Wessex Academic Health Science Network

NHS

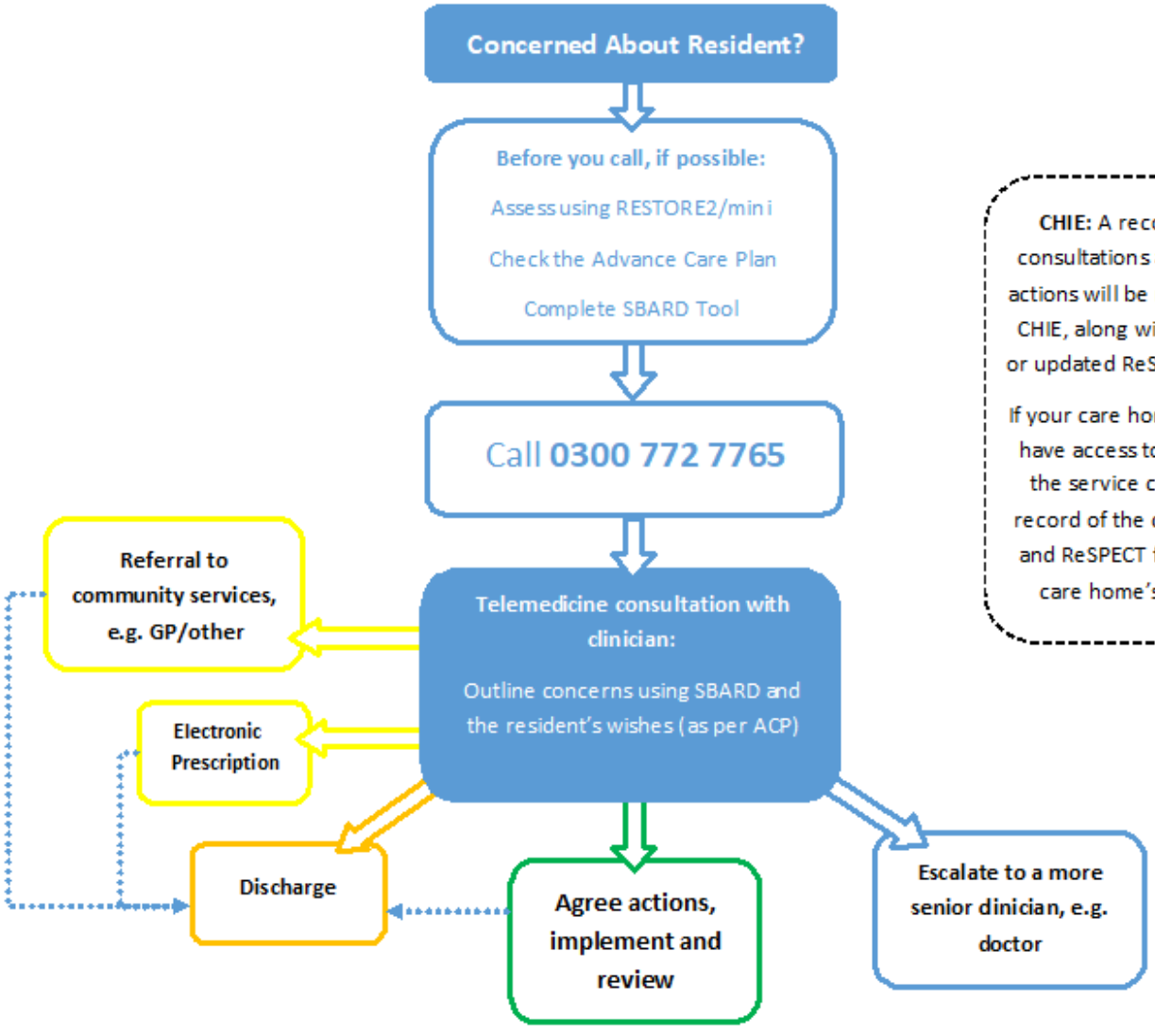
TELEMEDICINE SERVICE FOR CARE HOMES

WHAT IS THE SERVICE?

