Prompts for NHS funded Continuing Health Care

The following pointers are intended as a prompt for staff involved with NHS Continuing Health Care multi disciplinary team meetings. It is based on experience of Continuing health care meetings attended during the skilled assessors' project. It is not a definitive work and has been put together to aid staff when they are involved in continuing care to help them ask questions to establish if someone has a primary health need.

The framework is quite specific that evidence has to support statements on the decision support tool and that validated assessment tools have to be used. An assessment tool devised by an individual home will not count. The validated assessment tools we have come across during the secondment are listed in the domains.

A few useful cross references are included in this prompt but it does not cover everything and should be used along with a copy of the framework and the guidance notes for the decision support tool. The 2009 revised version of the framework has been used as a basis for this prompt sheet.

Primary health need.

Establishing a primary health need is based on the nature, intensity, complexity and unpredictability of the individual’s needs. (These primary health needs make up the word NICU as a way of remembering). Page 9 Point 47 of the guidance to the framework corresponds to Page 8, point 29 in the guidance notes for the Decision Support Tool. It is an important point as it highlights well managed needs. The point states

‘A well managed need is still a need and care plans and strategies can minimise behaviour issues. The decision support tool guidance notes page 8 (point 29) states that needs should not be marginalised because they are well managed. ‘Only where the successful management of a health care has permanently reduced or removed an ongoing need will this have a bearing on NHS continuing health care 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addressing behavioural issues, consideration should be given as to the present –day need if that support were withdrawn or no longer available and this should be reflected in the behaviour domain’.

This is a valuable point to remember as we have often heard people say at the multi disciplinary team meetings (MDT) that the need is well managed and therefore not a problem.

There is a new point in the revised version of the framework (Page 10, point 29) that says that any deterioration that can reasonably anticipated to occur before the next planned review should be documented and taken into account. This is especially of value when someone has a deteriorating condition but is not yet at fast track stage. If you think that the person will meet the criteria for NHS continuing before the next review consider it under this point.

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Continuing care and hospital discharge.

Again the framework guidance notes are quite specific, running from pages 18-19. This section gives information about delayed discharges, assessments for continuing health care and where the most appropriate setting may be for the assessment to take place. The framework also says who is responsible for funding the care until the full assessment has taken place. It states that if a person is in a hospital setting that before the NHS body gives notice in compliance with section 2 of the Community Care (Delayed Discharges) Act 2003 it ‘must take reasonable steps to ensure that an assessment for NHS Continuing Healthcare is carried out in all cases where it appears to the body that the patient may have need for such care’. This should be in consultation, as appropriate with the relevant LA.

NHS Continuing Health Care and the Mental Health Act 1983 is considered on pages 33-34 of the framework guidance notes.

Core Values and Principles are on pages 12-17 and covers consent, capacity, Advocacy and Carers.

Direct Payments and Individual Budgets and NHS Continuing Health care are discussed on pages 17-18 of the framework guidance notes.

Behaviour Domain

Any there any instances where the service user is resistant to personal care interventions? This can be physical aggression, verbal aggression, spitting, scratching, biting etc. Can also be a deliberate or purposeful stiffening of limbs and body to resist care interventions, especially when the service user no longer has a lot of physical strength to resist?

Are there any care plans or risk assessments in situ for management of the service user’s behaviour on the ward/unit etc?

Does the service use shout or exhibit other behaviours that could impact on their safety? What are the risks to or from other patients/residents/visitors from these behaviours?

Does the service user
  • make an incessant noise, repeatedly ask the same questions, sing, tap, bang, scream etc
  • Hoard items
  • Collect items up from their environment
  • Show signs of disinhibition
  • Night time disturbance to others
  • Show signs of Sundowning
  • Have times of day when the behaviour is more exaggerated.

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Is there any CPN involvement?
Any CHESS team involvement?
Any CMHT or mental health services involvement?
Any 1:1 support time.
Are there any medications that are given on an ‘As required’ basis to help manage behaviours?
Is there a forensic history that impacts on the current situation?

Are there any known trigger factors?
Are there any recorded ways or behaviour strategies in place to manage the behaviours?
Are there any repeated accusations against carers/family members that are unfounded?

