Care Home Data Sharing Report

29/06/23

A report by:

Digital Health & Care Innovation Centre

Prepared for:

The Scottish Government

Scottish Care
Voice of the independent care sector

Purpose of report

This report presents the findings of an engagement and co-design process with care home and other community professionals that mapped and analysed current and possible future state data sharing needs and methods.

Authors

Chaloner Chute (chalonerchute@dhi-scotland.com)

Gabriele Rossi (gabriele.rossi@dhi-scotland.com)

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1. Executive Summary

The challenges of data sharing across health and social care are well articulated including issues of fragmentation, access, and duplication. A key objective outlined in the Digital Approaches in Care Homes Action Plan is to "Identify needs and develop approaches for data gathering that supports better individual care planning, the provision of services, supports and activities, and reduces the reporting burden of care homes".

The implementation of digital care planning tools for care home residents in Dumfries and Galloway presented an opportunity to explore the potential of data sharing for person-centred care. In this project we brought together partners to explore care home data and how it relates to other teams, processes, and technologies outside of the care home. The project delivered a series of workshops with professionals spanning care at home, care homes, nursing homes, NHS, social care / work, third sector and technology providers. They covered:

- **Exploring Existing Systems:** The team had walk throughs of example care home and NHS systems to foster better joint understanding of methods, software, and data.
- **Comparing Care Home / NHS Systems & Data:** The team carried out a direct comparison of care home and NHS systems. They mapped the different data gathered by each system and explored the overlap between the data models.
- **Exploring the 'Art of the Possible' and High Impact Scenarios:** DHI depicted a 'what if' architecture that showed citizen held data sharing systems bringing the data together. This prompted to consider how it could be useful, with the team visualising three scenarios of care.
- **Exploring a Scenario: Care at Home to Care Home Transition:** The group decided to focus effort on visualising a more detailed current state map for the transition from care at home services to a care or nursing home.

This project increased understanding of the continuum of care leading up to a care home admission. It identified a heavy overlap and repeated capture of the data which care homes need at several junctures leading up to admission. The 'whole of life' nature of care homes will necessitate a multi-pronged strategy to encourage different data management regimes and their digital platforms to prepare to share data with care home providers in support of integrated care and improved health outcomes for citizens. The DHI recommends the following actions to enhance digital innovation in and around care homes in Scotland:

1) **Capitalise on the increasing richness of care home data –** the care home record for many people will be the best source of truth about someone's preferences, needs, medications adherence and in some cases clinical observations, vital signs etc.
2) **Align with the National Digital Platform roadmap** - as this will be a resourced and consistent method for those looking to interact with primary care records in the next several years. Consider a pathfinder project where care home software providers are offered access to sample (dummy) data in an NDP sandbox environment to show what they can do.
3) **Develop a citizen held record digital pathfinder -** At the end of many 'care at home' journeys there is a paper care file sat on a kitchen table that is not routinely making its way with the citizen into a care home environment. This could be digital, and it could enhance admission.
4) **Consider personal, experiential, and holistic data -** from outside of statutory services could be gathered by a citizen or their carers, in the lead up to a care home admission. DHI's Digital Front Door Pathfinder projects in Moray and Midlothian are exploring some of this.

2. Introduction

The implementation of digital care planning for care home residents in Dumfries and Galloway presented an opportunity to undertake further exploration of the potential of social care data and data sharing for person-centred care. During the pandemic, care home data sharing was supported through the development of tools such as Turas Care Management. However, such tools tended to provide a 'one way' flow of information for specific purposes with limited value for care home staff and residents, presenting issues around engagement and completion.

However, it is recognised that the effective sharing of data presents significant opportunity to enhance roles and relationships across health and social care, partnership and multi-sector working, and ultimately impact on the experience of people who access care and support.

The challenges of data collection and sharing across health and social care are well articulated including issues of fragmentation, access, and duplication of information. A key objective outlined in the Digital Approaches in Care Homes Action Plan is the need to "Identify needs and develop approaches for data gathering that supports better individual care planning, the provision of services, supports and activities, and reduces the reporting burden of care homes".

In this project we brought together a consortium of partners to explore care home data and to consider simulating the sharing of data. The project outputs provide insights on the data collected, the value and impact of sharing data and the wider potential of social care data in promoting positive care interactions and experiences, as well as integration of health and social care. The project identifies tangible scenarios of care home data sharing and provides insights on rights-based approaches to capturing, recording, and sharing data.

The initial proposal identified two stages:

1) Through co-design methods with relevant multi-disciplinary teams, develop an understanding of meaningful data sharing in the care home context.
2) Identify a test scenario to develop a simulation - using artificial data to demonstrate the sharing of data between care home and software or systems used by healthcare, third sector, family and friends or other members of the integrated care team. This would be developed using data sharing infrastructure co-managed by the citizen.

Stage two was predicated on discovering a high enough level of readiness in the services and technologies to make a simulation possible. After initial rounds of joint discovery work it became clear that while the technology could support simulation, there was the need for more extensive discovery and scoping to help the teams figure out why and how the data needed to flow within a service delivery context.

The project team decided to focus efforts on establishing a broad understanding across many teams and over several scenarios to identify innovation opportunities that are further detailed in this paper.

3. Project Summary

3.1. Method

The project steps included:

1) **Scoping -** Initial scoping was carried out between Scottish Care, Scottish Government, and the Digital Health & Care Innovation Centre (DHI). The scope was to help move forward collective thinking on how data sharing in and around care homes could be more person-centered and support better, more integrated care.

2) **Co-Design Workshops –** with care and support professionals spanning care at home, care homes, nursing homes, NHS, social care / work and third sector. Supporting the conversations were technologists from DHI, Mydex and Person-Centred Software. The workshop series covered:
    - **Workshop 1 – Exploring Existing Systems:** The team had walk throughs of example care home and NHS systems to foster better joint understanding of methods, software, and data.
    - **Workshop 2 - Comparing Care Home / NHS Systems & Data:** The team carried out a direct comparison of the Person-Centred Software (care home) and Lenus COPD (NHS) systems. They mapped the different data gathered by each system and explored the overlap between the data models.
    - **Workshop 3 - Exploring the 'Art of the Possible':** Based on the initial sessions, DHI depicted a 'what if' architecture diagram that showed how existing citizen held data sharing systems could bring the data together from these systems. This was used to prompt teams understand the value of this newly aggregated data and consider how and when it could be most useful.
    - **Workshop 4 - Identifying High Impact Scenarios for Enhanced Data Sharing:** The teams explored and visualised three scenarios where this kind of person-centred data sharing method could enhance care and support.
    - **Workshop 5 - Exploring a Scenario: Care at Home to Care Home Transition:** The group decided to focus effort on visualising a more detailed current state map for the transition from care at home services to a care or nursing home.

