SevernSide Home Visiting Policy

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1. Introduction

BrisDoc is committed to providing high quality patient care, delivered in the right place by the right clinician, that most appropriately meets the patient's needs, and that also makes the most efficient use of BrisDoc resources in accordance with its core values. This policy, which applies to all cases, is designed to support all Severnside clinicians in ensuring that:

- advice consultations are appropriately triaged to a home visit
- triage content for home visits is robust and consistent
- prioritisation is sound and
- ultimately patients receive a consultation most appropriate to their clinical needs.

There is sometimes a difference of opinion in these matters "in the moment" and some of these consultations can be difficult. BrisDoc will support all clinicians who adhere to this policy.

This policy is being introduced to ensure there is a clinically robust and consistent approach to triaging and managing home visits by all clinicians; that high standards for home visits are consistently met; that Operations staff may be clear about the expectations of all responsible for implementing this policy; and that the efficiencies of improved home visit triage and management are realised from a performance and resource management perspective. The successful implementation of this policy will be evidenced by reduced differences of opinion between clinicians, no breaches to visit target timescales, and an overall, sustained reduction in the number of urgent and inappropriate visits.

Patient Care

Patient focused - understanding our patients needs and ensuring we prioritise the "patients view" in all our everyday activities and actions.

Workforce Care

Teamwork and individual responsibility - every person counts, supporting each other, sharing information, valuing and encouraging.

Quality Care

Commitment to do what we say and improve what we do. A commitment to excellence and quality when serving patients and colleagues.

Resource Care

Optimising the use of all resources across the local health economy. Taking care of our working environment and equipment.

2. Principles

- The large majority of patients who need a face-to-face consultation can attend one of the Severnside Treatment Centres. The Severnside Treatment Centres have all the appropriate back up, equipment and support, and should be easily accessible to almost all patients in BNSSG at all times

- Home visits are by far the most resource-intensive part of the Severnside service. They can be under significant pressure at busy times, and visits referred inappropriately, or with insufficient information, cause delays, confusion and angst for staff, patients and families

- Patients who need home visits are often vulnerable and can be complex. The home visiting clinician "in the patient's living-room" is clinically isolated and the Severnside service should support them in their task as much as possible
- There are a number of patients for whom home visits are clearly indicated if a face-to-face consultation is needed (the obvious home visit cohort). For example, those who are terminally ill, those who are in care homes and those who are fully housebound
- Older age-groups should *not* be automatically referred for home visits; those who normally lead independent lives (with or without support) should usually be invited to attend a Treatment Centre
- There are some types of home visits which are more appropriately undertaken by a GP. Examples of these include mental health cases, complex end of life care (EOL) symptom management and patients requiring discussion relating to Do Not Attempt Resuscitation (DNAR) or escalation of care or completion of a ReSPECT form
- There is a group of patients or relatives who request home visits, who sit outside the above "no debate" group. These include patients who state they have **logistical** barriers to attending a Treatment Centre, such as no transport, and those who state that they cannot attend a Treatment Centre for **temporary clinical** reasons, such as severe dizziness. These are dealt with separately under "Difficult Areas" below (section 4.3)
- For those patients for whom a home visit is appropriate, the triage content should be clear and sufficiently comprehensive. The purpose of the home visit should be stated. Further detail on triage content is given under "Triage Information" below (section 5), including specific guidance on certain situations
- Where prioritisation is concerned, **emergency** home visits should ***not*** be offered. Severnside is not an emergency service. If the clinical situation requires a clinician to attend very quickly, for example, a dying patient in severe distress, then the triage clinician should note that before forwarding the case. The visit should be logged as requiring a 2-hour response and the triage clinician should speak to the shift manager or Workflow and Capacity Coordinator (WaCC) to request that the next available car is sent (if need be diverted) to that case
- The default prioritisation for all home visits should be undertaken within 6 hours, which reflects a prompt response and a pressing clinical need
- By exception, a home visit may be marked as requiring a 2-hour response only if the patient is in significant distress, is rapidly deteriorating, or there is some other unusual reason. The rationale for the 2-hour prioritisation must be recorded
- For cases where, say, a visit within 3hrs is acceptable, free-text that the case should be 'sooner end of routine', and speak to the despatcher or shift manager
- Patients who are normally fit and well in whom sepsis is suspected (please refer to sepsis telephone triage tool at Appendix 1) should have a 999 ambulance called. However, a home visit is appropriate if sepsis is suspected, hospital admission is not in the patient's best interests and end of life care in their usual residence is more appropriate.

3. Covid-19 pandemic

Severnside's Covid-19 precautions and processes remain in place at the time of the current review and update for this policy. The home visit policy still applies, but all information relating to home visiting during the Covid-19 pandemic is provided on the Covid page on the Clinical Toolkit at www.clinicaltoolkit.co.uk/covid-19.

4. Definitions

A home visit entails a clinician attending, assessing and treating a patient at their home, or on occasion at a temporary abode, plus arranging suitable follow-up if needed. The clinician should create a full contemporaneous record.

5. Eligibility

5.1 A Home Visit should be offered:

- Where a clinical need has arisen for a face-to-face consultation and the patient is terminally ill; in a care home; or fully housebound
- As above, where the patient normally goes out from time-to-time, i.e. is not completely housebound, but has a severe impairment of mobility or is clearly frail and/or confused, and traveling to a Treatment Centre is not feasible
- If the patient is acutely mentally disturbed, and the relevant steps outlined below under Section 4.3 have been completed
- If the patient is deemed to be "acutely housebound" and the relevant steps outlined below under Section 4.3 have been completed.

5.2 A Home Visit should not be offered if:

- There are logistical barriers, such as 'no transport' or 'children sleeping' (please see below for further detail)
- When a patient/relative simply demands a home visit and there is no clinical reason to justify such a course of action
- Sepsis is suspected in an otherwise fit patient (as above section 2, 999 should be called; this can be for an emergency *assessment* and the patient can be routed back to Severnside if the paramedic assessment suggests 'not sepsis/not acutely ill')
- The patient is on the "tackling violence register" or there is some other obvious potential risk to the home visiting clinician, such as the patient is under the influence of alcohol
- For patients with straightforward mechanical back pain, who should normally be managed over the telephone

5.3 Difficult areas

General

It is important in all cases to establish a rapport with the caller, whether they are the patient, a relative, a carer or another individual such as a concerned neighbour. It is preferable to gauge the full clinical story before a discussion about the next step is undertaken. The clinician must at all times be courteous and compassionate. On occasion, though, there may be a direct question from a patient/parent early in the discussion about whether a home visit will be offered. Please

acknowledge the request, and advise you will return to it once you have the full clinical information you need to determine the best next steps for the patient. Proceed to obtain the relevant history to understand the presenting problem and appropriate options. If a home visit has been requested by the caller but is clearly inappropriate, please be polite, apologetic and honest, e.g. 'I am very sorry, but our policy states that we are not able to offer home visits in this situation. Can I outline our other options?' The other options often depend on the time of day, particularly in relation to other services such as Minor Injury Units or the Urgent Treatment Centre.

