or bed by 2 carers. She is not able to assist with these transfers. Due to the impact of Pick's Disease on her muscles, Mrs. X is often 'floppy' and her head drops forwards, requiring the carer to support her head whilst feeding. She is floppy mostly on the right-hand side and needs lateral support to her trunk to keep her in an upright position for feeding (see Mobility domain).

Mrs. X presents with a 'HIGH' level of need as she suffers from dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway.

High

Mr. X is severely cognitively impaired and requires full assistance to eat and drink. He does not suffer any difficulties swallowing but does struggle to take adequate fluids. Mr. X is extremely resistant to prompts and often reacts angrily when staff attempt to encourage him to drink throughout the day. He will push their hands away and throw the beaker if he is able to grab it.

Mr. X has a history of recurrent urinary tract infections and urosepsis, exacerbated by lack of adequate fluids, and has required three recent admissions to hospital with dehydration. On each occasion he has required rehydration with intravenous fluids.

In an attempt to better manage Mr. X's condition, and prevent further admission to hospital, fluids are administered via subcutaneous infusion twice a week. A butterfly cannula is inserted into Mr. X's thigh and 2 litres of fluids are administered over a 24-hour period. Mr. X is nursed in bed on these days and tolerates the process very well. He does not appear to be bothered by the cannula and does not attempt to interfere with the equipment.

Mr. X presents with a 'HIGH' level of need as he requires subcutaneous fluids that are managed by the individual or specifically trained carers or care workers.

High

Weight Record – 2020

January – 68.6kg

February – 65.9kg

March – 63.6kg

April – 62.2kg

June – 60.9kg

July – 59.2kg

Section 2. Nutrition Domain

Mrs. X has lost almost 10kg since her admission to the home in January and has a BMI of 17. Her family indicated that she was always a fit lady and did not carry excess weight. She was very particular about her dietary intake and was a vegan. Mrs. X is now vegetarian as the home is unable to cater for her dietary preferences, which is disappointing.

The care home records do not indicate a varied diet and consist of processed foods such as vegetarian burgers and sausages. Mrs. X states that she does not enjoy the food and believes it to be unhealthy. She indicated at a recent care plan review that she was fed up with omelettes, which she is served 3-4 times a week.

Care records indicate that weight loss is due to energy loss/ataxia. However, it seems likely that Mrs. X's weight loss is partially explained by a lack of appropriate, tasty food options.

Mrs. X is under the care of the Dietician who has prescribed Fresubin supplements twice daily. Despite this intervention, she continues to lose weight, although the rate of this has slowed in recent months.

Mrs. X eats a normal consistency diet, but needs her food cutting up, with a plate guard, due to loss of dexterity. She would benefit from adaptive cutlery (right angled) to maintain her dignity when eating. This may also have the effect of increasing intake, as Mrs. X feels embarrassed eating in front of others as she sometimes spills her food.

Mrs. X was observed to be eating with her hands at lunch time as she was unable to coordinate the spoon and food. Mrs. X is a very proud lady, and this loss of dignity and independence is difficult for her and may well be affecting her appetite. The Nurse Assessor has spoken to the registered manager about providing a more varied, healthy diet to Mrs. X and ensuring she is provided with adapted cutlery.

Mrs. X is nutritionally at risk.

Mrs. X presents with a 'HIGH' level of need as her nutritional status is "at risk" and may be associated with unintended, significant weight loss

High

Mrs. X has a Percutaneous Endoscopic Gastrostomy (PEG), and all her nutritional needs are met via the PEG. On admission to the home, she had Jevity liquid feed prescribed which was administered via pump. Unfortunately, Mrs. X was very restless and would knock the pump over affecting its running. Consequently, Mrs. X was not receiving sufficient nutrition; she lost a significant amount of weight and her nutritional status was deemed to be at risk.

Due to ongoing difficulties with the PEG-feed and concerns about weight loss, dieticians reviewed, and the pump was discontinued. All nutritional needs are now administered as a Bolus feed every hour, over a period of 10 hours.