Cognition Domain

Does the service user have any cognitive impairment and if they do has a diagnosis been given.

If there is a diagnosis, who made it and do they continue to be involved with the service user?

What is the diagnosis? Some illnesses progress faster than others so it may be necessary to ask for a prognosis.

Has there been any formal testing of cognition? I.e. MMSE, Acer etc

Can the service user orientate to time, date and/or person?
Can they assess basic risks?

Can the service user recognise if they are in pain, hungry, thirsty, frightened etc and can they let someone know if they are?

Can the service user sequence tasks such as using the toilet, getting washed, dressed etc?

Can the service user comprehend and follow instructions? (These can be verbal or visual instructions)

Is the service user’s cognition variable/unpredictable

If the individual does not have English as a first language are they reverting to their original language?

A useful link is to the 7 stages of dementia (as identified on the Alzheimer’s web site) as this helps with determining the level of cognitive impairment.

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Recognised validated assessment tools include
The Mini Mental State Examination (MMSE)
Addenbrooke's Cognitive Examination (ACE)

Psychological and Emotional Domain

Does the service user have a problem with depression?

Does the service user have a problem with anxiety?

Have they recently been bereaved?

Does the service user receive any input or support from mental health services? (Could include CPN, consultant psychiatrist, CHESS team, CMHT)

Does the service user have hallucinations? These can be visual/auditory/touch/taste etc or in combination.

Does the service user respond to reassurance?

Are there instances of agitation, distress, anxiety etc?

Are they on any medication to help with any symptoms of depression, anxiety, agitation, hallucinations, mood etc?

Validated assessment tools include
The Hamilton Depression Scale
The Geriatric Depression Scale
The Cornell Scale for Depression in Dementia

Communication Domain

Can the service user communicate reliably in their first/main language?

- Does their conversation make sense?
- Are any responses appropriate and in context?
- Are there signs of confabulation, perseveration, echolalia etc?
- Does the service user have any word finding difficulties?

Are there any barriers to communication?

Is the service user registered blind, partially sighted etc?

Do they have any eye conditions – macular degeneration, diabetic retinopathy, glaucoma, hemianopia, Charles Bonnet etc?

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Hearing – are they hearing impaired? Do they have hearing aids and if so what type? Which ear? Can they manage the hearing aid? Do they prefer not to use hearing aids? Does written information has to be written down? Do they use British sign language or the manual deaf/blind alphabet? Are they socially isolated due to sight/hearing impairment?

If English is not a first language can they manage to make their needs known?

Can they say if they are pain, hungry, thirsty, frightened etc and if they do is it reliable or do staff anticipate/guess/use process of elimination to ascertain what the person is trying to convey?

Is there Pressure of Speech or any other similar condition?
Do staff anticipate needs because they know and are familiar with the individual?
Are the SALT Team (Speech and Language therapy team) involved or have they been involved in the past?
Is there any receptive and expressive dysphasia?

Mobility Domain

This domain is not just about the ability to weight bear and transfer but should cover all movement and should recognise pain on movement.

Can the service user mobilise independently?
Does the individual use any aids to assist mobility and if so can they use the aid safely?

Was the aid issued via OT’s or was it purchased without advice?

Are there any risk assessments for falls and/or moving and handling issues?

If there is an identified risk of falls what is the score and frequency?
Have reasons been identified for the falls?

What is the management strategy to reduce the falls?
What mobility aids are used?

Are these assessed regularly for their appropriateness?

Is the service user able to weight bear?

Do they need a stand aid?
Do they need a hoist and if so what type?

Can the service user change their position in a chair or bed or are they reliant on staff to change their position in order to manage pressure care?

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What is the frequency of interventions for pressure care.

What type of bed do they have?
What type of mattress do they have?
Do they require bed rails, crash mats, bumpers etc and if they do, is the type of equipment used care planned?
Do they have a specific type of chair? i.e. Tilt and Space, Kirton etc.
If they do who has provided this equipment and who maintains it (ASC, Health, the Home, the service user etc)
Can they maintain a good sitting position in the chair or do they have poor balance and body posture that requires additional support?

