Standard Operational Policy

Rapid Elderly Assessment & Care Team (REACT)

West Lothian

Introduction

REACT became operational in May 2013. The service was established to support frail older people at home, as an alternative to unscheduled acute hospital admissions. Older patients with frailty often have longer inpatient admissions and are at increased risk of complications such as health-care associated infections, delirium and falls. Therefore, delivering care at home is intended to provide better care and outcomes for frail older people. However we recognise that some diagnostic tests and interventions can only be delivered in an acute hospital setting, and it is important that frail older people are not disadvantaged and denied access to these if warranted. The focus of our service is patient-centred care in keeping with practice of realistic medicine. REACT is community-led with governance within the West Lothian Health and Social Care Partnership.

REACT encompasses the following services:

- Hospital at Home
- Rapid Access Clinic
- AHP Rapid Response & Discharge 2 Assess
- Rehab at Home
- REACT Care team
- REACT Respiratory Team

REACT aims

- An integrated Hub as single point of contact for frail elderly during an episode of acute deterioration
- To reduce unnecessary hospital admissions and unscheduled care, while improving the quality of care and patient experience
- Prompt comprehensive geriatric assessment and interventions through a rapid access clinic or assessment at home
- Liaise with and complement existing core services to provide effective multi-disciplinary assessment and interventions with shared decision-making towards patient-centred goals.

Contact details

REACT main number

Hospital at Home Coordinator

Rapid Response and Discharge 2 Assess

Respiratory Team

REACT Staffing ***- Hospital at Home, Rapid Access Clinic and Rehab at Home***

Medical

- 1.1 WTE Consultant
- 0.4 WTE Specialty doctor
- 2 WTE Clinical Fellows
- 0.25 WTE FY2

Nursing

- 1 WTE Band 7
- 5 WTE Band 6
- 2 WTE Band 5

Pharmacy

- 0.9 WTE

Admin

- 1 WTE team leader
- 1 WTE administrator

AHP

Rapid Response

- 1 WTE Band 7 AHP
- 1.6 WTE Band 6 OT
- 2 WTE Band 6 Physio
- 1 WTE Therapy Assistant Practitioner

Rehabilitation

- 2 WTE Band 6 OT
- 2 WTE Band 5 OT
- 2 WTE Band 6 Physio
- 2 WTE Band 5 Physio
- 1.8 WTE Generic Assistant

Hospital at Home

Referral criteria

- Resident in West Lothian
- Patient and family agree to referral
- Safe for assessment at clinic or at home

Exclusion criteria

- Acute chest pain
- Acute stroke
- Surgical problems
- Low GCS <9
- Shock
- Suspected fracture

REACT operating hours

Monday – Friday 8am – 6pm
If REACT patients require urgent input out of hours, they should contact NHS 24