Mrs. X needs to be positioned at a 45° angle whilst receiving the feed to reduce the risk of aspiration. She remains at very high risk of aspiration and requires very careful positioning pre-and post-feed. Mrs. X's feeding regime is time consuming and complicated. Whilst she was for a period prescribed the feed hourly for 10 hours and this was reduced to 8 hours, she additionally required input for oral feeding and additional boluses of water.

After her feeding regime was changed, Mrs. X put on too much weight, at a rate of 0.5kg per week. The dietician was involved in reducing the feed whilst still trying to retain correct nutritional content. Bolus feed every hour needs to be slowly administered by the RN via a syringe into the feeding tube; the tube needs to be flushed with sterile water before and after each feed, and before and after medications (twice daily).

Mrs. X needs to be put in a 45-degree position for feeds; this requires two carers to put her into the correct position and ensure it is maintained. She needs to be bolstered with pillows as she has a tendency to lean to the left, due to left-sided weakness and poor sitting balance.

Mrs. X remains under the care of the Dietician, who reviews her condition monthly.

Mrs. X presents with a 'HIGH' level of need as she has problems relating to a feeding device (for example PEG) that require skilled assessment and review

Section 2. Nutrition Domain

Severe

Mr. X has had a diagnosis of Crohn's disease for many years and has required various surgical procedures. Following a recent flare-up of his condition, Mr. X required surgery to remove damaged sections of his small intestine (small bowel resection). Unfortunately, this has resulted in complications and symptoms of short bowel disease (SBD).

Mr. X is presently unable to absorb sufficient food and fluids due to damage to his small intestine and is significantly malnourished. He requires total parental nutrition (TPN) via a central cannula to prevent further weight loss and ensure adequate fluids. Due to a high risk of infection and sepsis, aseptic techniques and proper maintenance of the line are vital; please see Skin domain.

Mr. X's nutritional regime is managed by the specialist Dietician who will visit daily, reducing to weekly providing no complications arise. Nursing staff in the home have undertaken, and will continue to receive, specialist training and direction from the Dietician.

Mr. X presents with a 'SEVERE' level of need as he is unable to take food and drink by mouth. All nutritional requirements taken by artificial means requiring on-going skilled professional intervention or monitoring over a 24-hour period to ensure nutrition/hydration, for example I.V. fluids/total parenteral nutrition (TPN)

Severe

Mrs. X has a diagnosis of stage 4 breast cancer. Sadly, no further medical interventions are possible or appropriate. Mrs. X is approaching the end of her life; the priority is tender loving care, and ensuring her comfort and dignity as far as is possible.

Mrs. X has now entered the palliative stage and is receiving anticipatory medications; see Drug Therapies and Medications domain. She is largely semi-conscious and is unable to take any nutrition or hydration orally. Subcutaneous fluids were discussed, but Mrs. X has an advanced directive confirming she does not wish to receive this type of care at this stage in the disease progression.

Mrs. X requires staff to perform oral care every four hours.

Mrs X presents with a 'SEVERE' level of need as she is unable to take food and drink by mouth, intervention inappropriate or impossible

Section 3. Continence Domain

Low Needs

Mr. X wears pads day and night. Continent of urine with occasional accidents. Continent of faeces. Mr. x is able to inform staff when he needs the toilet. At night likes to use the commode and a urine bottle in his room.

Mr. X has been diagnosed with Stage 5 kidney disease. He requires Peritoneal Dialysis (PD) via Continuous Ambulatory Peritoneal Dialysis (CAPD) which removes waste products from his blood because his kidneys can no longer do this adequately. Please see Other Significant Needs domain.

Mr. X uses a urinal (bottle) during the day so the staff can measure his urinary output; however, there are frequent accidents when he will spill the contents of the urinal onto his clothes. He requires prompts and assistance to use the urinal at regular intervals throughout the day.