In situations where a patient simply demands a home visit which is wholly unjustified, then the reason(s) for seeking a home visit should be explored. The home visit should be politely refused and alternatives offered. Such cases can be difficult, and patients have been known to threaten to complain or to take legal action. As stated in the introduction, BrisDoc and Severnside will be fully supportive of any clinician who adheres to this policy in a compassionate and courteous manner.

We have had numerous instances where inappropriate home visits have been offered by triaging clinicians under pressure, and then later the offer has been retracted by a firmer (usually more senior) clinician, and an alternative option arranged. This situation causes hassle and distress to all concerned, and must be avoided at all costs.

Children

We do not offer home visits to children, with very rare exceptions. There is a tiny number of children across BNSSG who are ventilated at home, and there is a further small number who are severely disabled and who need hoist-type transfer. For these children, it is not feasible that they attend a Treatment Centre. Other than such cases, we do not offer home visits to children. Children can be more appropriately assessed in a Treatment Centre where there is a comprehensive set of equipment available. It is not uncommon that a parent will press for a home visit, especially late at night. Various reasons may be given, such as the patient is "too ill", the weather is adverse, they have no transport, other children are asleep etc. Please listen and be sympathetic, but be firm that a home visit will not be undertaken. The other options are as follows and will depend on the time of day and particular circumstances:

- If there is likely an immediate serious clinical concern then an ambulance should be called for emergency paramedic assessment
- Offer phone review in an agreed time-frame, such as an hour, and, if needed, further phone reviews thereafter
- If during the night, and it is clinically acceptable to wait, consider offering a Treatment Centre appointment in the morning particularly if this will avoid unnecessary use of ambulance or ED services. However, face to face assessments should usually be undertaken within the 2 hour and 6 hour timeframes.
- Suggest a taxi to Treatment Centre, and where a transport problem appears genuine, and finances are stated to be an issue, use our Severnside taxi account
- Check if there is an open Minor Injury Unit or Urgent Treatment Centre within a reasonable distance
- It may be helpful to discuss the case with a colleague who is at hand, or with the Clinical Co-ordinator
- Please ensure that you check the Special Patient Notes tab on Adastra for all children, to see the Child Protection – Information System (CP-IS) which provides useful

background safeguarding information. Safeguarding concerns should not be a reason for offering a home visit. If the triage clinician has *immediate* safeguarding concerns they must contact the relevant service(s) in accordance with BrisDoc's Safeguarding Children policy. If there are 'softer' concerns e.g. a parent's ability to cope, then the child should be seen in a Treatment Centre as usual and an appropriate assessment made

Acute Mental Health Patients

If a patient is depressed, whether or not suicidal, and a face-to-face appointment is needed, then the patient should be seen at a Treatment Centre unless there are exceptional circumstances. Please see Suicide Risk Assessment Tool at Appendix 2. If a patient is acutely disturbed (e.g. deluded, hallucinating) and needs a face-to-face assessment, then a home visit may be the only option. Such patients are often, but not always, in care homes. In addition to the 'Triage Information' (section 5), the triage clinician should:

- Ring the relevant Crisis Team to see if they know the patient and can offer insight, background information or practical support
- Consider speaking to the psychiatrist on-call
- If it might help, speak to the police/paramedics (sometimes the latter are already on scene)
- There may be a dilemma between the Mental Capacity Act and the Mental Health Act; be broadly aware of the distinction (see Appendix 3) – the MHA is relevant to situations in which the *primary issue* is one of acute mental illness such as psychosis
- Consider carefully whether a physical cause can be ruled out. If not, and it is often difficult to be sure, then the patient is best seen in secondary care. Please refer to the medical team for this assessment and seek advice about where the patient should be sent when making the referral.
- Inform the shift manager or WaCC, and then speak directly to the home visiting clinician to explain the situation and discuss the case

Acutely Housebound Patients

It is fairly common that a patient or relative will give a **clinical** reason for being unable to travel to a Treatment Centre, for example, severe pain, constant vomiting, frequent diarrhoea etc. **Sometimes it is appropriate** that such patients are seen at home. Every effort should be made to determine that the patient is truly acutely housebound <u>*and*</u> will benefit from a face-to-face consultation (rather than, for example, phone review). It is also important to determine that a 999 ambulance is *not* needed. The following steps should be followed:

- Usually the caller is a relative; ensure that as much clinical information as possible is elicited from the caller
- Speak to the patient to check and confirm/clarify the story; if necessary (the patient is in the bathroom, for example) ring back after ten minutes to do so. If the patient cannot speak to the triage clinician at all, then clarify the reason. If it is because s/he is "rolling round in agony", or is "too ill to speak", then an ambulance response may be required
- Ask how the patient is managing to undertake core daily activities, such as getting to the toilet. A patient who, for example, is so severely dizzy that they are using a bedside bucket is unlikely to be able get to a Treatment Centre. A patient who needs to be carried or crawl to the toilet because s/he is so weak should have an ambulance called, unless there are clear reasons not to such as, for example, the patient is nearing the end of their life

- Ensure the sepsis triage questions are covered (Appendix 1)
- Ask when the patient last left the house; a patient who was out shopping that morning is less likely to warrant a home visit that one who has not been out for four days
- Check EMIS – which should be done anyway – but in particular check if the condition is recurrent and if the patient's own GP has undertaken a home visit for it
- Check if Severnside has visited in the past for the same condition (this does not necessarily justify a visit today, but helps to fill in the picture)
- If a home visit is thought to be justified, make clear to the patient/family, "We would not normally offer a home visit for this age group/condition, but we will do in this case because of….."
- Be absolutely clear regarding the **purpose** of the home visit, e.g. to assess hydration, to confirm the diagnosis, to consider injectable anti-emetic in order to avoid hospital attendance etc.
- Ensure record-keeping is comprehensive
- Again, please see the Covid-19 content on the Clinical Toolkit. A Covid positive patient or household with no transport may be acutely housebound if the patient/ parent cannot use a taxi or obtain a lift because of self-isolation requirements.