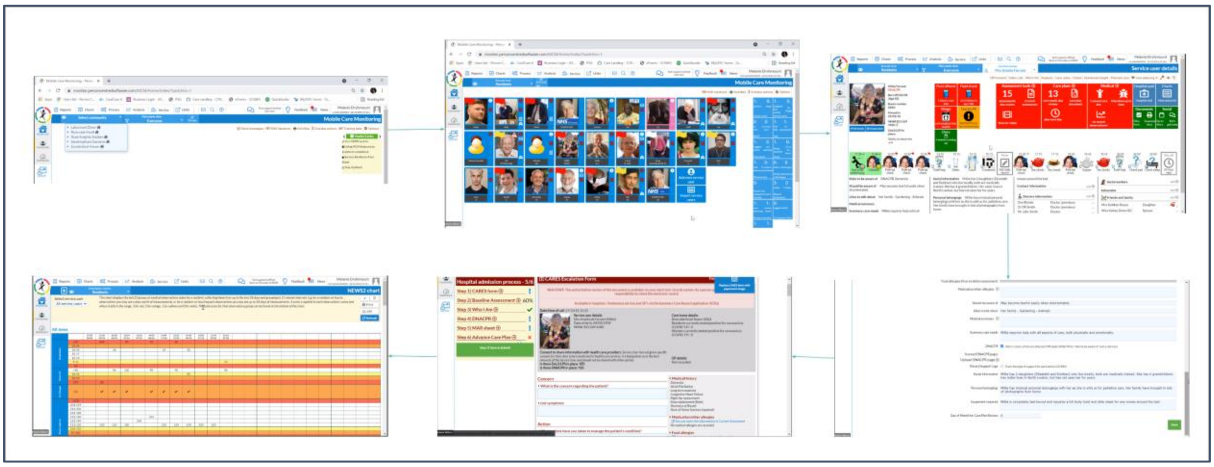
3) **Analysis and Reporting –** the development of some assets including state maps, slides, and reports to support knowledge exchange and stimulate possible future project work.

3.2. Workshop 1 – Exploring Existing Systems

This workshop compared two software systems live in the West of Scotland – Person-Centred Software (Care Home) and Lenus COPD (NHS). These two systems were selected as more modern systems that captured a lot of structured data that could be made available via an Application Programming Interface (API).

Example Care Home System: Person-Centred Software

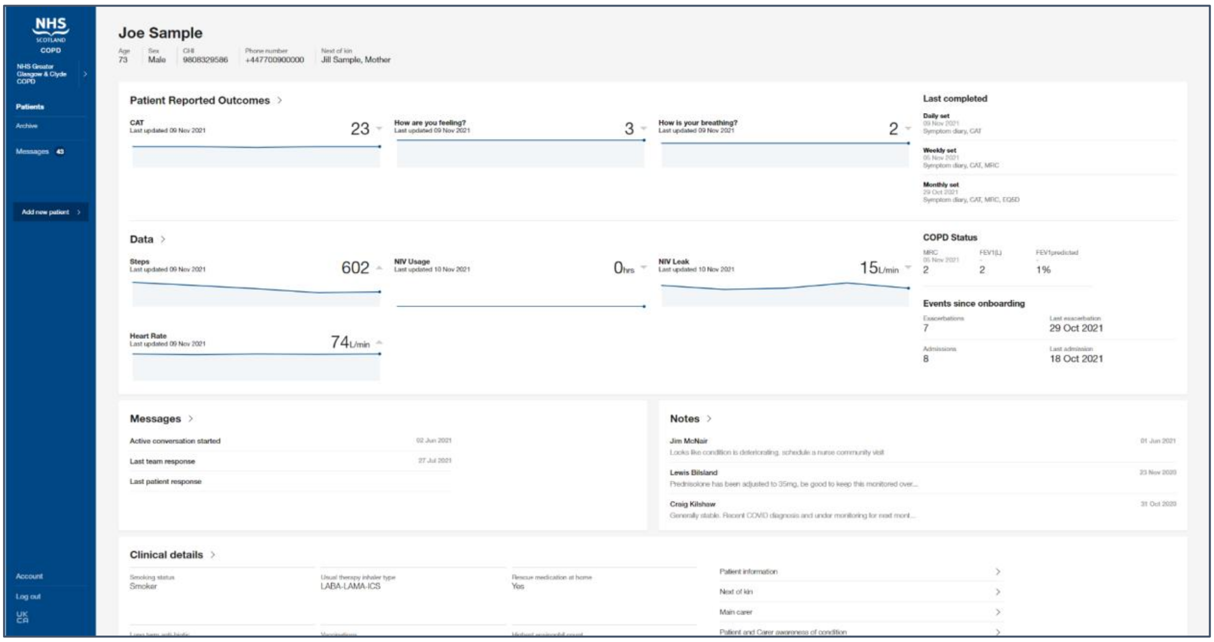
The team was given a walk-through of the Person-Centred Software system, currently in use in several care homes in Dumfries & Galloway (and elsewhere in Scotland / UK).



The 'hospital pack' was of particular interest as it neatly summarised the most important elements in the care home resident's record.

Example NHS System: Lenus COPD

The team also had a walkthrough of the Lenus COPD service – which is a remote management tool for people living with COPD. Patients provide symptom, outcome, wearable and home ventilator data which allows clinical teams to plan and deliver care more proactively.



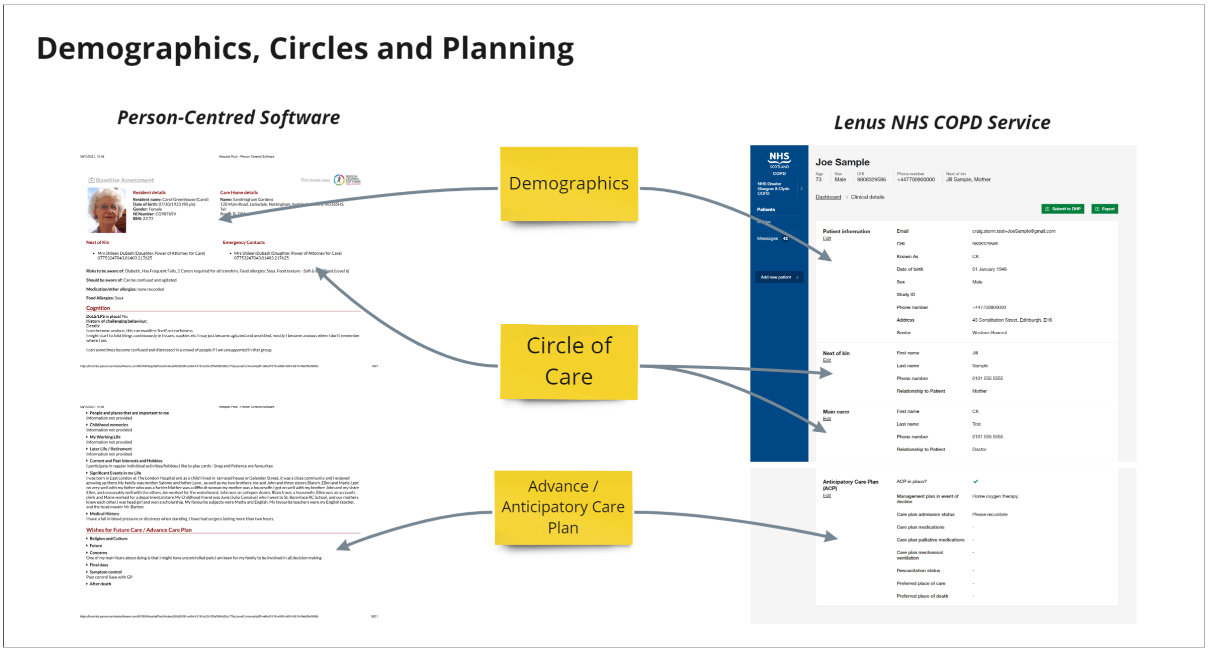
3.3. Workshop 2 – Comparing Care Home / NHS Systems & Data

The team carried out direct comparison of the Person-Centred Software (care homes in Dumfries & Galloway) and Lenus COPD (NHS GG&S / Lothian / Highland) systems. They mapped the different data gathered by each system and explored the overlap between the data models.