Mr. X will sometimes go to the toilet independently and uses the commode when he needs to open his bowels. He remains continent of faeces throughout the day and night but wears incontinence pads in case of occasional accidents.

A loaded bowel can affect the drainage of the dialysis fluid and it is important that Mr. X does not become constipated. Staff are required to monitor the frequency of bowel movements as Mr. X may not remember to inform them due to impaired cognition and short-term memory loss. Laxatives are prescribed and administered daily with good effect.

Mr. X presents with a 'Low' level of need as his Continence care is routine on a day-to-day basis; incontinence of urine managed through ... regular toileting and he is able to maintain full control over bowel movements

Low Needs

According to the care staff and his family, Mr. X is 'fiercely independent' with his continence needs. His Care Plan indicates that he has occasional urinary accidents, usually during the night, although he will robustly deny this if questioned.

Mr. X is, understandably, very embarrassed by incidents of incontinence and will attempt to hide them from staff; his bed sheets have been found, on occasion, in the bin in his bathroom and stuffed under his mattress. Staff need to be vigilant to ensure his room is kept clean and to handle any incidents of incontinence sensitively and discreetly. Staff check Mr. X's room every morning while he has his breakfast in the dining room to avoid upsetting or embarrassing him.

Mr. X is currently trialling a Convene (penile sheath) at night due to nocturnal incontinence. Discussions should be had with Mr. X about a range of continence products specifically for men that would maintain his dignity. A referral to the Continence Service has been made by his GP.

Mr X is usually continent of faeces, although has had a couple of accidents when he has been unwell.

Mr. X has a history of constipation and is prescribed a daily laxative with good effect. Mr. X has not suffered from constipation since his admission to the home, likely because he is now taking a regular laxative.

Mr. X presents with a 'Low' level of need as his continence care is routine on a day-to-day basis. Incontinence of urine managed through ... use of penile sheaths. And may have occasional faecal incontinence/constipation

Section 3. Continence Domain

Low Needs

Mrs. X is fully continent and takes herself to the toilet independently. She does not require prompts or assistance to meet her continence needs.

Mrs. X has a colostomy following surgery on her bowel five years ago. The stoma is stable and non-problematic. Mrs. X is usually able to care for the stoma and empty the colostomy bag herself, although she may need some assistance if she is feeling unwell or particularly tired.

Mrs. X presents with a 'Low' level of need as her continence care is routine on a day-to-day basis; ... has a stable stoma

Moderate Needs

Care Plan

Doubly incontinent. Wears pads day and night.

Completely unaware of toileting needs. Does not indicate needs.

No UTIs.

No bowel problems but is prescribed regular Lactulose once daily.

Nurse Assessor's comments:

Mrs. X is doubly incontinent and completely unaware of her toileting needs. Staff utilise pads in order to manage her incontinence and provide regular checks and changes of her pads to ensure her comfort and to reduce the risk of irritation to her skin.

She is prescribed regular laxatives once daily which are reported to be effective in maintaining a healthy bowel habit. She does not suffer with recurrent urinary tract infections and there is no evidence to indicate that Mrs X's continence needs are complex or difficult to manage.

Mrs. X presents with a 'Moderate' level of need as she continence care is routine but requires monitoring to minimise risks, for example those associated with ... double incontinence [...]

Moderate Needs

Care Plan:

Incontinent of urine.

Wears pads

Chronic UTI

Suffers with constipation.

Assessor's Notes

Incontinent of urine day and night.

Continent of faeces.

Refuses to wear continence pads – will remove and shred pads.

Section 3. Continence Domain

Staff have a toileting regime in place to promote continence which helps somewhat; however, accidents still occur.

History of recurrent UTI, now chronic (E-coli), managed with prophylactic antibiotics.

Treated with Senna for constipation but no chronic history/history of severe symptoms.

No history of bowel problems.

