Standard Operational Policy

Integrated Older People's Service (IOPS)
Edinburgh

Contents

Introduction

This operational policy has been written as a guide to all staff in the Integrated Older People's Service. This document summarises the aims, values and current operational procedures of the service. Our service is constantly evolving and it is anticipated that this SOP will be reviewed and amended periodically to reflect changes in working structure.

Background

The Integrated Older People's Service (IOPS) became operational in November 2015. It evolved from a pilot hospital at home service for South Edinburgh (previously called COMPASS+) and the redesign of an existing Day Hospital service at Liberton Hospital. The service developed out of a desire to support frail older people at home or close to home, as a potential 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 or close to home is intended to provide better care and outcomes for frail older people and supports the Scottish Government's 2020 Vision for Health and Social Care. A 2016 Cochrane review shows that admission avoidance H@H services have a similar mortality to hospital admission and may be associated with an improved likelihood of remaining in your own home at 6 months. (ref 1)

Service aims

1. To provide alternatives to admission for frail older people in South Edinburgh.
2. To provide rapid access, specialist outpatient assessment or hospital at home for older patients at risk of unscheduled acute hospital admission.
3. To provide multidisciplinary holistic care to support the needs of older patients with co-morbidities and frailty.

Values

- To deliver safe and high quality care to all service users.
- To support a professional working environment where multidisciplinary team working is at the centre of our practice and where the contributions of all team members are respected and valued.

To create an environment where the personal and professional development of all team members is encouraged and supported.

Members of the IOPS team

Medical staff

3 Consultants (1 x 5 PAs & 0.5 SPA for clinical lead for service, 2 x 1.5 PAs) (1 further to start Aug 19 – 3PAs). This provides consultant of the day, cover for Day Hospital and H@H teams.

2 FT specialty doctors

3 less than full time specialty doctors (2 working 4 days per week, 1 working 2 days per week)

(1 specialty doctor supports the Day Hospital and the others are based within the H@H team)

1 junior doctor for H@H and at least 1 junior doctor for Liberton Hub

Specialty Registrar on occasion, depending on training needs

Pharmacy Staff

Pharmacist less than full time but available by phone/email

Nursing staff

0.9 PT Charge Nurse (CN)

2 FT Advanced Nurse Practitioners (ANP)

1 PT Advanced Nurse Practitioner (ANP)

3 FT Trainee Advanced Nurse Practitioners (ANP)

1 0.8 WTE Deputy Charge Nurse (DCN)

7 FT Nurse Practitioners (NP)

1 PT Nurse Practitioner (NP)

4 Staff Nurses (SN)

7 Clinical Support Workers (CSW)

Secretarial & administrative support

2 FT administrative support

Physiotherapy

Overseen by 0.6 B7 Team Lead Physiotherapist

1.6 WTE B6 Specialist Physiotherapist (rotational and static)

1.0 WTE B5 Rotational Physiotherapist

0.5 WTE Physiotherapy Assistant Practitioner

0.67 WTE Physiotherapy Assistant

Occupational therapy

Overseen by Occupational Therapy Team Lead:

1 WTE Specialist Occupational Therapist

1 WTE Occupational Therapist

1 WTE Assistant Practitioner

Contact details

As phone numbers change as staff members rotate, please ask senior nurse for most up-to-date phone numbers of nursing staff. This list is also displayed in admin office and hospital at home office.

IOPS nurse (8am – 8pm Mon-Fri)

IOPS admin team

Consultant of the day

MoE consultant on call via switchboard

Interim Care ANP/NP

Occupational Therapy

Allied services

We work closely with other community teams in Edinburgh including social care direct/locality hubs for urgent AHP assessment (Prevention of Admission team), to provide increased home care and for less urgent AHP assessments, such as PT at home or the Falls team. We have good relationships with GPs and District Nurses. In general, we rely on DN teams to continue their regular input to the patients admitted to H@H to provide, for example ongoing wound management or Insulin administration. We also work with other community teams including the heart failure nurses, respiratory teams, palliative care teams and IMPACT. This joint working has been particularly successful for hospital at home patients and we hope to maintain close working relationships with both services.

Referral procedures

The following summarises common routes of referral to the service.

GP referrals to Liberton Hub

Routine:

- GP completes SCI Gateway referral
- Referral e-triaged by MoE consultants Liberton
- Appointment allocated by admin team

Urgent:

- GP contacts consultant via flow centre
- Case discussed, if accepted to IOPS GP is asked to complete SCI Gateway referral (MoE Liberton) and state in first line who case was discussed with and what assessment has been arranged. If review in Liberton hub: accepting doctor contact Admin support (07870910344 or 01315367872) to give patient details and identify appointment slot

Hospital referrals to Liberton Hub

- Email completed referral form to LibertonDayHospital@nhslothian.scot.nhs.uk. Details available on intranet.
- Discharge letters can be copied to Liberton Day Hospital but email is preferable.