Severe Back Pain

Again, it is fairly common that we are phoned by a relative, or sometimes by a paramedic, for a patient who has severe back pain. The triage clinician should aim to determine if the pain is likely to be mechanical in origin. This usually entails the younger age-group (roughly 20-40); there is often a clear trigger (sometimes at the moment of onset of pain, sometimes things like heavy lifting yesterday); there are no odd-sounding features (such as vomiting, difficulty urinating, abdominal pain, recent weight loss etc.); there are no cauda equina red flags and there may be a past history of similar problems. For patients where the diagnosis is probable mechanical pain, there will be little to be gained from a face-to-face consultation. The aim should be to manage the case with appropriate analgesia over the phone, with further phone review if needed. For patients for whom very strong oral analgesia ('the back cocktail' of a strong opiate, NSAID and diazepam) is not sufficient, or who cannot take oral analgesia for some reason, then referral to secondary care should be considered for parenteral pain relief.

For cases where the diagnosis is unclear, then there is a myriad of possibilities and it is not possible to be prescriptive in this policy. Take a thorough history, gauge the views of relatives/carers, and consider discussing the case with a colleague. Be particularly careful in older patients, especially with a first-ever episode. Bear in mind serious conditions such as leaking AAA and cauda equina, and take action as appropriate. A home visit *may* be appropriate for this group, but it very much depends on the circumstances; a paramedic may be needed, or in a case where the pain has become less severe, aim to arrange a Treatment Centre appointment.

End of Life (EOL) Care

It is commonplace that we get requests for extra drug supplies of various sorts for EOL patients. If dealing with such a request, please check if the patient is all right, with adequate symptom control. Please take particular care to make this enquiry if there are multiple requests over a weekend period. If there is any doubt, then please arrange a home visit to re-assess the situation and ensure there is no underlying cause requiring different treatment (for example, retention or constipation).

If dealing with a case where there has been recent rapid deterioration, the patient is distressed, and there are no just-in-case drugs in the house, then – especially if it is late – consider prescribing the four EOL drugs at triage for a family member to collect. The visiting clinician will not then be faced with a drug-supply issue at 1am. If there is no pharmacy open, then make that clear, and the home visiting clinician should consider their options (see section 6.3).

The Elderly

Beware triaging an elderly patient where there is no corroboration of the history. It is often the case that elderly patients are stoical and play down their symptoms/level of distress, or sometimes they are mildly confused. Sense-check the story with a third party, e.g. family member, where possible. A key question is *"How different from her norm is she right now?"* If the difference is wide, such as a patient who went out to the shops alone until two days ago is now chair-bound, then a home visit is likely to be indicated (unless a history of trauma/pain suggests that ED will be needed).

The elderly sometimes decline further intervention, such as a home visit or an ambulance. A key factor here is mental capacity, and assessing mental capacity over the phone is not easy. One stratagem to consider is to ring the patient back after 10-15 minutes and ask if they recall your previous conversation. If they do not, then act accordingly.

Abnormal Laboratory Results

This is a very thorny area. Please access EMIS to understand the background to the test being requested and, if needed, obtain alternative telephone number(s) for the patient. Click the "emergency access for urgent treatment" option when entering the record before contacting the patient. Usually, these cases can be managed over the phone (sometimes admission needs to be arranged over the phone) or the patient can be seen at a Treatment Centre. If unable to contact the patient, please use Connecting Care to check whether the patient has presented to hospital in the meantime or ask the operational team to phone the hospitals to check. Please remember that some patients may present at the Royal United Hospital in Bath. On occasion a home visit is appropriate, either to assess the patient more fully, to instigate treatment (e.g. high INR), and/or to repeat the blood test. Clearly this is an individualised judgement call, and the other aspects of this policy should be utilised to confirm that a visit is an appropriate course of action.

6. Triage information for all home visits

This policy aims to **standardise capture of triage information**, so that **all salient points are noted** in any given situation, and hence the home visiting clinician is fully supported in their task.

6.1 Core Information

EMIS

EMIS should be checked for **all** home visit triages. If a clinician is triaging remotely, or for some other reason does not have access to EMIS, then, where feasible, s/he should focus on non-home visit calls. Now that EMIS access and usage have become widespread, it is acceptable to access EMIS **in advance** of a "possible home visit" triage call, if the triaging clinician makes a

judgement that **prior** information will enrich their assessment. Click the "emergency access for urgent treatment" option.

The triaging clinician should copy from EMIS and paste into Adastra (see Appendix 4), or should free-text any *relevant* information which will assist the home visiting clinician's assessment and decision-making. This may include the drug list, recent pathology results or consultations, headline conditions/issues, ReSPECT decisions, comments from the patient's own GP, agreed management plans and quotes from recent hospital letters. It should be borne in mind that EMIS records are in reality variable in their layout and content. A vast and indiscriminate block of information from EMIS should *not* be copied and pasted. Selected relevant free-text is usually preferable. **In particular, if the patient is elderly and UTI is considered a likely diagnosis, which is a common scenario, then please ensure that the latest eGFR and any recent MSU sensitivities are captured to aid the visiting clinician's prescribing decision.**

The following should be captured, where possible, for all home visits, with certain exceptions such as deaths (see section 5.2). There are circumstances where the caller is uninformed or vague. If that is the case, ask if there is anyone else who can help; if not, elicit the best information possible. The list below may appear to be 'stating the obvious', but the reality is that important information is often missing from HV triage:

Presenting complaint and history of presenting complaint

- Outline the core reason for the call, whether from a patient, a relative or a health professional, e.g. abdominal pain, high potassium, 'not herself' etc.
- Explore the above as appropriate – how long, how severe, is it getting worse, what has been tried so far
- Clarify whether the patient has had *this* symptom pattern in the past and if so, what happened (this particular information is often missing)
- Gather other immediately relevant history e.g. discharged from hospital ten days ago or started new drug two days ago etc.
- Ask if the patient eating, drinking, mobilising, and passing urine (a 'yes' to all four lessens the likelihood of anything serious)

Past Medical History

- Clarify headline co-morbidities, and free-text or copy and paste

Drug History

- Copy and paste from EMIS if available, or free-text the list of medicines taken
- Or confirm an up-to-date drug list is at the house/care home
- Record the allergy information available on EMIS
- Make specific note of any drugs which might have a bearing today, such as an ACE in an abnormal potassium; NSAIDs with abdominal pain; warfarin etc.