Nurse Assessor's comments:

Since admission to the care home, Mrs. X's continence is noted to have declined and she is now incontinent of urine day and night. She requires full assistance from staff to meet her continence needs with the use of pads and regular toileting. She remains largely continent of faeces providing staff take her to the toilet regularly.

Mrs. X dislikes wearing pads and has a tendency to remove and shred them. She requires regular checks to ensure she is clean and dry.

Mrs. X has a history of recurrent UTI prior to admission which, unfortunately, went undiagnosed and untreated for some weeks. She became very unwell and was admitted to hospital with urosepsis having collapsed at home. Investigations while she was in hospital confirmed chronic infection and inflammation of her bladder lining. Mrs. X is prescribed prophylactic Nitrofurantoin to manage symptoms and prevent worsening infection. Staff are required to monitor for symptoms of exacerbation, such as: confusion, disorientation, agitation, poor sleep, frequent urination, discomfort – e.g. holding her lower abdomen, fever, loss of appetite. Mrs. X is sometimes able to communicate her symptoms to staff, but due to increasing cognitive impairment this is not always reliable and she relies on skilled monitoring and anticipation of symptoms by staff who know her well.

Mrs. X presents with a 'Moderate' level of need as her continence care is routine but requires monitoring to minimise risks, for example those associated with ... chronic urinary tract infections [...].

Moderate Needs

Mrs. X has an in-dwelling catheter which was inserted during a recent stay in hospital when she was unable to pass urine for a number of days, leading to her bladder becoming distended. Upon her return home, a trial without catheter was attempted, but had to be abandoned after Mrs. X did not pass urine for over 48-hours and was experiencing abdominal pain.

The catheter is managed by the District Nursing team, who change the tubing every three months.

The catheter has not been problematic to date and Mrs. X has not required any bladder washouts or catheter changes outside routine care, which is provided by the District Nursing team.

Mrs. X is fully continent of faeces and takes herself to the toilet independently.

Mrs X presents with a 'Moderate' level of need as her continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters [...]

High Needs

Catheterisation Records and Care Plan

Occasional continence difficulties during the day and night.

Occasional pain with bowel movement.

Disposable pads.

Nurse Assessor's comments:

Section 3. Continence Domain

Mrs. X is diagnosed with chronic renal failure and suffers with urinary retention for which she has a permanent urethral catheter in situ. She also suffers with constipation and is prescribed aperients which are effective in managing her symptoms.

Mrs. X's catheter has been chronically and frequently problematic having required 20 bladder washouts and 9 re-catheterisations in 3 months. She requires close monitoring of her urine output to identify when her catheter is blocked and requires prompt and skilled intervention in order to troubleshoot and provide appropriate care to reduce the risk of pain, discomfort and infection.

Mrs. X presents with a 'High' level of need as her continence care is problematic and requires timely and skilled intervention, beyond routine care (for example frequent bladder wash outs/irrigation ... frequent re-catheterisation)

High Needs

Mr. X is doubly incontinent and wears pads throughout the day and night. He is unable to alert staff to episodes of incontinence and is unaware of the need to void. He struggles to open his bowels now that he is unable to sit on the toilet.

Mr. X has a history of chronic constipation and faecal impaction leading to bowel obstruction. A stent has been inserted into his bowel. Mr. X requires careful management of this bowel to prevent reoccurrence, taking into account the fact that his bowel is now weakened.

Mr. X is prescribed oral laxatives twice daily, as well as a stool softener, which is usually effective in maintaining regular bowel movements. Staff monitor bowel movements closely and administer phosphate enemas if Mr. X has not opened his bowel for more than 48-hours.

If Mr. X has not opened his bowel after two enemas have been administered, staff perform manual evacuation to ensure he does not become impacted. Care records confirm this is required 1-2 times a month.

Mr. X presents with a 'High' level of need as his continence care is problematic and requires timely and skilled intervention, beyond routine care (for example ... manual evacuations)

Section 4. Skin Integrity inc Tissue Viability