Referral letters and emails are often generated by other OP departments and are reviewed and triaged as needed.

GP referrals to Hospital at Home (H@H)

- There is an agreed daily capacity for 3 new H@H patients from Monday to Friday, this should be confirmed by the H@H coordinator with the flow centre. This can be done by phoning 0131 446 4500 option 1 then option 4 before 9 am.
- GP contacts Flow Centre with a referral on 0131 446 4500 option 1 then option 4.
- Case discussed with call handler who will be aware of H@H capacity. If accepted to IOPS; the referring GP is asked to complete a SCI Gateway referral (MoE;

Liberton) and to state presenting complaint. Flow centre will add patient to expected patient list.

- Should a GP contact the flow centre and refer a patient once H@H have already accepted their quota of new referrals for the day or if they require specialist advice, then the flow centre will transfer the call to the IOPS consultant on call for discussion.

Weekend referrals:

- GP referrals will only be accepted for patients that have been under the care of H@H in the preceding six months, they will only be accepted if they are being referred with the same medical issue. GPs must be made aware that patients will not receive a medical review until the following Monday and that they are comfortable with this. All patients who have been accepted for review must be discussed with the on-call consultant at RIE.

Hospital referrals to Hospital at Home (H@H)

- Hospital referrals to H@H are made through the IOPS Nurse phone on 07989170797 Monday to Sunday 8-8 .

- If a supportive discharge is accepted, the patient's details are written on the white patient board and the **\iopsaccept** entry is entered into the TRACK EPR under correspondence.

  "This patient has been discussed with IOPS Nurse: on:
  *They have been accepted fo**r follow up** with the IOPS H@H team after discharge. Please contact the IOPS nurse on 07989170797 on the day of discharge to confirm follow up arrangements. If the patient is no longer suitable for H@H services please also contact the nurse phone. This number is accessed 8am - 8pm Monday to Sunday."*

- If a supportive discharge is initially accepted and then cancelled (for example, if a patient became too unwell for discharge home) then hospital at home team will use the **\iopsremove** code and put this entry under correspondence in TRAK EPR.

  *"This patient had been accepted for H@H follow up post discharge. However, following a conversation with: on: this is no longer required at present. Please remove any **details pert**aining to H@H follow up from the IDL.*
  We have removed their name from our waiting list and would ask you to contact the IOPS Nurse on 07989170797 if they require re-referral.

Service structure

IOPS includes three main services – our Day Hospital, our Hospital at Home team and our involvement with the Interim Care wards. Although, we work as one team it is simpler to describe each element in turn.

Liberton hub/Day Hospital

Overview

Who

Older people living in South Edinburgh and Midlothian.

What

We are a multidisciplinary team comprising medical, nursing, physiotherapy, occupational therapy and pharmacy. We provide outpatient assessment with further treatment and intervention as appropriate/required.

Where

Patients attend our clinics and Day Hospital currently within Liberton Hospital. Site may alter in future.

Why

Provide timely Comprehensive Geriatric Assessment in outpatient setting, with a view to provide diagnosis, improve health and functionally ability and reduce future risk of hospital admission.

Description of service:

Patients attending the Liberton hub will have a multidisciplinary assessment comprising input from doctors, nurses, physiotherapists, occupational therapists and pharmacists as appropriate to the clinical context.

Referrals are made either by their GP via SCI gateway or from hospital (other outpatients, such as PD clinic, following inpatient admission or ED attendance). SCI gateway referrals are triaged daily by Consultant of the day. Urgent referrals can be discussed with Consultant of the day and urgent assessments can usually be arranged within a few days.

Most patients are initially reviewed by nursing and medical staff in our clinic. Initial assessment is carried out with a letter generated to GP summarising this (Letter 1). This

assessment is comprehensive and will include assessment of the following, in addition to reason for referral: frailty status, falls, bone health, cognition, pain, nutrition, mood and continence. Anticipatory Care Plans are discussed when appropriate (See doc 1). If further assessment by AHPs (not being provided already in the community), nurses or medial team is required, patients are given a date to attend the Hub, usually within the next week. In general, patients attend weekly whilst assessments or therapy are carried out. Patients are reviewed by either a Consultant or trainee in clinic. All patients seen by our trainees are discussed with Consultant or Specialty doctor that day. Occasionally, patients are brought directly to the Hub for their initial assessment; they are then reviewed by our Specialty doctor during their initial few visits.