Social History

- Most home visit patients are elderly - do they live alone?
- If yes who else is around – carers, family – and if so, for how long
- Can the patient let the visiting clinician in? If not, how will access be gained e.g. is key safe number needed (if so, please log it in the Adastra record)
- If the carer or family will be nearby and wish to be present at the visit, please obtain their telephone number and clearly log in the notes a request for the visiting clinician to ring when en route to the visit

- Take care to ensure that a home visit will not place the visiting clinician in a vulnerable position. Be vigilant for alerts on EMIS and/ or special patient notes within Adastra which may flag, for example, the presence of an unfriendly dog at the residence or a history or aggression to healthcare professionals. Such risks may impact on whether a visit is an appropriate course of action, may require the driver to enter the property with the clinician or require other action to reduce any potential risk to the visiting clinician (for example, shutting an aggressive dog away prior to arrival).

Differential diagnoses

- If an obvious possible diagnosis (or a couple of options) come to mind, then it is appropriate to lay them out, but writing out a lengthy list of possible diagnoses should be avoided
- In cases where there are multiple diagnostic possibilities, it is preferable to note that the diagnosis is unclear and a face-to-face assessment is needed.

What is the visit actually for?

- Please specify if possible: is it to confirm a diagnosis or because it is very unclear what is going on?
- Is it primarily to check over and reassure?
- Is it to assess and provide symptom relief, such as in EOL cases?
- Is it to support another health professional, such as a DN or paramedic?
- Is it to take a specific action, such as to repeat a blood test?
- **Please note that this is a "setting out of the stall" for the home visiting clinician; it is *not* inviting the triage clinician to *tell* the HV clinician what to do and, unless it is very clear-cut (such as a repeat blood test), then specific actions should *not* be promised**

6.2 Connecting Care

Where feasible and appropriate triage clinicians can also use Connecting Care to help build a richer picture of a patient's needs, for example including their social care history/services, mental health care records.

6.3 Additional Information

In some cases, more detailed information is needed, as discussed above under mental health patients.

There are other cases which warrant "digging deeper", such as those which are medically complex, or which involve a possible safeguarding issue, or where the relative appears disproportionately worried/distressed.

Be particularly careful where EMIS access is not possible; we are at risk of becoming deskilled in these cases. Obtain as much information as possible at triage, including accessing Connecting Care (particularly if the patient has had a recent admission locally) and the Summary Care Record on Adastra. The latter should provide a medication list and headline information about the past medical history. Seek to speak to with family or a carer who know the patient well.

Deaths

- Expected deaths should, where feasible, be verified by the district nurses or by staff in a nursing home. However, on occasion, Severnside does need to visit to verify an expected death. Such cases should be triaged as requiring a 6-hour home visit, unless there are unusual circumstances, which should be made clear in the notes. Please see the Covid pages on the Clinical Toolkit for further information about remote verification of death and updated guidance related to issuing death certificates while Covid legislation is in place www.clinicaltoolkit.co.uk/covid-19.
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- If a visiting clinician is present at a visit at the time a patient dies, the clinician must ensure that this is logged as a learning event. The primary purpose of this is to enable follow up with and support to the clinician if the circumstances may have been difficult or distressing. Severnside is also required to report all deaths to CQC if we were present at the time of death. The governance team will action this reporting on receipt of the incident.
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- For “unexpected but no surprise” deaths, the relevant protocol should be followed, attached at Appendix 5.
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- Unexpected deaths should be attended by the police (on behalf of a Coroner’s Officer) and not by Severnside.

7. Case Prioritisation

The default prioritisation for a home visit should be 6 hours. The 2-hour timeframe is significantly over-used for home visits. 2-hour cases should *only* be used where the patient is in significant distress or is rapidly deteriorating or is in some other way at pressing risk. If requesting a 2-hour visit, the rationale must be justified in the case record. In cases where a visit within 3-4hrs would be reasonable, consider logging it via free-text ‘sooner end of routine’ and speak to the despatcher or the shift manager to ask that the case be given priority within the routine batch.

‘Emergency’ visits should not be used. Please see under **“Principles”**. Severnside is not an emergency service.

Any change to priority must be made by a clinician.

8. Duties, Responsibilities and Standards

8.1 Triage Clinician

The triaging clinician has the responsibility to make a professional assessment and decision about how the patient’s clinical needs are best met. Having elicited the minimum core (and if needed additional) information required, a decision should be reached as to whether a home visit is appropriate and at which priority. Additional advice should be sought from a colleague at hand or from the Clinical Co-ordinator if needed.

The triaging clinician will inform the patient that they may wait up to the maximum waiting time i.e. up to 6 hours, unless by exception they have a 2-hour priority. Once the visit is confirmed or despatched to the car the operational team will telephone the patient to confirm the likely

timeframes for the visit, and check they have the patient line number in case there are concerns or the patient deteriorates while waiting for the visiting clinician to arrive.

The triaging clinician is responsible for giving the patient worsening advice and instructing them to contact NHS 111 and/ or the Patient Line number if they are concerned that their condition is changing before the visiting clinician arrives. The patient should be advised that they can only use the Patient Line number during the current out of hours period, after which they should contact their own practice or NHS111.

8.2 Clinical Coordinator

In knotty cases, the Clinical Co-ordinator will support triage clinicians in their assessment and decision-making with respect to the need for, and priority of a home visit. Unless the case is exceptional, the triaging clinician should retain the line of contact with the patient/relative. The CC should *not* be used as a 'referee' where there are differences of opinion, either between the triaging clinician and a patient, or between the triaging and home visiting clinicians. The CC will work with the Shift Manager to support the mobilisation of the visiting resource, and the meeting of Key Performance Indicators, by providing advice and guidance as needed.

8.3 Home Visiting Clinician

Overall

The home visiting clinician is responsible for the clinical assessment and management of the patient at home; for recording their consultation (see below); and for taking appropriate action regarding follow-up. For example, for forwarding the case if further phone review is needed, for speaking to the DN directly if an extra visit is needed, for checking with a local pharmacist if an unusual drug has been prescribed etc.