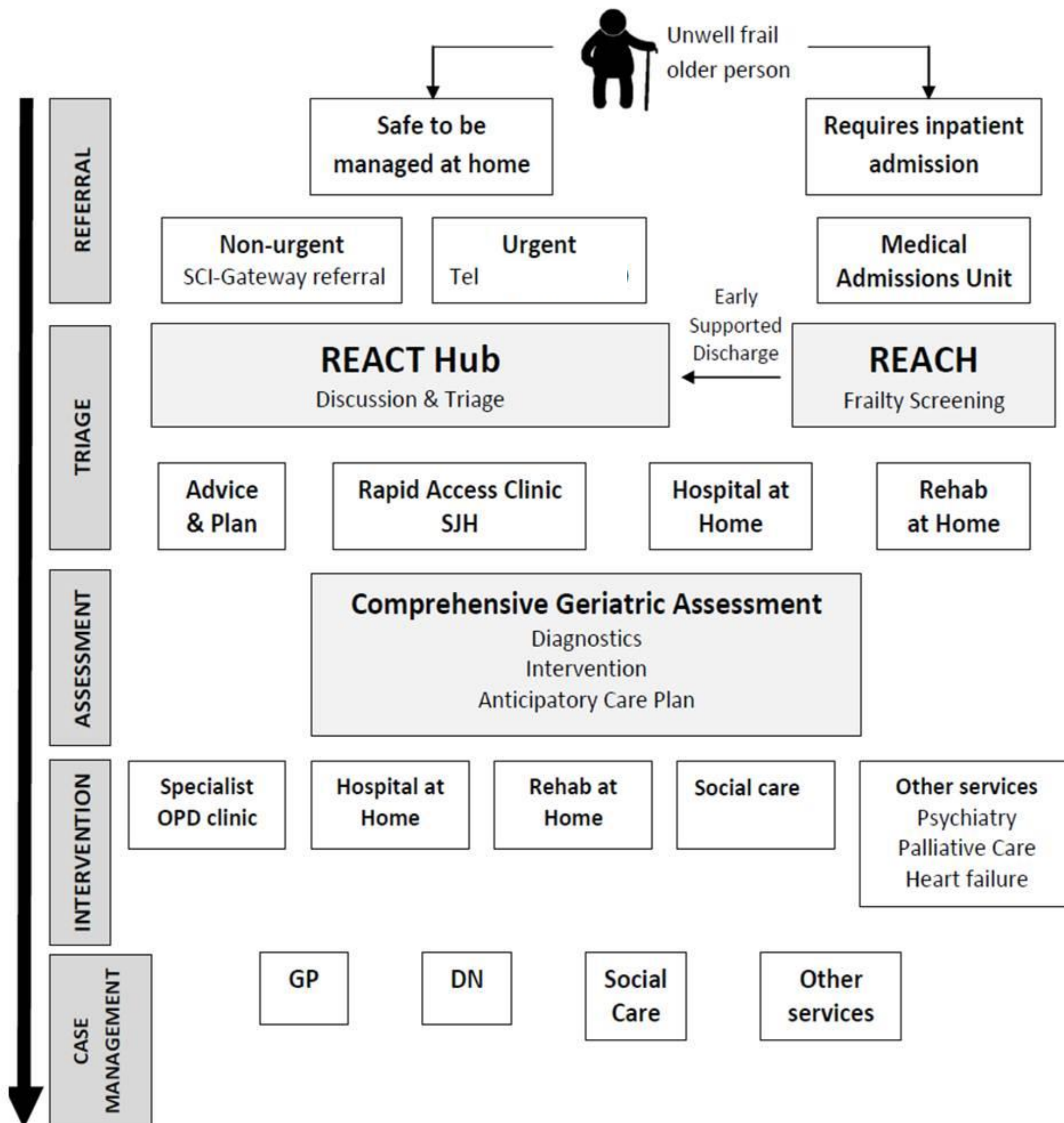
Referrals

- Urgent assessment or clinical discussion
  All referrals should be discussed with the Co-ordinator by phoning the REACT number 01506 524149 with the following potential outcomes:
  - Clinical advice or signposting to more appropriate service – document on Virtual clinic
  - Hospital at Home assessment – admit to H@H
  - Rapid access clinic assessment – allocate clinic appointment
  - AHP assessment - transfer call to AHP co-ordinator

- Non-urgent referrals
  These should be sent via SCI-gateway for Active Clinical Triage by a Geriatrician to the most appropriate service, which may be clinical advice, a diagnostic test or a different specialty.

- Supported discharges
  All referrals should be discussed with the Co-ordinator as above. There needs to be clear medical and nursing needs for Hospital at Home input that cannot otherwise be done by another core service. Out of hours referrals for supported discharges can be emailed to REACTNPs@nhslothian.scot.nhs.uk ensuring all referrals fulfil criteria above.

REACT Pathway



Hospital at home

Daily structure

0900 **Safety brief** – What safety issues do we need to be aware of today?
5 minute briefing led by the Co-ordinator. Examples:
Patient issues: similar names, at risk of deterioration, environmental risk
Professionals: new members of staff, absences, skill mix
Processes: new protocols, infection control
Patterns: recent near-misses, recently identified safety issues
Heads up for today: teaching, meetings, anticipated referrals

0905 **Home visits**

Planning
Visits are allocated the day before by the Co-ordinator. Each staff member should spend time planning the visit by reading the referral and clinical notes, preparing kit, phoning ahead to patient or family members, liaising with AHPs, pharmacist, other teams etc.