Can the service user assist staff with transfers and is their ability to assist reliable?

Are Physiotherapists or OT’s involved?

Is there any limb rigidity or tremors?
Are there any contractures and if so where and to what extent does this impact on care? Have any stretching exercises been prescribed to maintain nerve innovation and if so what is the frequency of these exercises?

Does the service user have any difficulties with Kyphosis or other condition that affects the position of their head and neck? This can impact on breathing, chest infections, swallow ability etc.

Kyphosis is an excessive outward curvature of the spine causing hunching of the back – used to be called ‘dowager’s hump’ in older women and can be associated with osteoporosis and long term steroid use.
Lordosis is an excessive inward curvature of the spine. (Not as common as Kyphosis)

Does the service user need t-rolls, pillows, sheepskin pads between limbs when in bed or a chair to prevent pressure areas?

Assessments
Bensham Falls Risk Assessment
FRAT (Falls risk assessment tool) for Older People

Nutrition Domain

Does the service user have in any needs in this domain?
What is their weight and BMI?
Is this stable or has there been a recent weight loss or gain?
Any there any recognised eating disorders?
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Does the service user need to be supervised while eating?
What type of diet does the service user have?
Do they need any supplements and if so what type and what frequency?
Does the service user need any extra calories adding to their meals?
How long does it take for them to eat?
Is there a Choking risk?
Has there been a SALT team assessment – any dysphagia or other aspiration risk?
Is there a dehydration risk?
Are Sub cut fluids needed and if so what is the frequency for them to be used?

Does the service user need careful positioning to reduce choking risk?
Does it have to be a skilled carer who assists with meals or can it be a new/inexperienced carer?
Does the service user have any problems maintaining their head in a suitable position for eating?
Are they able to hold their head in a good position for swallowing?
Kyphosis or Lordosis?
Are there any problems with mal-absorption?

Recognised validated assessment tools include
Malnutrition universal screening tool (MUST)
The Derby Nutritional Scale

Continence Domain

Is any incontinence mechanical i.e. the individual knows they need the toilet but cannot get there without help? When that help is not available when needed the person is then incontinent.
Is the service user incontinent of urine?
Is the service user incontinent of faeces?
Does the service user require any bowel management?
Do they take aperients? And if so are any on an ‘as required’ or ‘prn’ basis.
If they are on a ‘prn’ basis, who decides when they are needed?
Prn stands for ‘pro re nata’ and is Latin for when necessary.

Does the service user need suppositories or enemas?
Who judges when these are needed?

Does the service user have a history of Urinary tract infections?
Does the service user have any urinary retention?
How is the continence managed?
Are they on any prophylactic antibiotics for the Urinary Tract Infections? (UTI’s)

Do they use pads?
Have they been assessed by the continence advisor?

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Are they allowed any extra pads?

Does the service user have a catheter? If so is it a supra-pubc catheter?
Does the individual use a convene?

Does any incontinence interact with any skin breaks?
Does the service user have any renal disease?

Is the service user prone to episodes of diarrhoea?
Has the service user had C diff?
Has the service user had MRSA?

Does the service user have any nocturnal continence care needs?

Does the individual have a stoma? Is the stoma site stable?
If the stoma is for the bowel, how far up the bowel is the stoma site as this may impact on both nutrition and skin integrity. If the stoma is high up then nutrients do not have as much time to be absorbed and the stomach contents are very acidic. Therefore any leakage at the site may very quickly impact on skin integrity. The stools tend to be very watery as well which can have an impact on hydration.

Skin Integrity Domain

Does the service user have needs in this domain?

What type of mattress do they have on their bed?
Does their chair have a pressure cushion?
What type of skin does the service user have? Dry, flaky, fragile etc
Do they have any skin conditions – eczema, dermatitis, psoriasis, itchy skin.
Is there a risk of skin breaks – scratching, skin flaps etc?
Are there any existing pressure areas and if so how long have they been in existence?
What are any wounds like?
What is the size and shape of any wound?
What type of dressing is used and how often is it changed?
Is the wound healing?
Is there a specialist dressing system in place?