Record-keeping

Where a full set of triage information has already been elicited, this should *not* be unnecessarily repeated, nor should it be copied and pasted into the visiting clinician tab on Adastra. Rather, something like, "Triage noted and recapped" should be recorded, along with any further salient history. The rest of the assessment should be fully recorded, as usual. Where there is a debate about onward management, particularly hospital admission, this should be documented fully, especially in circumstances where the final decision is to keep the patient at home. These are higher-risk situations. Shared decision-making should be demonstrated, e.g. "Discussed options with son and agreed……" etc.

The clinician should use the tough book to acknowledge receipt of the case and to report their start time, and arrival time.

Cars and Sharps

The Severnside cars are fully resourced with the equipment, consumables, and medicines a clinician may need. The clinician is responsible for ensuring their clinical practice is safe and does not put others at risk, notably in the management of sharps, which should be in accordance with infection control and sharps management guidelines.

Paper Records

Paper copies of case records or notes must ***not*** be taken on home visits. Printed notes present a significant information governance risk.

Anticipatory prescribing, ReSPECT decisions and end of life care

We are often asked to become involved in end of life care cases. Not infrequently we find that 'just in case' medications are not available. However, there have also been a number of cases, especially during long weekends, when Severnside has visited a patient who is clearly pre-terminal, and we have recognised the clinical position, but have taken no clear action on drugs/charts etc. A further phone-call/home visit (sometimes several) then ensues during the course of the weekend. **Hence, if a home visiting clinician recognises that a patient is likely pre-terminal, especially over a weekend, then just-in-case drugs should be prescribed, the relevant charts completed and the DNs informed. Similarly, a ReSPECT form should be completed to reflect the appropriate treatment plan and resuscitation status.**

In a situation where there is no pharmacy open and there appears to be rapid deterioration, with inadequate drug supplies at the patient's home, then the home visiting clinician should endeavour to sign out appropriate controlled drug(s) from the Treatment Centre to supplement those in the car. The cars routinely stock midazolam, levomepromazine and hyoscine, but not injectable morphine or oxycodone.

In EOL cases, it is usually good practice to undertake a joint visit with the district nurse, if feasible, or at least to speak to the DN both en-route to, and following on from the visit. This is to ensure that those closely involved with the patient's care are "on the same page". Advice may always be sought from St Peter's and Weston Hospices via their advice lines.

Prescribing and/or dispensing medications at home visits

It is not possible to prescribe electronically from the visiting cars. However, the norm should be for the visiting clinician to issue or arrange a prescription for the family or carer to take to a pharmacy.

- This will usually be done by handwriting an FP10. In addition, the medications should be prescribed on Adastra but, instead of selecting print or electronic prescription, select 'record as handwritten'. This will ensure the medical record accurately reflect your prescription. A log of hand-written prescriptions for each car is kept by the driver. The clinician will be asked to sign against each prescription used for prescription security audit trail purposes.
- There are a small number of pre-printed FP10s in the car, to support correct prescribing of 'standard' end of life injectable medications. This should avoid the potential for errors in the wording for controlled drug prescriptions, but the clinician will need to add in the appropriate quantities and cross off any medication(s) which are not required. Again, Adastra should accurately reflect what has been prescribed.
- If handwriting an FP10 for controlled drug(s), please add the medication(s) to Adastra first. Adastra will then provide the correct wording for a controlled drug prescription. This can be copied onto the FP10 to avoid errors and ensure there are no delays in dispensing the medication at the pharmacy.
- Alternatively, the visiting clinician can prescribe the medications on Adastra and select 'store for later'. Amend the first line of the notes to add in that EPS is required and by when, including the pharmacy and its postcode. The case can then be forwarded to the CC for the EPS to be issued. This option is helpful if multiple medications are required,

or unusual end of life medications. Please ensure that the shift manager is aware that the EPS is required to ensure it is actioned promptly.

The visiting cars also carry medication, and the current stock list is available on the Clinical Toolkit. Stock medication can be issued if the pharmacies are closed and the medication is required before they reopen, or the patient has no carer/ family who can obtain the medication for them. Again, the visiting clinician must ensure that the Adastra records log the name, dose and dosing instructions for the medication, plus the batch number and expiry date for any medications dispensed. The driver will log any medications issued from stock to ensure stock is replenished.

Injectable morphine and oxycodone are stored at the Treatment Centres, but not part of core stock in the cars. If a patient requires controlled drugs from stock, the visiting clinician will be responsible for checking out these drugs from the Treatment Centre into the car safe. The visiting clinician is responsible for safe custody of these medications while visiting.

8.4 Driver

The driver is responsible for the efficient and lawful conveyance of the clinician to visits and for the safety of the vehicle. Vehicle safety includes ensuring it is roadworthy at the start of a shift. The driver will ensure the vehicle is appropriately stocked, clean and tidy at all times.

The driver will offer to escort a clinician into and away from the patient's home and provide a check on the clinician's safety during the visit by phoning the clinician if they have been in with a patient for more than half an hour. The driver is responsible for reporting any lone working concerns to the Shift Manager.

Drivers will work in accordance with all SOPs relevant to car management.

8.5 Workflow and Capacity Coordinator (WaCC)

The WaCC is responsible for despatching and monitoring visits in accordance with the procedure set out in the Home Visiting Standard Operating Procedure.

When the WaCC notes that a visit has been put through which does not meet the criteria outlined above, they will liaise with the triaging clinician to seek confirmation of the rationale. They will also liaise with the shift manager.

8.6 Re-Triage

Visits may be re-triaged if a home visit has been put through which does not meet the criteria outlined in this policy. There are also occasions where the clinical situation changes and this may require the priority to be altered or the visit to be stood down. For example, if new information is received that, for example, pain has settled and the patient is now asleep, or, on the contrary, that pain has worsened. Visits should *not* be re-triaged to try to avoid breaches.

Re-triage of cases should be referred to the original triage clinician where possible, but can be undertaken by the visiting clinician or the clinical coordinator. If a patient is deteriorating (as reported by the patient/relative or NHS 111), and are not due to be visited swiftly, then a telephone re-assessment should be made by the most readily available clinician.

8.7 Patient Line Number

Most patients should be advised to call back to Severnside by ringing NHS 111. However, there is a 'patient line' to enable direct call back for some patients during the same out of hours period. Please give the patient line number to patients for whom you are arranging a home visit, to enable a direct call back if their symptoms change or worsen while waiting. The patient line also has an important role for palliative patients. Please ensure that you advise that the patient can only use the number during the current out of hours period, otherwise they will be advised to call back to NHS111.