The team found significant overlap in the following areas:

- Demographics – name, date of birth, etc.
- Circle of care – next of kin, main carer, other professionals
- Advance care planning – care preferences, end of life plans, etc.
- Co-morbidities – diagnoses and associated information
- Medications – medication lists and adherence data
- Observations – symptoms, vital signs, experience / outcomes data

The image below depicts the direct read across between the interfaces in the two systems.



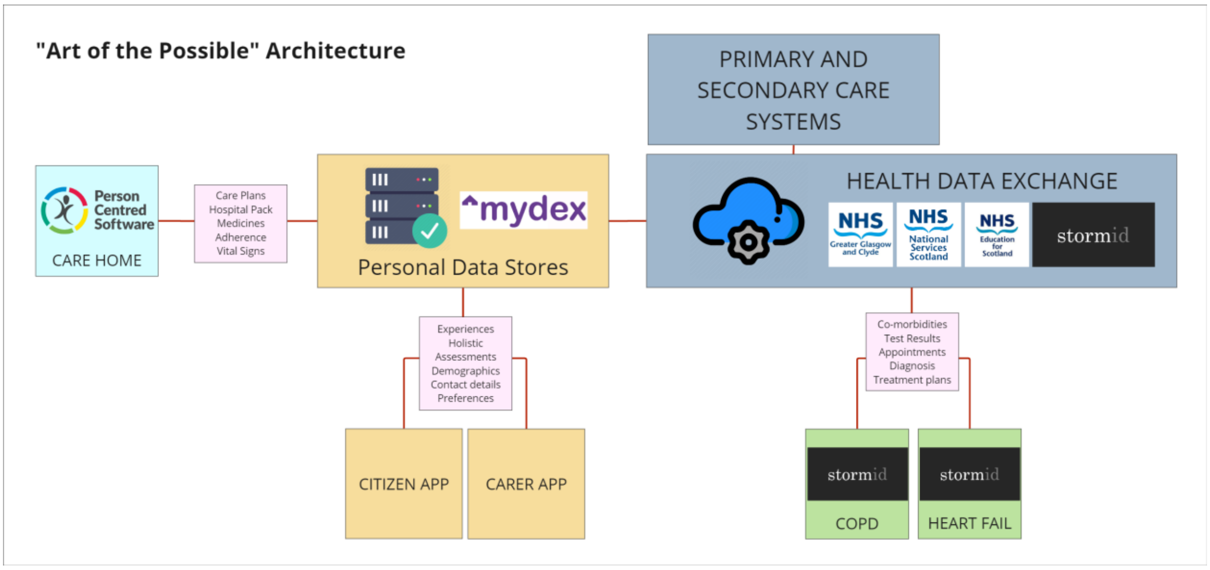
Appendix 1 includes a larger version of this and similar visualisations across the other overlapping areas listed above.

Working with these interfaces and an understanding of intent and working methods across the multidisciplinary teams allowed the group to properly consider a joint data model.

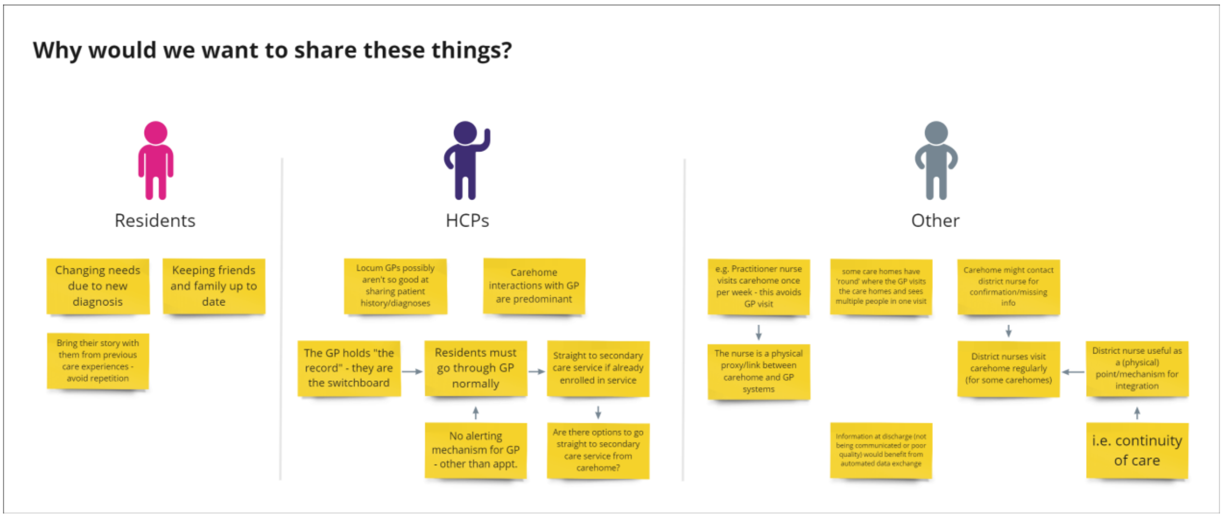
While the data sets appeared quite different to begin with, the co-design conversation identified that in many cases the differences are superficial with the same underlying intent driving the data gathering processes and structures. This highlighted that the knowledge the teams were looking for was frequently the same, but that they asked different questions in different ways to get to the information. In some cases, the IT systems dictated the way the data was collected, and with time and development this could be changed to better support new joint ways of working.

3.4. Workshop 3 – Exploring the 'Art of the Possible'

Based on the initial sessions DHI depicted a 'what if' architecture diagram to illustrate how existing citizen held data sharing approaches could bring the data together from the 2 systems.



This was used to prompt teams understand the value of this newly aggregated data and then to consider how and when it would be most useful.