We have protocols in place to support our team to carry out mood, continence and cognition assessments. We have a visiting Old Age Psychiatry Consultant to support a Cognitive Assessment MDT, allowing us to diagnose dementia and arrange appropriate support and follow up. Our nursing team can provide advice and support to maintain health, manage pain, continence and bowel issues. Our Physiotherapy team will provide a comprehensive individualised assessment of the patients needs and provide ongoing treatment within the Hub or refer on/signpost to other community based services. They offer both class based and individual sessions of exercise prescription. Additional expertise in vestibular assessment and treatment are available as well alternative modalities for pain management. Our Occupational Therapy team will provide a holistic assessment of patient's essential day to day tasks such as self care and leisure, providing individual treatment and intervention plans to support them living at home as independently as possible, to their full potential. More specific assessments e.g. falls/cognition will be carried out through use of both formal and informal assessment measures. They can also advise on applicable community based resources. Therapy staff can provide home visits for further assessment depending on needs.

We have direct access to blood testing, plain X-rays, & ECGs. We can refer patients for ECHO, ambulatory ECG monitoring, ambulatory blood pressure monitoring, outpatient radiology and further investigations as required. We can provide blood transfusions for stable ambulatory patients. We provide IV therapies, such as IV Iron infusion or one off IV Zolendronic Acid.

The duration of attendance at the Liberton hub can range from 1-6 weeks but if required patients may attend for a longer period.

All patients attending on a daily basis are listed on the white boards within Liberton Hub. There are 3 meetings during the course of the day to support the timely management of patients attending. We hold a 9am Huddle; all patients attending the DH that day are discussed and those professionals due to see each patient is marked on the white board. Patients that may be ready for discharge are highlighted with a 'pink sheet'. This allows us to ensure those being discharged have a medical review beforehand. We review the letter generated from clinic for all 'New' patients to DH to ensure everyone familiar with the issues and management plan. Patients are then discussed again at a 1pm huddle (ensure all being seen in timely fashion and discuss any arising issues) and then at a multidisciplinary meeting

at 3pm. During the course of the day each member of the MDT updates their section of the MDT entry on trak (this is added by trainee either on the previous day or that morning). This allows for the MDT entry to be updated swiftly during the meeting mainly with the ongoing plans for each patient.

Each patient attending the DH, will have an Outcome entered into trak. The following outcomes are used: Returning, Discharge to GP or Tests and review. The outcomes are written on a patient list during the MDT and administrative staff then enter these details thereafter and arrange subsequent follow up and transport.

The decision to discharge a patient from the Liberton hub is taken by the whole team during the multidisciplinary team meetings. A letter summarising their attendance is sent to GPs after discharge (Letter 3). If a medical review has occurred during the course of their attendance a brief medical update letter can be generated (Letter 2).

All patients with any outstanding investigations (including bloods or xray reports) are outcomed 'Tests and review'. We have systems in place to follow up these results with a BOXI report generated to ensure all are followed up. Our Specialty doctor runs a review clinic when follow up is required beyond the scope of the patients' initial Hub assessment.

Patients are telephoned in advance of their initial assessment to ensure attendance. Transport is often arranged by our administrative staff. If a patient does not attend, our nursing team will contact them by telephone to ascertain why. If there is concern regarding a patient who did not attend we can arrange a home visit by the Hospital at Home team.

Checking and actioning results

- Blood tests may not be available until the next working day. The junior doctor carrying the bleep has responsibility for checking outstanding results and this is allocated every morning at the rapid run down. They should aim to review the clinics for 'closed books' for the preceding 2 weeks.
- If a patient is being discharged and all their results are not available they will be given an outcome of 'Tests and review'. This will allow us to follow up these results. When a result has been reviewed on TRAK it must be signed off and actioned. A note should be entered on trak stating the action taken and GP emailed if relevant.
- Nursing staff keep a record of MSUs sent off and check this daily for results. If abnormal they will consult with medical team appropriately. ?? **They sign off and action the result on trak??**

Working with the secretarial team

The secretarial team at Liberton process clinical letters for IOPS in one of three ways:

1. They review and check letters entered directly into TRAK – secretaries should be made aware of referral letters and initial clinic letters by email listing patients name and date letter complete.

2. Patients discharged from the Hub should be added to the discharge board in the Hub. Once completed & ticked by all members of MDT (this should take less than 2 weeks), the secretaries will remove the name from the board.

3. The secretaries will process all letters completed on G2. Once completed the letters are reviewed by secretarial team, moved to correct location in trak and then Consultant of the day (via email) reviews each letter and authorises to GP.

Transportation

Transport is either by Scottish Ambulance Service, Patient Transport service or individuals make their own way to department.

Patient transport is usually arranged by the patient or their relative/carer.

Prior to making an appointment for the patient the admin team telephone and speak with them personally to arrange this. Information on how to arrange transport is then given along with the SAS telephone number.