Is the service user cachexic? (Cachexia is a condition of abnormally low weight, weakness and general bodily decline associated with chronic disease. (Occurs in conditions such as cancer, C.O.P.D, pulmonary disease, tuberculosis and malaria).
Does the service user have a recognised eating disorder?
Do they have skin folds that increase the risk of sore areas?
Are they on steroids?

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Have they had long term steroid use?
Do they have liver or kidney problems that result in itchy skin?
Are they on any medications to relieve itching?
Is the service user in any pain from wounds or pressure areas?
Does the service user try to resist interventions on wound care?
Has the service user had MRSA?
Has the service user had C diff?
Are they on any prescribed creams and ointments?

Validated assessment tools
Waterlow score (The higher the score, the greater the risk)

Braden Scale. (not widely used in Cumbria. The lower the score the higher the risk)

Maelor Scale (The higher the score the greater the risk)

Breathing Domain

Is the service user prone to chest infections?
Do they use a nebuliser and can they manage it themselves?
Do they use Inhalers, Volumatic or spacer or other equipment and can they use it correctly.
Does the service user need any mechanical equipment to help them breath i.e. Bi-pap, c-pap, cough assist machine, suction machine etc? If so what is the frequency with which they need to use the equipment?
Who has supplied this equipment?
Who is trained to use this equipment?
Does the service user need Oxygen and if so, is it via a concentrator or oxygen cylinder? Is there a falls risk from trailing tube wires and trip hazard?
Is there any kyphosis or lordosis that affects breathing ability and restricts lung capacity?
Is there a muscle condition that affects breathing ability and restricts lung capacity?
Is the condition degenerative?
Does it impact on their ability to take part in activities of daily living?

Medication and Drug Therapies Domain

What medication is the service user on?
What is the frequency for the medication?
Is any of it soluble or in liquid form?
Is the service user concordant with taking medication?
Are they aware they are taking medication?
Is the administration of medication overt or covert?
Do any care plans exist for covert medication?
Is the service user in any pain?

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If the individual is not able to say if they are in pain are there any assessments such as the Abbey Pain Scale for people with dementia?
Do they take any prophylactic medications?
Has the service user had C diff in the past?
Are any of the medications on an as required or PRN basis?
Who judges when to give this medication?
Is any of the medication adjustable within the prescription?
Is the service user on Oxygen?
Do they have dialysis?
Do they have any specialist medical equipment?
Is the service user on any controlled drugs?

If the service user has a PEG and medications are administered via the PEG are there any BAPEN guidelines in the file or care plan for the BAPEN Guidelines? (British Association for Parenteral and Enteral Nutrition)
Do they have supplements, thick n'easy, creams, ointments, lotions etc on prescription?

If the service user is on any anti-psychotic medications are they care planned according to NICE guidelines?

Assessments
Abbey pain scale for people with dementia
Nice Guidelines
BAPEN guidelines

Altered States of Consciousness (ASC) Domain

Has the service user had any Tia's? (Transient ischaemic attacks)
Has the service user had seizures?
Are they on any medication to control seizures?
Has the service user had any Vasovagal attacks?
Do they have Vasovagal syncope?
Where there are episodes of altered states of consciousness do care plans exist?
Does medication have to be given and if so how is this administered?
Rectal diazepam is a skilled task.
Is the service user in another consciousness and unarousable at times?
Do medications for seizures etc cause drowsiness and increase risks in other areas i.e. mobility and falls?
Do episodes of ASC impact on other areas of care i.e. service user is so tired after an event that they need to sleep for long periods. This can impact on nutrition, hydration and tissue viability.
Has the service user had any episodes of altered states of consciousness?
(Head injuries that result in a loss of consciousness should be considered under a History of ASC and marked at a minimum of low)
Following a serious head injury is the service user at risk of developing seizures?

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Validated Assessment Tools
The Glasgow Coma Scale.

Other

Any other factors including sleep pattern, dialysis, heart failure, heart disease, renal failure or other previous health problems that have been resolved but left other problems i.e. lymphodema as a result of previous radiotherapy treatment etc.

Also consider if there are any written directives by the individual

Are there any areas of care that could result in difficulties for the service user, i.e. unsuitable accommodation, carers needs, family dynamics that could have an impact on care etc

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