Telemedicine is a service allowing assessment and clinical support of residents using teleconferencing, when the clinician and resident are not physically in the same place.

Information for care home staff

The Telemedicine Service Pathway



CHIE: A record of all consultations and agreed actions will be recorded on CHIE, along with any new or updated ReSPECT forms.

If your care home does not have access to CHIE (yet) the service can email a record of the consultation and ReSPECT form to the care home's NHS.net

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1. WHEN TO USE THE SERVICE AND HOW TO ACCESS IT

☎ 0300 772 7765

The Hampshire Hospitals Foundation Trust (HHFT) Telemedicine Service provides clinical support to care homes **seven days a week 8am – 8pm**. The service is new and we are actively recruiting team members, but once we have a full team it will be open 24/7. We will let you know as soon as we achieve this. If you are answer yes to the questions below then the Telemedicine Service should be accessed.

a) Does the resident's health need urgent attention?
b) Could a trip to hospital negatively impact the resident's psychological wellbeing?

1.1 When TO use: For Unexpected and Sudden Change

Call the Telemedicine Service if your resident has a health event which is unexpected and/or sudden. For example:

- Higher than usual RESTORE2™ score
- General deterioration: The person is off food/drink, unable /unwilling to mobilise, not passing urine or opening bowels
- Any type of fall or trauma (incl. head and neck) or broken bone: including those on blood thinners
- Suspected infection (e.g. urine infection, chest infection)
- Symptom control
- Breathlessness
- New confusion / delirium
- Sudden and unstable diabetes management
- Swallowing deterioration
- Chest pain
- Suspected stroke
- Abdominal pain
- General pain management

1.2 When NOT to use: For Routine and Predictable Care

The service is not appropriate for routine and predictable care, such as those you would normally access via the GP or Community Pharmacy. For example:

- Repeat prescription
- Chasing a test result
- Stable RESTORE2™

2. RESTORE2™

2.1 What is it?

- A tool that helps assess and manage a deteriorating resident
- Recommended by the British Geriatric Society (2020)
- Should be used alongside an anticipatory care plan or treatment escalation plan
- Consisting of three parts in addition to your knowledge about the resident:

1. Soft signs – recognising early indications that your resident may be unwell
2. National Early Warning Score (NEWS2) and guidance on what to do
3. SBARD – a standard tool to communicate your concerns

2.2 What if my team is not trained to complete clinical observations?

You can use RESTORE2™ mini which uses Soft Signs and SBARD to help identify and communicate concerns about residents' health and wellbeing. It does not include NEWS2™ (which is the part involving clinical observations). RESTORE2™ mini can be found here:

https://westhampshireccg.nhs.uk/restore2/ (scroll halfway down and select the RESTORE2™ mini tab).

2.3 How can I find out more about RESTORE2™?

- **West Hampshire CCG resources** – to access the workbook, training pack, competency documents and online videos, please visit:

  https://westhampshireccg.nhs.uk/restore2/

- **Health Education England resources** – 14 short (2-3 mins each) videos, to help you improve the skills you need to use RESTORE2™. Videos 5-10 are particularly useful for staff who are new to taking clinical observations (please note, these videos do not prove competence – your Nurse Facilitator or Enhanced Health Care Practitioner can guide you through the competency assessment). Video 12 shows how to use the SBARD tool to communicate the relevant information to the Telemedicine Service. Titles of the videos are shown in the table below, and all videos are available on YouTube from: www.youtube.com/playlist?list=PLrVQaAxyJE3cJ1fB9K2poc9pXn7b9WcQg

1. Introduction to sepsis & serious illness	2. Preventing the spread of infection
3. Soft signs of deterioration	4. NEWS What is it
5. Measuring the respiratory rate	6. Measuring oxygen saturation
7. Measuring blood pressure	8. Measuring the heart rate
9. Measuring the level of alertness	10. How to measure temperature (ear)
11. Calculating and recording a NEWS score	12. Structured communications & escalation
13. Treatment escalation plans & resuscitation	14. Recognising deterioration in people with learning disabilities

2.4 Are there any other considerations?

- The RESTORE2™ tool and Health Education England video clips are for generic care home use
- When accessing the Telemedicine Service, your homes will also need to include extra and essential information included on the SBARD prompt card in Appendix 1
- Always clearly and accurately document any referrals, discussions and decisions in your residents' care records
- Your home must have an NHS.net email address to enable secure sharing of confidential information about residents (if you do not have an NHS.net email address then refer to section 5).