9. Taking and Management of Samples

The taking of samples at a home visit should be by exception and where the result will either confirm a diagnosis e.g. a high potassium, or inform onward short-term treatment e.g. that the appropriate antibiotic has been given.

All samples must be labelled with the patient's name, date of birth, NHS number, and the date and time the sample was taken. Accompanying pathology request forms must include the patient's own GP, to ensure the report is sent to the patient's own surgery for follow up and inclusion in their primary care record. Unless fully completed the laboratory will reject and dispose of the sample without analysis.

If blood tests have been required during the out of hours period, the case should be forwarded for Clinical Coordinator follow up to ensure the results are reviewed and actioned as appropriate. Please amend the first line of the home visit records to state the action required by the CC (for example, 'CC follow up blood results at 5pm on Saturday'), to aid prioritisation and management of cases in the consult and hold queue. Urine samples and swabs will not usually change management during the out of hours period, and the patient or their representative should be advised to follow up the results with the patient's practice.

All infection control principles and sharps management standards must be adhered to by the clinician, in order to ensure the safe management of the sample, and the safety of the driver. The clinician has sole responsibility for the safe bagging of samples; for presenting it the driver for delivery to the laboratory; and for the safe disposal of any sharps and consumables. The driver is responsible for ensuring it is safely delivered to, and received by the laboratory, or that it is taken to a Treatment Centre from where it will be delivered to the laboratory on a planned "sample run".

10. Tough-book and Case Records

The tough book is the tool through which visits are received by the car and the record of the consultation is documented in Adastra. Primarily it is a clinical tool and as such should be available for the clinician to take into the consultation, should they so wish, rather than retained in the car for visit planning. This decision rests with the clinician.

The clinician is responsible for ensuring that s/he is logged in correctly at the start of the visiting shift, and logs out at the end of the shift. The clinician is responsible for logging the clinical notes from the visit, saving and closing the case. The clinician is also responsible for logging on the tough book when the car is 'en route' to, and then 'arrived' at, the home visit. It is important that this is logged at the appropriate times, not later.

11. Phablets

The visiting clinician is provided with a phablet from which 2-touch help in a crisis can be raised from the driver; access to the internet for the eBNF and the clinical toolkit can be obtained. Visiting clinicians should ensure they have the phablet with them and know how to use it to obtain help in a crisis.

Phablets will be used in accordance with BrisDoc IT policies and are not for accessing social media or downloading material not related to work.

12. Safe Working / Communications

All Severnside vehicles have trackers for the purpose of supporting despatch and monitoring vehicle location. Trackers support the safety of home visits in the context of lone working. It should be noted that the trackers can be used to monitor driving performance and in the event of a serious incident, data may be used to support an investigation.

Drivers will offer clinicians support for the safe access to and egress from a patient's home. The driver will ensure the clinician takes the phablet with them and is able to use it to call for a help in an emergency. The driver can enter the premises with the clinician, and also provide chaperone support if this is required.

By exception a clinician may drive themselves on home visits. Those who do are typically an Emergency Care Practitioner and the operational team will be aware. Clinicians who do drive themselves will work in accordance with the Lone Working and Personal Safety policy.

13. Concerns

If the visiting clinician does not feel that the home visit referral was appropriate, this should be fed back to the Clinical Coordinator or Shift Manager, and should be reported as learning event for follow up and feedback. Judgemental comments should *not* be recorded in the patient's notes. It is acceptable for the home visiting clinician to speak to the triage clinician, although conflict must be avoided. If the home visit does not appear to be warranted then either clinician can re-assess the case and change the plan, although this is likely to cause disappointment to the patient/family for whom an expectation has been created. As stated earlier, such situations should be avoided if at all possible.

Patient demands have increased over the years, with increased expectations and the misconception that it is their "right" to be provided with a home visit come what may. This is not the case, and Severnside will provide support to clinicians who do not offer a home visit that is not appropriate, should a complaint be received.

14. Monitoring Home Visit Targets

The target time for a home visit will be included in the case record as a comfort call note. Clinicians/drivers are responsible for managing visits with a focus on optimising safe patient care and meeting targets, and will inform the control room of any issues/concerns. The WaCC and Shift Manager are responsible for reviewing and monitoring overall visit performance and, with the support of the Clinical Coordinator, managing the despatch of visits to ensure they are seen in accordance with clinical priority needs and within target.

15. Deviation from Policy

- Exceptional circumstances may arise where it is deemed that deviation from this policy is appropriate. In such a case, a learning event should be logged to enable review and follow up of any learning. In other situations where there is a particularly difficult consultation for whatever reason, then a learning event should also be submitted.

16. Measuring For Improvement

The outcome of the implementation of this policy will be measured against a baseline using the following metrics:

- Number of emergency, urgent and routine HV
- Number of inappropriate HV
- Quality of HV triage
- Visit breaches
- Case priority at closure
- Complaints
- Incidents

These metrics will be reported within Severnside's dashboard, with oversight from the Urgent Care Services Leadership and Operational Board.

17. Equality Statement

BrisDoc aims to design and implement policies and practices that meet the diverse needs of the local population and workforce. It is about creating fair and equal access to services and employment opportunities for all. It is about reducing disadvantage experienced by some groups in comparison to others.

BrisDoc's Equality and Diversity Policy takes into account the provisions of the Equality Act 2010 and the general and specific duties, ensuring as far as possible that BrisDoc eliminates discrimination, advances equality of opportunity and fosters good relationships. It is about ensuring no one receives less favourable treatment on the grounds of; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

In carrying out its functions, BrisDoc will take into account the different needs of different groups in their area. This applies to all the activities for which BrisDoc is responsible, including policy development, review and implementation.

Equality Impact Assessment
BrisDoc's commitment to equality means that this policy has been screened in relation to paying due regard to the Public Sector Equality Duty as set out in the Equality Act 2010 to eliminate unlawful discrimination, harassment, victimisation; advance equality of opportunity and foster good relations; and the Equality Delivery system. See Appendix 6 for the EIA screening matrix in relation to this policy.

18. Related Policies

Medicines Management
Safe Driving
Lone Working & Personal Safety

Incident Management
Data Protection, Confidentiality and Disclosure
Records Management
Safeguarding Children
Infection Prevention & Control

19. Related Standard Operating Procedures

Home Visiting
Car prescription log control
Management of Deaths

20. Change Register

Date	Reviewed and amended by	Revision Details	Issue Number
August 21	Anne Whitehouse	Change OOHs and bass to Severnside and Treatment Centres throughout, updated end of life care and IUC language throughout.	2

Appendix 1 – Tools to support recognition of sepsis at triage

The Sepsis Trust provides screening tools to support identification of sepsis during telephone triage. The tools are age specific and can be accessed within the Professional Resources content at

www.sepsistrust.org.