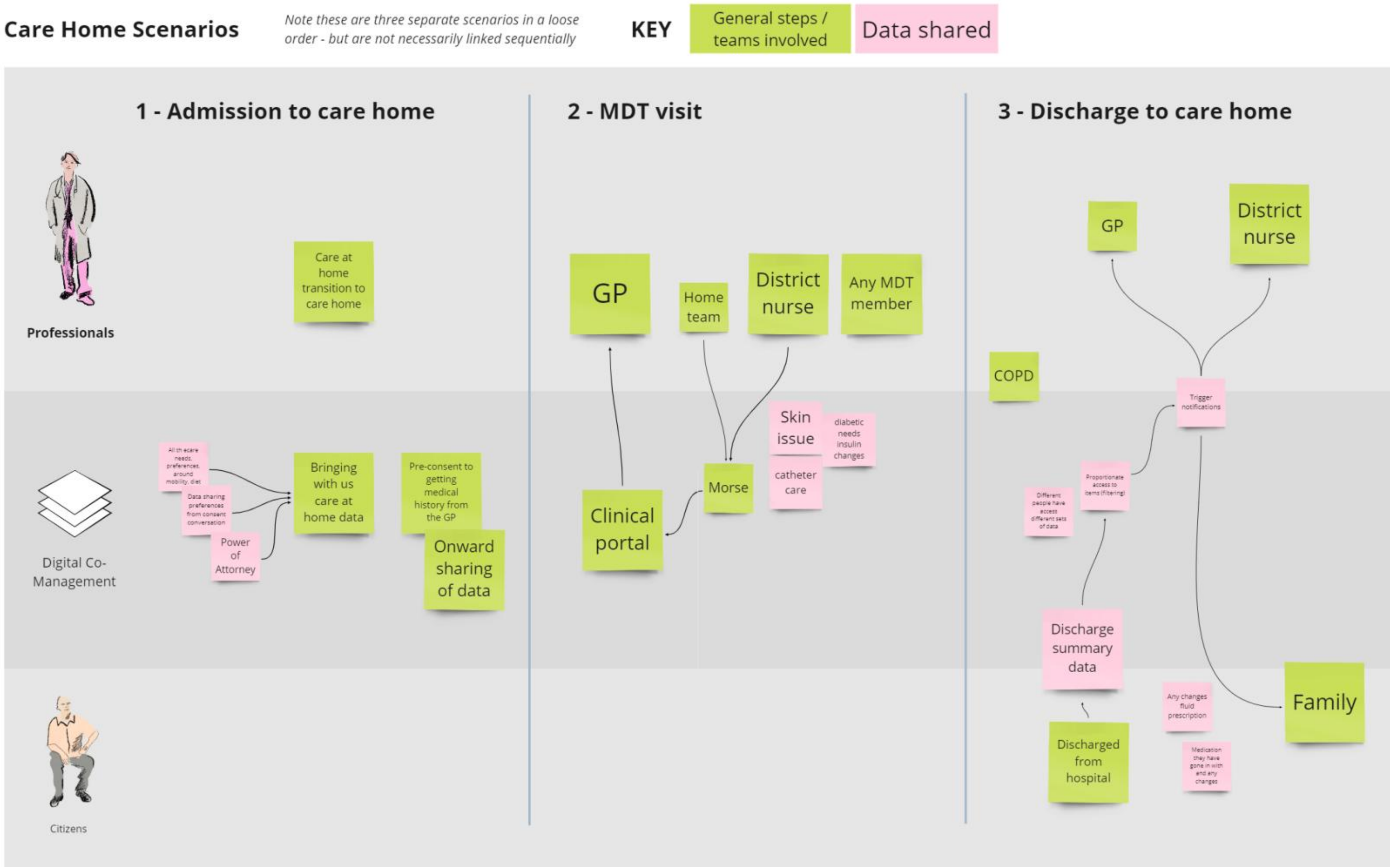
The value of sharing this newly aggregated data was depicted through several lenses:

1) **Residents (Citizens) –** e.g., 'telling their story once', keeping friends / family up to date.
2) **Health & Care Providers –** GP / Care Home data sharing – currently puts a lot of pressure on GPs as the conduit for care homes needing access to records. For care homes there is no way of routinely alerting GPs to change or risk. (The DHI/Scottish Care Project on Care Home Assessment Tool (CHAT) established a core data set and identified decision support tools which could assist this aspect.)

GP or nurse routine visits to care homes work well as a physical / verbal method of data sharing – but this is dependent on positive relationships, can break down and does not happen everywhere.

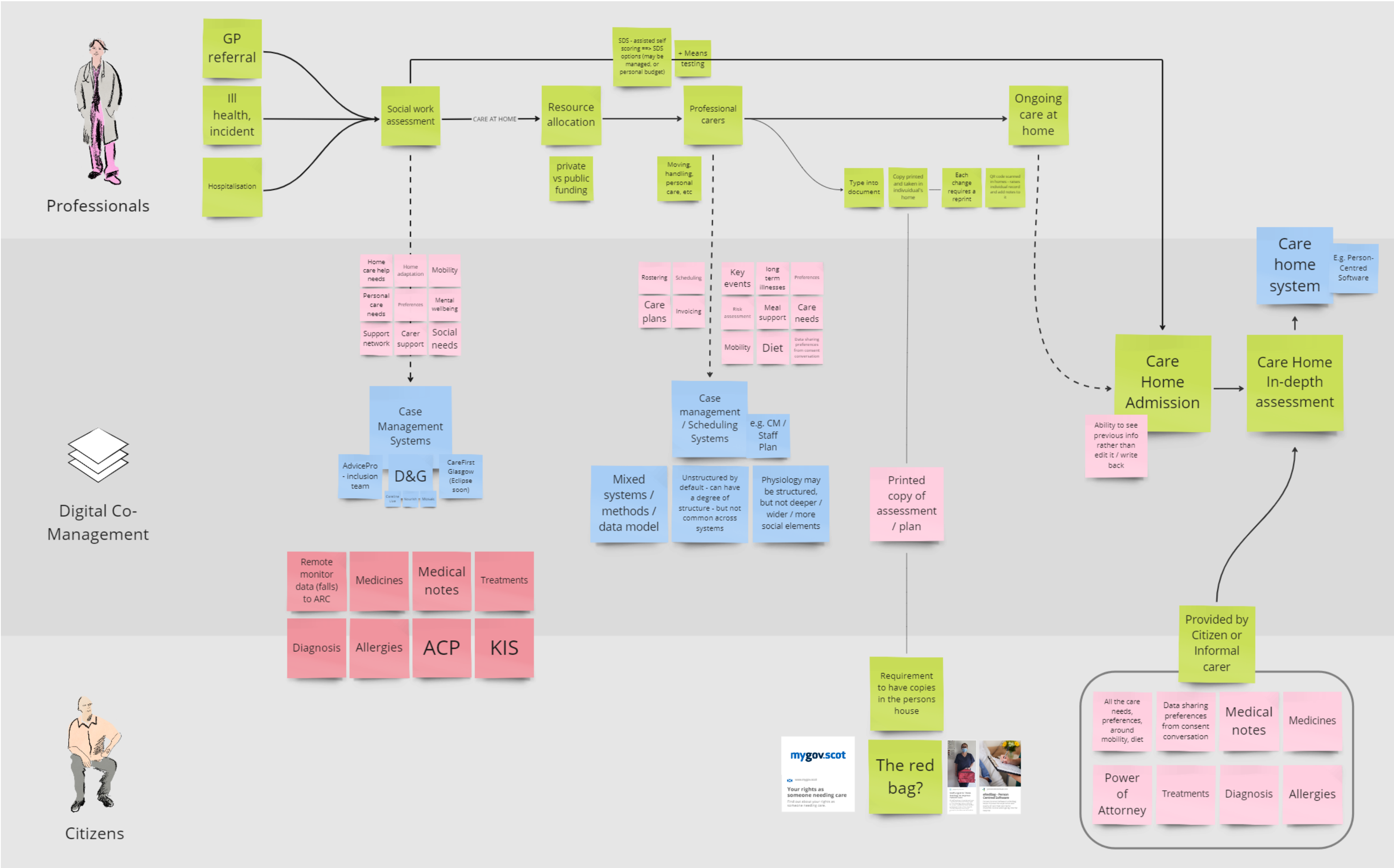
3.5. Workshop 4 – Identifying High Impact Scenarios for Enhanced Data Sharing

The teams explored and visualised three scenarios where this kind of person-centred data sharing method could enhance care and support.