3. FUTURE WISHES & DIFFICULT CONVERSATIONS

3.1 What is my role in supporting advance care planning?

- As the resident's main carer, you are ideally placed to discuss your residents' future wishes
- Discussions and documentation should take place on admission to the care home
- Wishes about future events such as hospital admission and end of life care should be documented clearly in the Anticipatory Care Plan (ACP)
- If you identify residents without this documentation, flag this up with your manager
- It is essential that all staff caring for the resident know the contents of any ACPs and associated documentation so they can ensure this is considered and communicated on the resident's behalf

- These conversations can be challenging
- The **Rockwood Clinical Frailty** score is a simple screening tool to help you identify a resident's level of frailty. It can help you build an overall understanding of your resident's general condition and guide your advanced care planning conversations (it is available from: www.bgs.org.uk/sites/default/files/content/attachment/2018-07-05/rockwood_cfs.pdf)

3.2 What is an Anticipatory Care Plan (ACP)?

- An ACP helps residents make informed choices about how and where they want to be treated and supported in the future
- It requires health and care practitioners to work with residents and their carers to ensure the right thing is done at the right time by the right person to achieve the best outcome

It should involve a holistic approach covering all aspects of the resident's health and wellbeing, including normal daily activities of living such as eating and drinking to end of life care wishes.

3.3 What key things should be included in an ACP?

- The resident's individual preferences (considered alongside clinical assessment), to provide a summary of recommendations for health care professionals to consider when responding to an emergency or situation when the resident may be deteriorating
- The person your resident has appointed to act as 'Lasting Power of Attorney (LPA) for health and welfare' (where they have named someone)
- The mental capacity of the resident, as highlighted in the 'Mental Capacity Act', along with any deprivation of liberty safeguards processes that apply
- More information on LPA and the mental capacity act can be found on the following NHS website:
  www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/giving-someone-power-of-attorney/

3.4 What is ReSPECT and how can I use it?

- Recommended Summary Plan for Emergency Care Treatment (ReSPECT) is an example of an ACP, and is endorsed by the Telemedicine Service

- The ReSPECT process creates personalised recommendations for a resident's clinical care in a future emergency in which they are unable to make or express their choices
- The form is usually started and signed by a Hospital doctor/consultant or a GP. You can contribute and be an advocate for your resident's wishes to be considered as you know your residents well
- A number of electronic resources are available to help you use ReSPECT, including the ReSPECT form, digital guide, a leaflet and letter for residents/relatives, posters and training slides. To view / download these, please visit:
  https://www.resus.org.uk/respect/downloads/

3.5 What are the benefits of using ReSPECT?

- A nationally recognised ACP – developed by The UK Resuscitation Council with the support of the Royal College of Nursing and Cancer Support Macmillan
- The ACP of choice for the Telemedicine Service – the service can start ReSPECT forms, review and amend existing versions to ensure they are appropriate for current needs. They can email them immediately to the care home if required

3.6 Are there any other tools and forms I can use to support my residents' ACPs?

Full name of tool / forms	**Referred to as…**	**How can they be used**
Treatment Escalation Plans	TEPS	Allows the resident and staff to be aware of the limits of treatment in the event of deterioration in the resident's health
Do Not Attempt Cardiac Resuscitation forms	DNACPR	A document that is issued and signed by a doctor, designed to guide those present (mainly healthcare professionals) to provide immediate guidance should the person suffer a cardiac arrest

4. INFECTION PREVENTION AND CONTROL

- If your home has clinical observation equipment (e.g. thermometers and/or a mobile digital device like an iPad), this should be given the same care and attention regarding infection prevention and control as all other areas of your practice