Under 5s sepsis screening tool telephone triage

5-11 years sepsis screening tool telephone triage

Age 12+ and adults sepsis screening tool telephone triage

Appendix 2 – Suicide Risk Assessment

Thoughts of suicide - initial assessment

Static factor Demographic or historical

Dynamic factor Can be amenable to change

Patient with thoughts of self harm or suicide

Send patients requiring physical treatment to emergency room

Assess risk of self harm or suicide

Home and work
People who die by suicide in England are more likely to be:

Male · Unmarried · Living alone · Unemployed

Mental health
Treating mental illness can reduce risk of self harm and suicide

- Affective disorder
- Schizophrenia
- Personality disorder

People with conditions like these could be seen by mental health teams

Self harm plans
Asking about suicide plans can be helpful. Consider introducing the subject gently, starting with questions like:

How is your mood?

Sometimes people who feel down can start to feel hopeless about the future. Has this happened to you?

Have you ever had any thoughts come into your head about life not being worth living?

Try to find out how prepared they are. Do they have a considered plan about how they would end their life? What preparations have they made?

History
Finding out about a patient's past can reveal further risk factors, such as:

History of self harm · History of alcohol misuse · History of drug misuse

Assess protective factors

Several factors have been identified that can mitigate risks, if present:

- Family support
- Strong religious faith
- Having children at home
- A sense of responsibility
- Problem solving skills

Loss of protective factors can increase risk for the patient, for example if a partner and children leave the patient

Estimate risk

Assess overall risk, taking into account risk and protective factors

Low risk → High risk

- Minor mental health problem. Engages with treatment
- At risk of suicide but has protective factors. May have suicide plan
- Well thought out suicide plan. Can't see point in treatment as "nothing will change"

Management plan

Consider whether any dynamic risk factors could be modified, and whether the patient is willing and able to engage with a management plan

- Manage in primary care. Discuss treatment for mental health problems, such as talking therapy, medication, or both
- Ask about friends/family who could help them. Give contact details for Samaritans. Consider mental health referral if support unavailable. Plan next appointment
- Contact mental health services urgently. Consider whether it would be unsafe for them to leave the building alone

Appendix 3 – Mental Capacity Act

A short guide to the Mental Capacity Act 2005

Five key principles:

- Presumption that an individual has capacity, until proven otherwise
- Individuals have a right to be supported to make their own decisions
- Individuals must retain the right to make what may seem to be eccentric or unwise decisions
- Any decisions made on behalf of someone deemed not to have capacity must be undertaken in his/ her best interests
- Anything undertaken under the act should be the least restrictive of their rights and freedoms.

Assessing capacity

This is about assessing an individual's ability to take a particular decision at a particular time i.e. mental capacity is decision and time specific.

Stage 1

- Inability to make a decision due to impairment of or disturbance in the functioning of the mind or brain

Stage 2

If there is impairment, that impairment has made the person unable to make a particular decision. They cannot make a decision if they cannot:

- Understand the information relevant to the decision
- Retain the information
- Use or weigh up the information as part of the decision-making process, or
- Communicate their decision

Acting in a patient's best interests if they are deemed not to have capacity

- Consider the person's wishes and beliefs
- Consult relevant people (e.g. relatives)
- Do not impose your own view on what is best
- Respect appropriate advanced directives

DOLS (Deprivation of Liberty Safeguards) under the Mental Capacity Act

- Provides for lawful deprivation of liberty of those people who lack the capacity to consent to arrangements made for their care or treatment in either hospitals or care homes, but who need to be deprived of liberty in their own best interests to protect them from harm.

Principles for the out of hours period

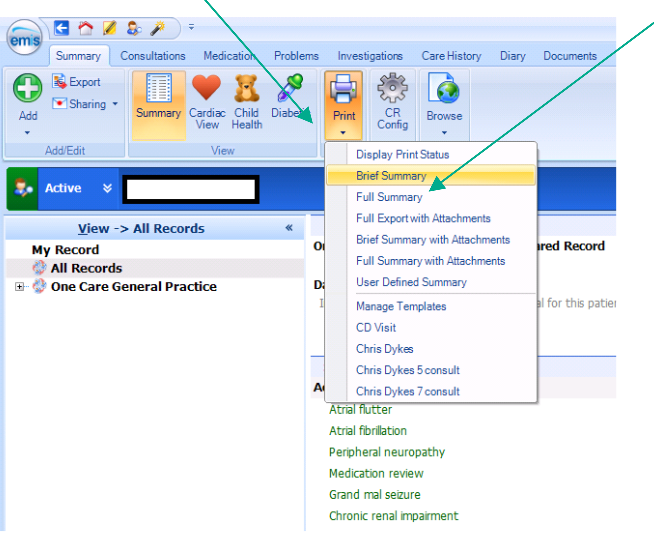
- Generally difficult to meaningfully assess capacity without seeing the patient face to face.
- If in doubt, seek advice.

Appendix 4 – EMIS

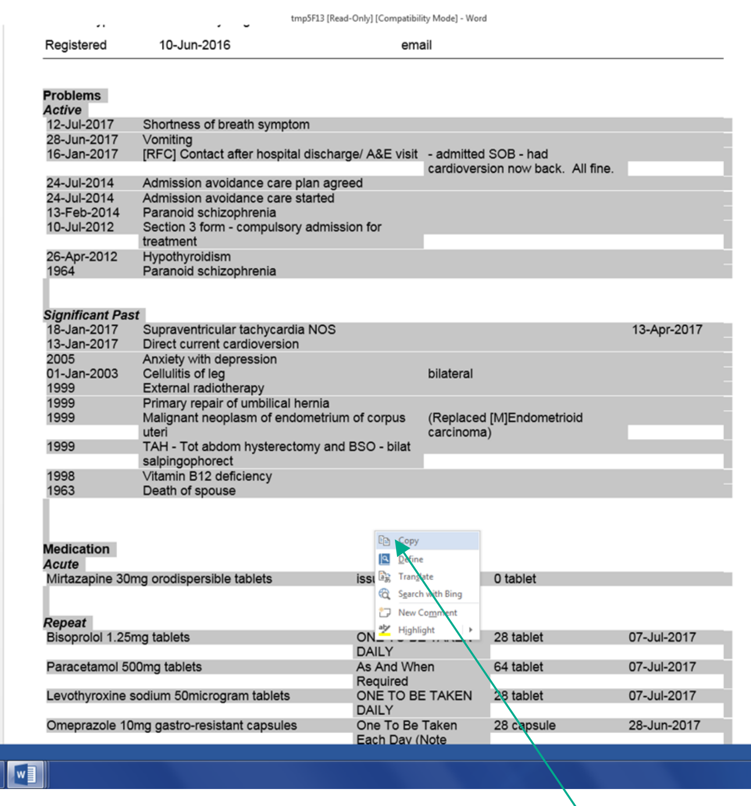
<u>To copy/ paste from EMIS to Adastra:</u>

Firstly, please ensure that the patient you are viewing in EMIS matches the patient you are copying information about into Adastra.