Travel
Facemasks will need to be worn if staff travelling in the same car.

Initial assessment
Assess patient and environment: is it safe, is the patient stable
Introduce self and service, confirm identity of patient and family members
Confirm contact details – telephone numbers, keysafe

Clinical assessment
Routine observations including weight
Clinical history and examination
Blood tests, urine, ECG
4AT, MUST and Waterlow
Differential diagnosis and initial management plan
Escalation and anticipatory care plans

Medication
Full medication reconciliation should be completed using a minimum of 2 sources. Document if dossette box in use, which pharmacy supplies this and when it is delivered/collected.
Check for any concordance issues.
Urgent acute medication should be prescribed on HBP prescription pads (Dr's prescribing) or on individual named nurse prescribing pads (held by the Nurse Prescriber themselves).
To Take Out Packs (TTOs) medication can also be taken out from the REACT drug cupboard, after completing an outpatient prescription for records, ensuring box clearly labelled with patient's name and date and accurate instructions. Medication that is not clearly labelled as a TTO pack cannot be dispensed to the patient. These items may be administered by medical and nursing staff using appropriate prescribing and administration documentation.

Dossette box changes require a change form as well as a prescription for any new meds.
Non-urgent medication changes should be done by the GP practice following REACT discharge. All medication changes should be documented in the 'Ward Round/Review' section of TRAK EPR.

Storage of NHS prescription pads
Information regarding the storage of NHS prescription pads can be found in the following document.
https://policyonline.nhslothian.scot/Policies/Document/Independent%20and%20Supplementary%20Prescribing%20Framework.pdf
The points of note are:

- "Prescription pads should be stored in locked areas when not in use. You should not store prescription pads away from your place of work. In particular you should not store pads at home or in your vehicle except when travelling between places of work"
- "You are responsible for the safety of your named pads and should take reasonable steps to prevent loss or inappropriate use. You should only use one prescription pad at a time"

Escalation
Concerns are escalated to 1) Coordinator 2) REACT medic 3) Consultant geriatrician

Anticipatory care plans
Discuss ACP at earliest opportunity, use REACT ACP document to guide conversations. Include key decision makers eg NOK, POA.
Discuss escalation thresholds eg admission to hospital, intravenous treatments, in event of deterioration.
Document all discussions clearly on Clinical Notes.
Once a full ACP is completed, document in Significant Information section of EPR as this is then visible to all subsequent clinical episodes.

AHP review, equipment, care
Contact Rapid Response AHP in person or by phone. Liaise with Co-Ordinator to order equipment if AHP input not required.
Urgent increase in POC should be requested through Social work, new acute care needs can be met by Crisis Care.