Based on this, the team agreed that the remainder of the project should focus on improving the data flow as part of transition into the care home. This would support care home admission processes directly and support hospital discharge into care homes in an indirect manner.

3.6. Workshop 5 – Exploring a Scenario: Care at Home to Care Home Transition



KEY

General steps / teams involved	Relevant data not normally available
Data shared / needs	Key software systems

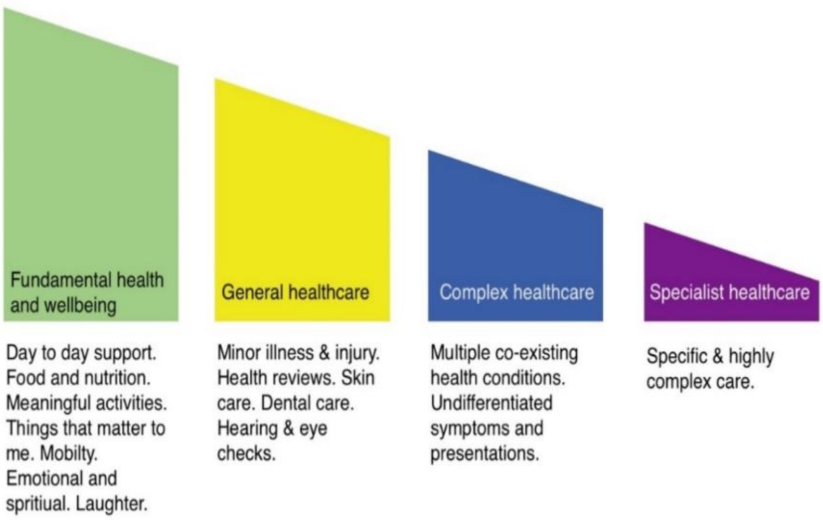
The team had identified the transition from care at home into care homes as an area where better data sharing could bring significant improvement. The image above is a depiction of the current high-level flow with citizens usually either being referred from social work directly into residential care or receiving care at home currently with the potential for transition into residential care in the future.

In most situations the citizen is already being assessed multiple times by different health, care, and other support organisations.

On the NHS side the GP remains the main record keeper and provides an increasingly burdensome conduit service for many different community organisations where the GP Practice effectively administrates the record on behalf of many other organisations but is generally unable to share it. This can range from secondary care teams in the NHS, through to social security systems looking for proof of clinical need to approve benefits claims. Within Local Authorities (e.g., social care / work) the increasing use of Self-Directed Support means that citizens are employing a wider range of care at home providers with a large diversity of methods and IT systems. This diversity continues to expand as more community (e.g., third sector) services are developing systems to help manage case work, scheduling, and other activities in parallel.

Understanding the different data management regimes

The diagram below represents the healthcare needs of people living in care homes from the Scottish Government Healthcare framework for adults living in care homes (2022).



The data relating to any of these needs may be captured during a citizen's journey towards a care home. Broadly speaking there are two data management 'Regimes' at play here, with differing cultural, organisational, legal, and regulatory drivers. Regime A covers the full spectrum from a clinical record keeping perspective, but majors on 'general healthcare', 'complex healthcare' and 'specialist healthcare' (the three right most boxes in the above image). Regime B is mostly focused on 'fundamental health and wellbeing' with some reference to the other areas.

Regime A – Clinical, Safety & Protection Records

This Regime, represented in red notes on the map, includes data that:

- Is predominantly medical (medicines, treatments) and risk (telecare) or deficit (diagnoses / morbidities / long term conditions) focused,
- Citizens can't always access, remember, or accurately describe,
- Citizens shouldn't or can't access without professional mediation,
- Is very sensitive and if wrong or out of date then significant harm could result,
- Organisations typically access via other organisations (often manual or verbal),
- Is subject to very stringent data governance and organisational culture that has not historically supported effective data sharing.
- Is increasingly conforming to standards for data storage and sharing.

Regime B – Personal, Informal & Community Care Records

This Regime, represented in pink notes on the map, includes data that:

- Is predominantly social, economic, environmental, and behavioural,
- Citizens can access better due to legislative / regulatory / best practice requirements for services to leave citizens with copies of their data,
- Citizens can better understand and articulate because it is not overly technical or scientific,
- Typically focuses on 'about me', history, preferences, needs, goals, schedules, and other forward planning data that isn't as time critical, sensitive, or overtly risky to use if wrong or out of date,
- Is increasingly required to be collected from the citizen's perspective to ensure citizen voice leads processes – e.g., registered services, Self-Directed Support.
- Organisations or people often depend on the cared for person or informal carers to hold and share this information (e.g., power of attorney).
- Is often governed more flexibly to reflect the diverse and interconnected nature of community care and the extended care network that must be involved to support good care outcomes.
- Is still fragmented and diverse with no clear standards or significant organisational effort to develop or agree said standards.

In many cases citizen's or their informal / unpaid carers are asked to provide both Regime A and B data, with professionals in care homes having to make do with or verify the higher sensitivity / risk data found in Regime A – often via phone calls to the GP practice.

The Regime B data required as part of moving into a care home includes items like – mobility, personal care needs, preferences, mental wellbeing, support network, social needs, key past events, diet, power of attorney, etc.

The required Regime A data includes medicines, treatments, allergies, vaccinations, anticipatory care planning elements e.g., DNACPR and preferred location of care for end of life.

4. Possible Future State Development

The distinction between Regime A and B is important as it reflects two environments which are shaped by different organisational, cultural, technological, and regulatory drivers. Regime A usually dominates discourse and technological progress and because this regime tends towards a medical model it is important to create a space for the generally more holistic and person-centred data in Regime B. This will help us to follow the recommendations laid out in the Scottish Government Framework for Healthcare in Care Homes (2022):

"Health and social care professionals must work together to address any healthcare needs within the nurturing environment of the care home and ensure that people living in care homes are not over-medicalised."

From a care home point of view this distinction can help to shape a roadmap that delivers progress in both Regimes without necessarily having to achieve a single method to bring these different worlds together.