From the summary screen on EMIS, select "print" on the top bar, then choose "brief summary"



The following will then appear:



tmp5F13 [Read-Only] [Compatibility Mode] - Word

Registered 10-Jun-2016 email

Problems
Active

12-Jul-2017	Shortness of breath symptom	
28-Jun-2017	Vomiting	
16-Jan-2017	[RFC] Contact after hospital discharge/ A&E visit	- admitted SOB - had cardioversion now back. All fine.
24-Jul-2014	Admission avoidance care plan agreed	
24-Jul-2014	Admission avoidance care started	
13-Feb-2014	Paranoid schizophrenia	
10-Jul-2012	Section 3 form - compulsory admission for treatment	
26-Apr-2012	Hypothyroidism	
1964	Paranoid schizophrenia	

Significant Past

18-Jan-2017	Supraventricular tachycardia NOS		13-Apr-2017
13-Jan-2017	Direct current cardioversion		
2005	Anxiety with depression		
01-Jan-2003	Cellulitis of leg	bilateral	
1999	External radiotherapy		
1999	Primary repair of umbilical hernia		
1999	Malignant neoplasm of endometrium of corpus uteri	(Replaced [M]Endometrioid carcinoma)	
1999	TAH - Tot abdom hysterectomy and BSO - bilat salpingophorect		
1998	Vitamin B12 deficiency		
1963	Death of spouse		

Medication
Acute

Mirtazapine 30mg orodispersible tablets	Issu	0 tablet	

Repeat

Bisoprolol 1.25mg tablets	ON... DAILY	28 tablet	07-Jul-2017
Paracetamol 500mg tablets	As And When Required	64 tablet	07-Jul-2017
Levothyroxine sodium 50microgram tablets	ONE TO BE TAKEN DAILY	28 tablet	07-Jul-2017
Omeprazole 10mg gastro-resistant capsules	One To Be Taken Each Day (Note	28 capsule	28-Jun-2017

Select the text with the mouse that you wish to copy, then "right click the mouse" and select "copy" from the drop down box. You can then paste into the adastra case record (right click the

mouse and select paste from the drop down options). Please paste this content underneath your triage assessment.

We recommend that you avoid copying and pasting large quantities of text, and take time to reduce any unnecessary content to make it easier for the visiting clinician to see the important and relevant information. In most instances it is alright to copy all the text, including allergies, although in patients with multiple comorbities it may be helpful to reduce some of the less clinically relevent items.

Appendix 5 – Unexpected but no Surprise Deaths

Origin Nursing Home
BrisDoc Professional Line

NHS 111 Call

BrisDoc GP OOHs

Death

Police

999 Call

Ambulance Service

Phone Triage
Confirm whether expected or unexpected

Attend and confirm:
No Active Resuscitation
Expected or unexpected

Home Visit

Confirmation of death by the BrisDoc clinician or ambulance clinician
[BrisDoc telephone support available for past and recent medical history]

Evidence of Suspicious Death
Call 999 - Request urgent Police attendance, remain on scene

EXPECTED

Advise family / carer to contact funeral director.

Advise family / NOK to contact patient's GP regarding notification of death and arrangements for collection of Medical Certificate of death.

UNEXPECTED 'but no surprise'

Advise family / carer to contact funeral director.

Advise family / NOK to contact patient's GP regarding collection of Medical Certificate of death.

Advise family / carer that patient's GP may require referral to Coroner.

If ambulance clinician – contact BrisDoc to request Adastra record for own GP notification

ADDITIONAL DECISION MAKING SUPPORT

Healthcare professional contacts On-call Coroner's Officer (via 101).

On-call Coroner's Officer decides whether family funeral director can collect deceased or whether Coroner's Office will attend.

Appendix 6 - Equality Impact Assessment

This equality impact screening matrix is intended to identify if the implementation of a new scheme (procedure, project, policy etc.) being introduced by BrisDoc might adversely affect someone with a protected characteristic and/or risk BrisDoc breaching its Public Sector Equality Duty or fail to comply with the Equality Delivery System. Key criteria will be considered against each protected characteristic and if the implementation of the policy, project etc. would cause, or would have the potential to cause, an adverse impact on the person a full equality impact assessment should be undertaken.

To be completed by the key document author and attached to the key document when submitted for consideration and approval.

Policy/Guidance Title: Out of Hours Home Visiting policy

Completed by: Home Visiting policy development group

Date: 9th May 2017, reviewed 20.8.2021

		Yes / No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	Age	Y	Children
	Disability	N	
	Religion or belief	N	
	Sex	N	
	Sexual Orientation	N	
	Marriage/Civil Partnership	N	
	Pregnancy and maternity	N	
	Gender reassignment	N	
	Race	N	
2	Is there any evidence that some groups are affected differently?	Y	Children
3	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	Y	There are very clear clinical advantages of seeing a child at a Treatment Centre including full suite o equipment, being able to treat and review, aligned with in hours care and accepted practice. The exception will be ventilated children and children in their last days of life.

4	Is the impact of the policy/guidance likely to be negative?	N	It is intended to be positive so visiting resources can be directed to those with the greatest need.
5	If so can the impact be avoided?	N/A	
6	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7	Can we reduce the impact by taking different action?	N/A	

If you have identified a potential discriminatory impact of this document, please progress to undertaking a full equality impact assessment.

CHANGE REGISTER

Date	Version	Author	Change Details
23.5.17	3	CL Nicholls	Inclusion of all BrisDoc practices and services, values slide, related policies and procedures, rationale, CQC standards, new reviewer.