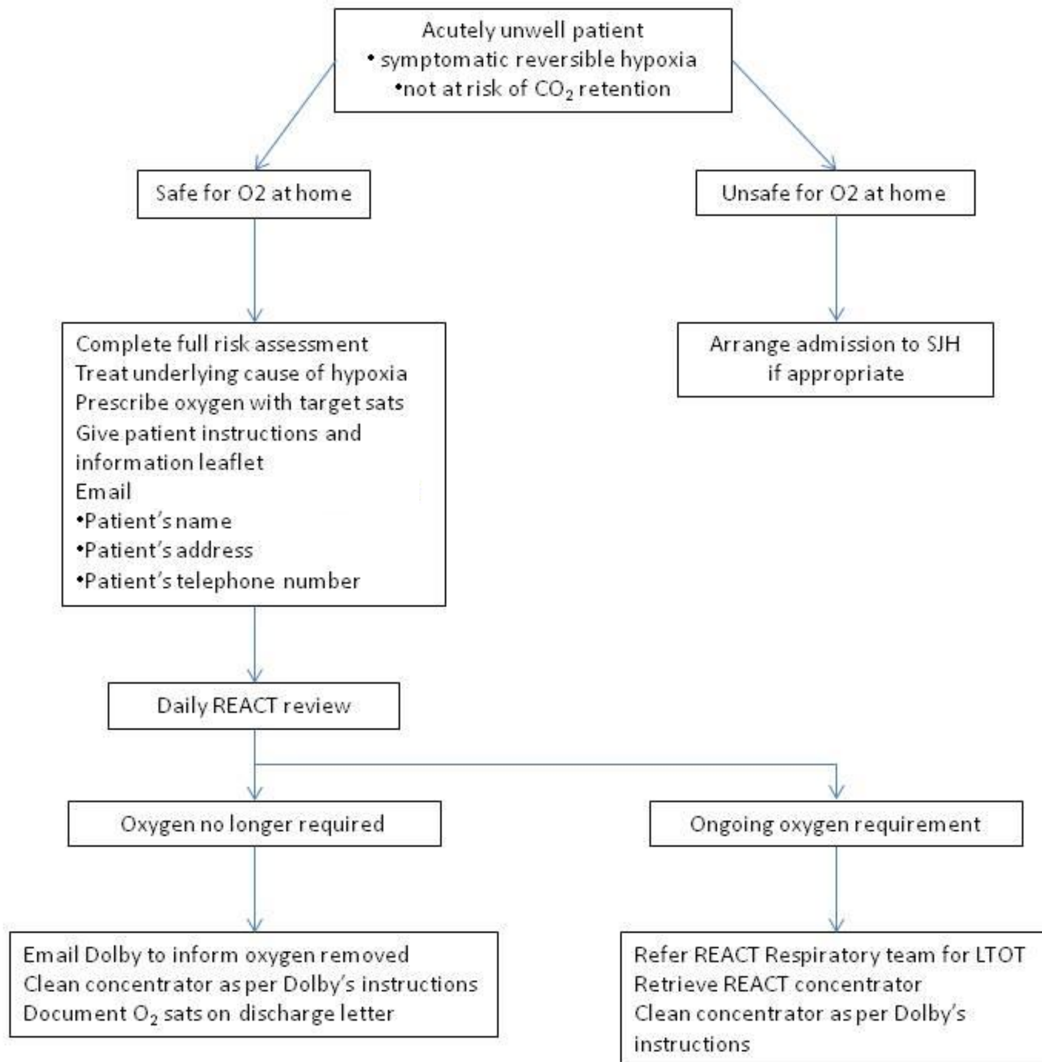
Communication
Clearly communicate working diagnosis and management plan as well as any agreed anticipatory care plans with patient, family and other relevant parties involved eg care providers, District Nurses. Leave a REACT leaflet with our contact details.

Investigations
Further investigations such as radiology, echocardiography, pulmonary function tests, endoscopy should be requested on TRAK if indicated.
Consider BRAN: What are the *Benefits*? What are the *Risks*? Are there any *Alternatives*? What if we do *Nothing*?
Please confirm if family can transport patients to SJH.

Discharge
Check all issues are resolved. Check medication changes and patient has enough supply of any new medications started. Ensure patient and family aware of above and confirm any outstanding investigations and follow up plans.

1530 **Afternoon Huddle**
Multidisciplinary team discussion of each patient assessing clinical progress and planning ongoing management.
Record issues and plan in Clinical Notes.
Record any medication changes in Ward Round/Review.

1630 **Post-huddle**
Co-ordinator plans next day's visits.
Prepare prescriptions, kit, and documentation for next day's work.
Telephone calls to patients and families for any updates from the huddle.
Write discharge summaries for discharged patients.
Email GPs with any urgent information eg medication changes.
Ensure all areas clean and tidy.
One REACT nurse stays on till 1800h for any troubleshooting.