Some key enablers are already being explored in Scotland that are relevant to this challenge. These sections break down each digital platform capability and then describe the likely time frame in which the development may support care home data sharing.

4.1. Regime A

4.1.1. The National Digital Platform (NDP)

Purpose: NES Technology will create a Clinical Data Repository for the storage and sharing of structured, standards based clinical records. The NDP can already handle advance care planning (e.g., Respect) and Vaccines records with live integrations already in place into other NHS systems. Over the coming 2-3 years NES Tech and NHS National Services Scotland (NSS) will be integrating the NDP more fully into GP systems to create a 'Once for Scotland' patient summary that will cover diagnosis, co-morbidities, treatments, allergies, vaccinations, and other Regime A data.

Timing: This is the most likely consistent source of Regime A data for care homes in the medium term (3-5 years).

4.1.2. Digital Front Door (DFD)

Purpose: Is a programme to develop a single starting point for citizen's looking to engage with digital health and care services in Scotland. In the short term DFD is likely to focus on the most standardised services available with supporting infrastructure – e.g., guidance, navigation, records access for vaccines, allergies, appointment booking etc. The DFD is relevant to the care home data sharing agenda, because it is likely to provide a method for unpaid carers, friends family or other delegates to interact with and reuse health and care data for themselves and those they care for.

Timing: In the medium term (4-5 years), this platform might allow citizens to update the 'About Me' for someone in advance of transitioning into a care home.

4.1.3. National Alarm Receiving Centre Platform (ARC)

Purpose: A new national ARC platform is being procured for Scotland to support Telecare Providers (Local Authorities and Housing Associations) to make the Analogue to Digital shift. Each telecare service provider will be able to call off on the framework contract and implement the same ARC platform. This new platform will provide a standard way for falls and other safety data to be collected and shared. It will extend into proactive telecare monitoring, allowing services to see analyse home environment trends leading up to frailty and falls to enable proactive support. Over time this platform will likely be the most structured, consistent source of data about a citizen's activities of daily living, independence, mobility, and general safety likely within a care at home environment This could greatly enhance the decision-making around when a transition to a care home may be appropriate and provide a rich history to the care home when the time comes. There is an impending need to use this platform before the analogue phone system is switched off in 2025 and so this platform will be implemented in the short term.

Timing: This could be a source of telecare data to inform care home admission in the short to medium term (2-3 years).

4.2. Regime B

4.2.1. An Integrated Care & Health Record

Purpose: The platform is proposed as part of the National Care Service. Alignment work is underway between this and the National Digital Platform. The scope for this platform is currently unclear. Regime B has an extensive and highly fragmented set of record systems across thousands of organisations, including Local Authority Case Management Systems, scheduling systems used by private personal care providers and web tools used by small charities.

Timing: Integrating so many fragmented systems across many sectors to achieve a fully integrated care and health record is a large and long challenge. That said, assuming continued political will and sufficient resources, it would be reasonable to expect core local authority based social care and social work records to be shareable via such a platform across some of Scotland in the medium term (4-5 years). This is unlikely to extend into private, third and independent sector organisational records as an early priority. From a care home point of view, this could be a medium to long term (5-10 years) place to access records from these non-statutory services.

4.2.2. Digital Identity Scotland

Purpose: This is a Scottish Government programme to provide a single citizen identity service for Scotland. This means a single national login that citizens can use across services. In this scheme each citizen has their login and a Personal Data Store to store key information about themselves. When they transact with an organisation, they can store copies of their records and reuse the data with other organisations to make it easier to access services and improve the quality of services provided. The scope is domain agnostic – it could include housing, education, social security, health, care etc. Initially it will be provided to public sector organisations and their commissioned third and private sector partners. Over time as trust grows, and assuming continued political will and resource, it is likely that it will extend to cover a broader range of sectors and organisations.

Timing: From a care home perspective, this may be a medium term (4-5 years) way to access data that supports access / eligibility decisions spanning broader public sector organisations.

4.2.3. Care Home Assessment Tool (CHAT)

Purpose: Also referred to as the Turas Covid Assessment Tool for Care Homes (TCATCH). This is an app developed and connected to the National Digital Platform by NES Technology. It supported assessment and sharing of data by care homes and remote decision support by GPs when someone showed early signs of deterioration (e.g. Covid-19 symptoms).

Timing: This project completed in 2022 and yielded many lessons about the needs and challenges in this area. It provides a starting point for how care home data can enable primary care to enhance their support to care homes.

4.2.4. DHI Integrated Care Programme

Purpose: DHI has several pathfinder projects emerging in the integrated care space (e.g., Moray, Midlothian, national work for The Promise). They are all focused on empowering citizens using a Personal Data Store to integrate care between public, private, third and independent sector services. The design ethos is to provide citizens with a place that they can accrue a rich picture of themselves and their history as they live their lives. They can then consent to share with service providers from different sectors and domains to access support more easily without constantly repeating their story. These pathfinders are supporting the National Digital Front Door Programme by developing Regime B capabilities that attempt to connect the often messy and fragmented community care environment. From a care home perspective this is relevant, along with the Digital Identity Scotland programme, as they are methods that seek to support data sharing beyond the health and care focus of much of the current national infrastructure work. Care homes are necessarily concerned with more than just health and care record sharing, and so this programme may help to fill in some of the gaps left by other major programmes of work.

Timing: Personal Data Stores are just starting to go live in Scottish test beds and are significantly less complicated from a data sharing and governance point of view than national inter-organisational sharing platforms and methods. Significant use by care homes is likely possible in the medium term (4-5 years) but will need additional organisational structure and governance to take these from R&D into ‘Business as Usual’ service delivery.

5. Conclusion

This project increased understanding of the continuum of care leading up to a care home admission. It identified a heavy overlap and repeated capture of the data which care homes need at several junctures leading up to admission. This data is not currently routinely available to care homes without significant verbal and manual effort and good quality partnership working and relationships in the local health and care economy.

The 'whole of life' nature of care homes will necessitate a multi-pronged strategy to encourage many different domains and their digital platforms to prepare to share data with care home providers in support of integrated care and improved health outcomes for citizens.