- If your home has an existing '**Cleaning of Care Home based Equipment' policy**, this should be sufficient. If not, please **follow the instructions** in the following table to ensure that the equipment does not become a source of infection transmission between residents
- For all equipment – if used on a resident with an infection e.g. COVID-19, MRSA, allocate a device for single resident use (or for mobile digital devices: where possible)

Item	Method	Frequency
Mobile Digital Devices, e.g. iPad	• Wipe front and back with a microfiber cloth and a simple soap. Dry and replace any accessories • Don't use harsh chemicals, hand gels and abrasive wipes (these can damage the screen's protective coating) • Use minimal fluid – take care not to let any fluid leak into the sides / front screen or any openings	Daily, or every use if the device is used by residents
Blood pressure Machine	• Wipe cuff thoroughly with a disposable cloth wipe or detergent wipe. Wipe the cables and rest of the monitor • Take care not to let any fluid leak underneath the buttons	Every use
Temporal or Tympanic Thermometer	• Wipe entire device with disposable cloth/detergent wipe • Remove lens cap and pay particular attention to the lens (check inside of lens for any build-up of debris, clean with wipes and dry with a paper towel)	Every use
Pulse Oximeter	• Clean all over with disposable cloth or detergent wipe wiping - particularly the inside of the probe • When cleaning inside, take care not to allow too much fluid to go beneath the rubber • Dry with paper towels	Every use

5. DIGITAL SUPPORT

If your care home has connectivity issues please recall the telemedicine service on 0300 772 7765

APPENDIX ONE

	Adapted SBAR Tool to support care home escalation decisions
S Describe Situation	1. My name is [**insert name**] and I work for [**name of care home**] which is a care home with trained nurses/without trained nurses [**advise as appropriate**] 2. I need to talk to you about [**insert patient name]** who resides at [**insert home address with post code]** who's date of birth is [i**nsert residents date of birth**] and NHS number is **[insert]** 3. I need to talk about an urgent situation that has arisen ***briefly describe the current situation*** 4. I know who holds the resident's Power of Attorney and their contact details/next of kin contact details
B Provide Background	5. The client has lived with us since **[date of admission to care home]** 6. They have been admitted to hospital **[add in number of admissions and time in hospital]** in the last 6 months 7. In the last month the client has been admitted to hospital with [**add in reason for admission**] and/or seen by the GP with **[add in reason]** 8. They are also known to suffer from [**outline all known medical problems in clients records with particular note of underlying heart problem, diabetes, respiratory problems, renal problems, dementia]** 9. The clients' medication list includes [**include all medication**] 10. The client **does**/**does not** have an Advance Care Plan (ACP)/Current Respect/DNACPR form which states 11. The Rockwood (clinical frailty) score is [**add in score**]
A Provide client assessment	Summarise the facts and give your best assessment on what is happening:- 1. I think the current problem is [**insert problem**] **OR** I don't know what the problem is but the client is deteriorating 2. I have [**describe the action you have taken e.g. given pain relief, medication, sat the patient up**] 3. The normal NEWS score when the clients is well is [**add in score]**. The current NEWS score is [**add in score**] 4. The most recent weight is [**add in weight**] kg. Weight on admission [**add in weight**] kg. 5. The client is currently able/not able to eat & drink 6. The client is currently able/not able to walk. Their the normal mobility is [**describe whether they use a frame etc.**]

R Make Recommend-ations	2 recommended outcomes are possible: 1. **Convey the person to hospital for further assessment**. This decision will be based upon the previous medical history, their co-morbidities and the likelihood that hospital care will improve outcome (for example., the resident will be a candidate for treatment which can't be delivered in the care home e.g. oxygen/intravenous treatment). 2. **Stabilise the person in the care home** either with an agreed action plan and clear criteria indicating when a further referral is needed **OR** Palliate the person in the care home which may require an updated ReSPECT form to be sent, end of life medications prescribed (available locally) and a drug administration form sent to allow the community team to deliver medication.
D Decision	1. Document Decision