REACT Oxygen pathway
Acutely unwell patient
• symptomatic reversible hypoxia
•not at risk of CO_2 retention
Safe for O2 at home
Unsafe for O2 at home
Complete full risk assessment
Treat underlying cause of hypoxia
Prescribe oxygen with target sats
Give patient instructions and
information leaflet
Email
•Patient's name
•Patient's address
•Patient's telephone number
Arrange admission to SJH
if appropriate
Daily REACT review
Oxygen no longer required
Ongoing oxygen requirement
Email Dolby to inform oxygen removed
Clean concentrator as per Dolby's instructions
Document O_2 sats on discharge letter
Refer REACT Respiratory team for LTOT
Retrieve REACT concentrator
Clean concentrator as per Dolby's
instructions

Administering Intravenous Medications to People Out With a Hospital Setting

- Patient consent for IV treatment should be confirmed and documented prior to administration of the first dose. Where the patient lacks capacity for this decision, an 'Adults with Incapacity' form should be completed and filed in the patient notes.
- The decision to administer IV medication should always be made by the responsible consultant or senior speciality trainee in conjunction with the nurse practitioners.
- The rationale for the administration of IV medication should be documented in the patients management plan and include a review date and estimated length of course of treatment. In the case of antibiotics, the choice should be in line with the hospital at home antimicrobial policy.
- IV medications should be prescribed in line with the NHS Lothian Safe Use of Medicines Policy and Procedures on the appropriate drug administration document. Administration should be recorded in the clinical notes to include drug given, batch number, and expiry date.
- Wherever possible, two registered practitioners should prepare and check medication to be administered intravenously, one of whom should also be the practitioner who then administers IV medication. In exceptional circumstances where delay would cause harm, preparation and administration can occur without a second practitioner.
- All necessary medication and equipment should be taken to the patient's home. Equipment may be stored in the patient's home where appropriate following risk assessment.
- All relevant equipment should be cleaned in line with the NHS Lothian Infection and Prevention Control Policy and guidelines
- All sharps should be managed according to NHS Lothian Safe Handling and Disposal of Sharps.
- Medications must not be left in patients home unless labelled for patients own use by a pharmacy.
- If an error occurs you must take immediate action to prevent any potential harm to the patient and report as soon as possible to the prescriber/responsible senior clinician, the Co-ordinator and document your actions through Datix.
- If a patient experiences an adverse drug reaction, take prompt action to treat this. Notify the prescriber/responsible senior clinician immediately, record this in the patient's notes, and report via the Yellow Card Scheme.
- Staff administering the IV medication must be familiar with and adhere to NHS Lothian Operational Procedure for the Management of Anaphylaxis and carry the appropriate medication and equipment to manage anaphylaxis.
- Cannula site should be routinely checked at the time of each IV administration.

Medications should be administered in line with:

- NHS Lothian (2019)Safe use of medicine policy and Procedure
- The UK Injectable Medicines Guide
- NMC Standards for medicine management.
- NHS Lothian (2013) Infection Prevention and Control
- NHS Lothian (2013) Safe Handling and Disposal of Sharps

Criteria for IV Therapy at Home

Patients who require initiation of IV medication should meet the REACT criteria to be safely managed at home.

- Patients who have no history of anaphylaxis or have previously received >1 dose of the required medication without adverse reaction.
- Known allergies are clearly documented in the notes.
- The patient is able to give informed consent or have the appropriate 'Adults with Incapacity' documentation in place prior to initiation of therapy.
- The home environment has been risk assessed and deemed safe for administration of IV medication.
- The patient, family members and/or care providers should be aware of how and where to access additional medical assistance if required.

Guidelines and protocols

All members of staff should have access to the REACT shared drive where relevant guidelines are stored including:
H@H antimicrobial formulary
H@H heart failure guidelines
REACT anticipatory care planning document

Admission to hospital

If a patient requires admission to hospital for investigations and interventions that cannot be delivered at home, ensure patient and family are in agreement. Arrange an admission bed by contacting Site & Capacity on 07903969548, then handing over to Med Reg on call on Bleep 3630. Ambulance transport arranged by phoning 0345 6023999. You will need details of the patient's weight, access to house, how they can transfer safely and clinical reason for transport.