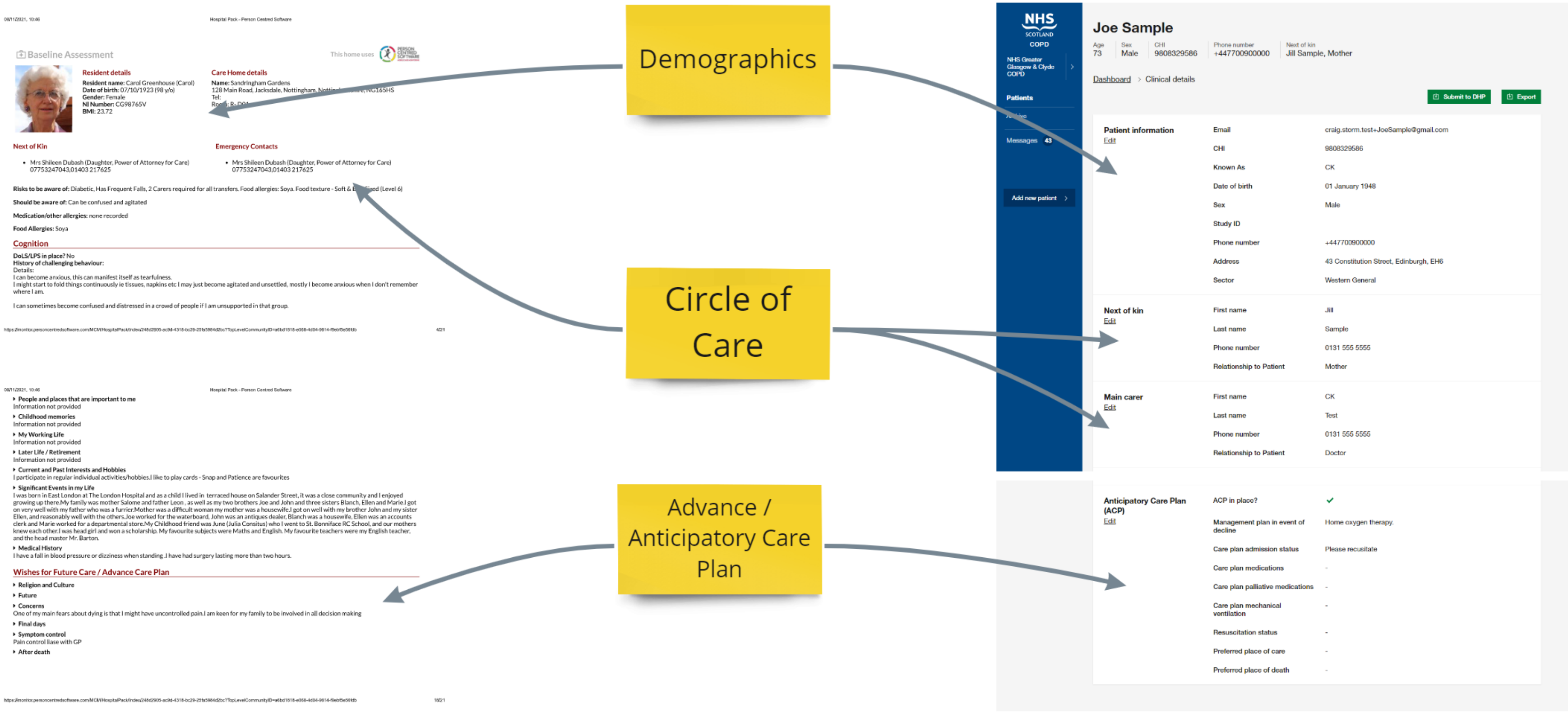
The DHI recommends the following actions to progress and enhance digital innovation in and around care homes in Scotland:

1) **Capitalise on the richness of care home data and an increasing professional expertise –** the care home system the team explored during the project was a rich source of data about someone's preferences, needs, medications adherence and in some cases clinical observations, vital signs etc. This degree of day to day living data is not routinely available for most populations – and could be used to significantly improve visiting or remote clinical care offered to care homes. When the Lenus COPD service was described the immediate reaction by the care home professionals is that between them and their residents, they could generate the data to take part in remote monitoring initiatives (where typically these have been aimed at people living independently).
2) **Understand the National Digital Platform roadmap and delivery timescales for their Clinical Data Repository** - as this will be a resourced and consistent method for those looking to interact with primary care records in the next several years. Consider proposing a pathfinder project where care home software providers are offered access to sample (dummy) data in an NDP sandbox environment to show the potential for two-way sharing and better coordination between primary care and care homes in the future. As part of this the CHAT project's data model (primarily focused on care home data going to primary care) could be built upon to support data coming from primary care to care homes. This kind of data model work should align with the Scottish Government Care Home Data Review initiative.
3) **Develop a citizen held record / red bag / hospital pack digital pathfinder project -** to capitalise on existing practice and regulatory requirements. At the end of many 'care at home' journeys there is a paper care file sat on a kitchen table that is not routinely making its way with the citizen into a care home environment. This file has much of the story care home professionals ask the citizen to repeat during admission. Add to this the expanding use of 'hospital packs' handed to citizens as they leave care homes for hospital and 'red bags' with their notes as they leave hospital again. The system is already completely dependent on 'citizen held' records following them as they transition between services – but there is no infrastructure to make this more secure, consistent, and scalable. In best case scenarios professionals are having to manually copy records at each juncture. At worst case the records never appear, and they must start from the beginning with the citizen and call the 'switchboard' (GP Practice) to fill in the gaps. There is an opportunity to model the 'digital red bag' and give it to the citizen in their Personal Data Store to support the care transitions described above.
4) **Consider personal, experiential, and holistic data -** from outside of statutory services could be gathered by a citizen or their informal circle of care as they go about their daily lives. It is possible to develop upstream methods that both help people stay independent and as a byproduct have the necessary story already held and shareable when they need additional support or transition into a care home. DHI's Digital Front Door Pathfinder projects in Moray and Midlothian are exploring how to manage this in a care at home context. These programmes are not explicitly targeting care homes, but DHI would welcome discussion of how additional project work could capitalise of these existing pathfinders to extend into care home transitions.

Appendix 1 – Comparisons between Person-Centred Software (Care Home) and Lenus COPD (NHS)

Demographics, Circles and Planning

Person-Centred Software ***Lenus NHS COPD Service***



Co-morbidities

Person-Centred Software

08/11/2021, 10:46 Hospital Pack - Person Centred Software

CARES Escalation Form

This home uses PERSON CENTRED SOFTWARE

NHS STAFF: The authoritative version of this document is available via your electronic records system. As a person providing care it is your responsibility to check the electronic record.

Date/time of call: 08/11/21 10:45

Service user details:
Carol Greenhouse (Carol)
Date of birth: 07/10/1923
NI Number: CG98765V

Care home details:
Sandringham Gardens
128 Main Road, Jacksdale, Nottingham, Nottinghamshire, NG165HS Room: R- D01
Residents currently tested positive for coronavirus (COVID-19) : 0
Workers currently tested positive for coronavirus (COVID-19) : 0

Consent to share information with health care providers: YES
Is there DoLS/LPS in place: NO
Is there DNACPR in place: NO

GP details:
Dr Alex Trompetus: 01264 213 123,
Dr Graham Smith: 0191 237654, Surgery Road
Mrs Jane Faulkner: 01344412310, 15 Blackbird Place

Concern

What is the concern regarding the patient?

List symptoms:

Action

What actions have you taken to manage the patient's condition?

MedicalHistory

I have a fall in blood pressure or dizziness when standing .

I have had surgery lasting more than two hours.

Medication/other allergies

No medical allergies are recorded

Food allergies

Soya

Handover

08/11/21 05:11 - Repositioned to avoid pressure ulcer
08/11/21 04:45 - Pad needed changing
08/11/21 01:12 - Repositioned to avoid pressure ulcer

https://monitor.personcentredsoftware.com/MCM/HospitalPack/Index/248d2905-ac9d-4318-bc29-25fa5984d2bc?TopLevelCommunityID=a6bd1818-e068-4d04-9814-f9eb f5e56fdb 1/21

Diagnoses / Co-morbidities?