Discharge letters

Write discharge letters as soon as possible after discharge. If there is going to be a delay, please email the GP Clinical Inbox with relevant information.
Use short code \idlreact [spacebar]
List diagnoses relevant to H@H admission, then background issues.
Ensure Med Rec is accurate.
Do not cut and paste from other pages on TRAK.
Include information useful for future reference, eg. Oxygen saturations at discharge for COPD patients, weight on discharge for heart failure patients, functional status.
Document all anticipatory care discussions, even if only initiated, for GP to follow up and update KIS.
For patients who are admitted to hospital, sufficient to document reason for admission, and do not include medication list as this may change during inpatient stay.

REACT Rapid Access Clinic

The Rapid Access Clinic aims to deliver comprehensive geriatric assessment for frail elderly patients who need assessment, but not the acute service of Hospital at Home. The majority of referrals to this clinic are via e-triage following SCI gateway referral from Primary Care but can also be made via the Hospital@Home Coordinator.

Patients are routinely booked into this clinic on Mon / Wed / Thurs, and other days by arrangement.
The aim is for a single visit, face to face appointment. At present patients are seen at home.

Patients may be assessed in the designated REACT clinic room provided this has been pre-arranged which is particularly useful if investigations such as radiology or echocardiography is co-ordinated on the same day as clinical review.

In general, most patients are seen and discharged with follow up of results and their further investigations once available. A clinic letter is generated and sent to the referring practitioner.

If further clinic follow up is required this is done by telephone where possible.

Patients are referred on to AHP or to other specialist clinics if required.

Procedure for assessing patients is the same as for Hospital at Home.

Respiratory Team

The multidisciplinary specialist team consists of a consultant respiratory physician (x2 sessions per week), respiratory nurse specialist, respiratory physiotherapist and physiotherapy support worker

What we can offer:
Comprehensive review of patient's respiratory management
Further investigations as indicated ie: PFT's, Chest CT
Review of respiratory medications
Inhaler technique advice
Airway clearance
Breathing control
Pacing/ spacing advice
Home based physical activity programme
Support provision of LTOT where indicated in liaison with respiratory consultants

Via:
Initial telephone assessment with patient
Face to face home assessment, if required
Ongoing input via telephone or NHS Near Me where possible

How to refer
Verbal referrals to RRT office or by telephone

Resources – these are available for use within H@H/ Rehab for any respiratory patients
New Aerochamber Spacer guidance- simple and with images
How to cope with being short of breath- positions of ease
How to cope with being short of breath- breathing exercises
Energy Conservation
Using and looking after your home nebuliser
Airway Clearance- ACBT leaflet (this should only be provided following physiotherapy assessment)

The REACT Respiratory MDT meeting is held every Tuesday.

Rapid Response AHP

A multidisciplinary team comprising occupational therapists, physiotherapists, support workers and links with social work.
The team works in line with Lothian's Home First Approach, ensuring assessment of health and social care needs are determined quickly and effectively during a crisis.

Aim
To provide urgent AHP assessment intervention to facilitate discharge from and prevent admission to hospital.
We will respond within 24 hours of referral.

What We Offer
Short term care and rehabilitation in patient's homes.

Referral Criteria

- Able to be managed medically in the community.
- Is currently experiencing a crisis and is unsafe to remain at home/at risk of hospital admission without therapy assessment and intervention.
- Has occupational therapy/physiotherapy goals.
- Requires urgent equipment/adaptations to remain at home safely.
- Requires a package of care to ensure safety at home whilst receiving AHP input – this will be assessed by the therapist in the short term.
- AHP assessment not fully completed in hospital.

How to refer
Email
Telephone
Once referrals are obtained they are screened by the team and allocated to the appropriate therapist.

Discharge
If further rehabilitation needs are identified they will be passed onto the rehabilitation team for a longer more focused rehabilitation intervention.
If no further rehabilitation needs a discharge letter will be sent to the GP via TRAK.
If a permanent package of care is required this will be arranged in collaboration with social work and the care at home team.