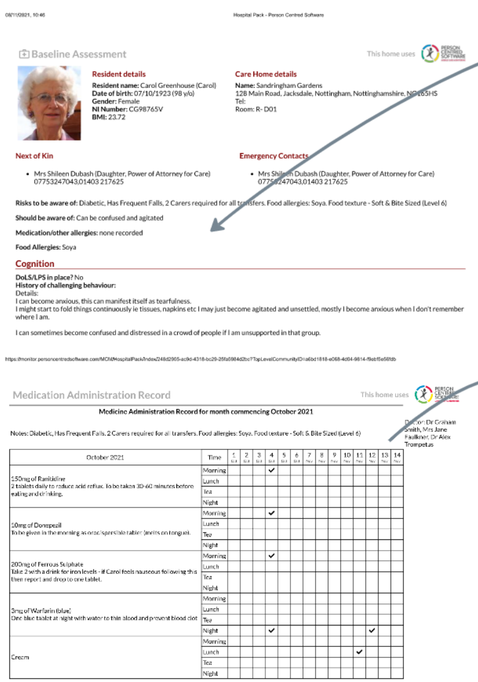
Lenus NHS COPD Service

Co-morbidity
Edit

Malignancy	-
Respiratory failure	✓
Asthma overlap	✓
Pulmonary fibrosis	-
Bronchiectasis	✓
Pulmonary hypertension	-
Previous pneumothorax	-
Deep vein thrombosis / Pulmonary thromboembolism	-
Obstructive sleep apnoea	-
Ischaemic heart disease	✓
Heart failure	-
Valvular heart disease	-
Arrhythmias	✓ Other arrhythmia or Pacemaker
Peripheral vascular disease	-
Cerebrovascular disease	-
Osteoporosis	✓
Diabetes mellitus	-
Liver disease	-
Frailty	✓
Cognitive impairment	-

Medications

Person-Centred Software


Baseline Assessment

Resident details
Resident name: Carol Greenhouse (Carol)
Date of birth: 07/10/1923 (98 y/o)
Gender: Female
NI Number: CG98765V
BMI: 23.72

Care Home details
Name: Sandringham Gardens
128 Main Road, Jacksdale, Nottingham, Nottinghamshire, NG165HS
Room: R- D01

Next of Kin
- Mrs Shileen Dubash (Daughter, Power of Attorney for Care) 07753247043,01403 217625

Emergency Contacts
- Mrs Shileen Dubash (Daughter, Power of Attorney for Care) 07753247043,01403 217625

Risks to be aware of: Diabetic, Has Frequent Falls, 2 Carers required for all transfers. Food allergies: Soya. Food texture - Soft & Bite Sized (Level 6)
Should be aware of: Can be confused and agitated
Medication/other allergies: none recorded
Food Allergies: Soya

Cognition
DoLS/LPS in place?: No
History of challenging behaviour:
I can become anxious, this can manifest itself as tearfulness.
I might start to fold things continuously ie tissues, napkins etc I may just become agitated and unsettled, mostly I become anxious when I don't remember where I am.
I can sometimes become confused and distressed in a crowd of people if I am unsupported in that group.

Medication Administration Record
Medicine Administration Record for month commencing October 2021
Notes: Diabetic, Has Frequent Falls, 2 Carers required for all transfers. Food allergies: Soya. Food texture - Soft & Bite Sized (Level 6)

October 2021	Time
150mg of Ranitidine. 2 tablets daily to reduce acid reflux. to be taken 30-60 minutes before eating and drinking.	Morning / Lunch / Tea / Night
10mg of Donepezil. To be given in the morning as orodispersible tablet (melts on tongue).	Morning / Lunch / Tea / Night
200mg of Ferrous Sulphate. Take 2 with a drink for iron levels - if Carol feels nauseous following this then report and drop to one tablet.	Morning / Lunch / Tea / Night
3mg of Warfarin (blue). One blue tablet at night with water to thin blood and prevent blood clot	Morning / Lunch / Tea / Night
Cream	Morning / Lunch / Tea / Night

Medications

Resident normally arrives with medication

Medication records can be conflicting e.g. discharge records

Medicines adherence?

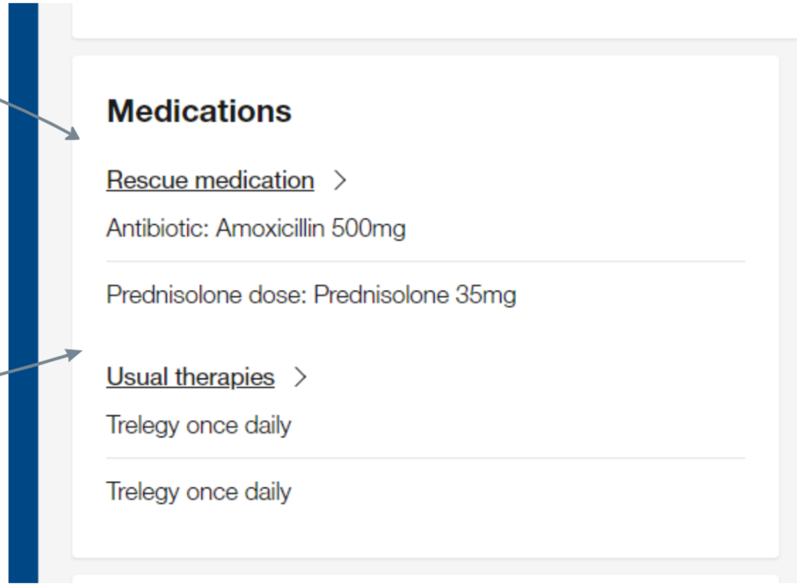
Lenus has medicines prescribed - maybe adherence recorded in regular question sets

Lenus relies on taking medicine data out of statutory systems - i.e. only as good as source record

Is an area in Lenus for clinical notes - adherence may go here if pertinent

What would be the use? Research maybe?

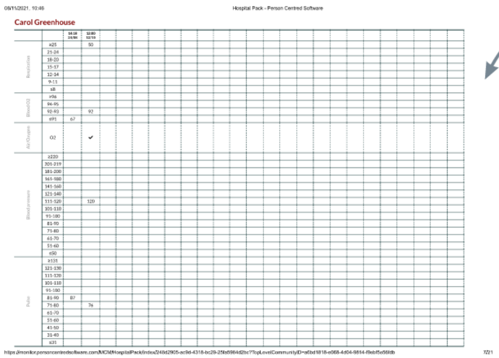
Lenus NHS COPD Service



Observations

Person-Centred Software

Lenus NHS COPD Service



Observations from PCS

EQ5D type questions in Lenus

Obs. taken if cause for concern (i.e. not emergency) in carehome

Flags

As part of recording vital signs - note cause for concern - with possible flag raised according to severity

e.g. Flag - need to record blood pressure at regular intervals

e.g. eating, sleeping, soft-signs monitoring/recording in carehome

Frailty (all assessments updated monthly in carehome)