Rehabilitation at Home

A multidisciplinary team comprising occupational therapists, physiotherapists and therapy assistant practitioners.

The team provide goal focused rehabilitation to improve patient's function and health and well-being. Intervention is participation focused with an emphasis on community led approaches supporting longer term self management.

Aim
To proved patient led, goal focused rehabilitation.

What We Offer
Comprehensive assessment and a range of therapeutic rehabilitation interventions including but not limited to –

- Home exercise programs.
- Functional tasks practice.
- Symptom management strategies, such as fatigue, anxiety, pain.
- Supported self management.
- Community access support and links with local longer term support options.
- Cognitive rehabilitation strategies.

Referral Criteria

- Able to be managed medically in the community.
- Requires home or community based AHP assessment.
- Goals identified or wish to participate in rehabilitation for acute and long term health conditions.

How to refer
Referrals for rehabilitation intervention should be made to the West Lothian Single Point of Access for Rehabilitation (SPAR).
Email
Telephone

Once referrals are obtained they are screened and prioritised –
Priority 1: > 24 hours (Rapid Response)
Priority 2: 2-5 days
Priority 3: Up to 10 days

Outcomes and Discharge
Outcomes are measured using the Canadian Occupational Performance Measure (COPM) http://www.thecopm.ca/

The rehabilitation team is split into the East and West locality. The assessment and treatment intervention aims to be completed within a 6 week period.

Once discharged from the service a summary is sent to the patients GP via TRAK.

West Lothian Care Home Team

WL CHT has been in operation since February 2019. WL CHT is an Advanced Nurse Practitioner led community service governed within the West Lothian Health and Social Care Partnership.

The service was established to support the staff and residents in 16 Care Homes for older adults in West Lothian. There are 12 private Nursing homes and 4 LA care homes included in this service provision. Many of the residents within our care homes are very frail and have very complex needs as a result.

The focus of our service is to empower and enhance clinical skills of care home staff to enable them to deliver patient-centred care in keeping with practice of realistic medicine.

We also aim to provide support to the care home staff and residents during times where the residents care transitions through secondary and primary care interfaces.

WL CHT Aims:
Rapid access to advice:
-Skin integrity/Wound management
-Palliative Care
-Continence
Supporting/facilitating NH discharges from hospital
Training
Education
Development of clinical skills
Signposting and working with specialist services

We hope to see a reduction in avoidable admissions to hospital and a reduction in workload generated by care homes to other services.

Contact Details:
Stoneyburn Health Centre:

WL CHT Staffing:
2 whole time equivalent Advanced Nurse Practitioners
2 Whole time equivalent Community Nurse Practitioners
1 Part time Staff Nurse

Clinical Governance & Risk management
All clinical incidents and near misses should be reported as per current NHS Lothian procedure.

Adverse Weather
In Adverse weather please refer and adhere to NHS Lothian Adverse Weather Policy

Lone Worker Policy
All staff should adhere to Lone Working Policy available on intranet. All trainee staff will be accompanied on all visits.

Patient safety and clinical incidents
Any patient safety concerns or clinical incidents should be reported using the datix system. Learning from such incidents will be reviewed in the REACT M&M meeting.

Quality improvement
There are lots of potential quality improvement projects and all members of the team should be encouraged to look at ways of improving.

Education
Relevant educational events and training for the team will be integrated into our working with a mixture of on the job teaching and training and where appropriate planned teaching sessions. Support is provided for nursing staff completing further training as appropriate. All NP/ANP are allocated a medical mentor to support their development.

Performance data
Key data on number of patients seen and length of stay is produced in a weekly BOXI report.

Leave and absences
Annual leave and study leave should be planned ≥6 weeks ahead ensuring there is adequate staffing. The team leave calendar is stored in the REACT shared drive.
If you are running late or unable to attend work, phone the Co-ordinator as soon as possible so your work can be reallocated.

Parking and Mileage
Complete a parking permit request form and submit after signoff.
Submit mileage on e-Expenses.