All patients are telephoned at least 2 days in advance of future appointments to remind them and identify if transport is ordered or requires to be ordered. Admin staff will order this if a patient is unable to do so themselves.

If attending by this form of transport patients stay is lengthened to the pickup time, which is usually 3pm. If a patient has been seen and can leave prior to this then admin staff call SAS to inform and they try to collect them sooner where practically possible.

Blood transfusion

Patients can receive regular or urgent blood transfusion at the Day Hospital. They are referred and assessed in the same manner. Once they have a date for their transfusion we arrange for the cross match to be carried out by either IOPS H@H (Edinburgh patients) or Merrit (Mid-lothian patients). For those carried out by IOPS, a bed is blocked out on the ward but the bloods and trak entries are made in the Day Hospital episode. Thus, these patients are not admitted to the virtual ward.

Hospital at home

Overview

Who

People with frailty living in Edinburgh. At time of update we cover south Edinburgh, NE Edinburgh & Ladywell MP, Murrayfield MP & MC within NW Edinburgh. Our overall aim is to cover all of Edinburgh by 2020.

What

We are a team comprising medical and nursing staff. We provide assessment and management to people in their own home during an acute illness, as an alternative to admission to hospital.

Where

We provide care in the patients' own home

When

The IOPS nursing team operates from 8am until 20:30pm Monday to Sunday. Senior medical cover is available on site from 9am until 5pm Monday to Friday and out with these hours senior advice is provided by the RIE on-call Medicine of the Elderly consultant.

Why

To prevent hospital admission for older patients who can alternatively be assessed and managed at home or close to home.

Description of Service:

Hospital at home accepts referrals from GPs via the flow centre and early/post discharge support from hospital for patients registered with a GP from SW/SE/NE and selected NW practices. The list is available on the IOPS shared drive.

Once a patient has been accepted they will be reviewed at home on the same day or next day or at another agreed time with the referrer if not urgent. The first clinical assessment will typically be conducted by a nurse practitioner or an advanced nurse practitioner with a medical review (GPST, STR, specialty doctor or consultant) within 24 hours. However, for a supported discharge, if a patient has received a senior medical review as part of their inpatient stay, then a senior review from the medical team within H@H may not always be required.

If for any reason a senior medical review will not occur within 24hrs (for example if a patient is referred by a GP on a Friday afternoon), then the referrer will be informed of this before

the referral is accepted. If the referrer agrees this is acceptable and safe, then the patient referral can be accepted.

Weekend GP referrals will only be accepted if the patient has been under the care of Hospital at Home during the previous 6 months, is being referred with the same medical issue, that the GP accepts that they will not have a medical review until the following Monday and that the on-call consultant at RIE is contacted for advice.

Supported discharges can be accepted at weekends by the duty nurse practitioner. These patients should have been reviewed by a senior member of the medical team prior to referral.

The frequency of reviews will be dictated by clinical need but where necessary patients will be reviewed on a daily basis. A typical admission to the Hospital at home ward would be for one week. Thereafter, care would typically be transferred back to the patients' General Practitioner.

Hospital at Home systems:

Systems in place linking with Flow Centre:

How to admit a new patient to the hospital at home virtual ward

1. Patient name, CHI number, reason for referral and urgency of referral is provided by Flow centre via the flow centre workbench.

2. The IOPS nurse coordinator is responsible for regularly reviewing the flow centre workbench to ensure that patients referred to H@H by the flow centre are seen in a timely manner.

    I. The flow centre workbench is accessed through TRAK, sign in using your unique identifier and set location to "RIE EXPECTED PATIENTS".

    II. Click on tools (in top left hand corner)

    III. Click on "Flow centre WB"

    IV. Any patient referred to H@H will appear in this list. You will be able to see at a glance if they are 'Urgent, Same Day or Next Day'

    V. To ensure that the flow centre handlers are aware that you have seen the referral; access the referral by clicking on the blue bus icon.

VI. Click on ‘NHS Lothian Flow Centre’ this will allow you to visualise the questionnaire containing the patient information taken during the referral phone call.

VII. Change the status from ‘Pending’ to ‘booked’. This will ensure that the call handlers at the flow centre know that we have seen the referral and are taking steps to see the patient.

3. Before a patient can be moved into our own virtual ward they must first be discharged from the expected list:

    I. Click on the patient you wish to admit to the Hospital at Home virtual ward.

    II. Click ‘ED Menu’ and then ‘ED Disch’. You will now be on the patient discharge screen: Select ‘Flow centre Discharge’ Enter your password and click update.

4. IOPS coordinating nurse emails the H@H email group to advise of any new referrals and then adds patient name to the Hospital at home white board in Liberton hub

5. Admit patient to the virtual ward. (Administrative support are able to do admit and to make up a new patient folder):

    I. Open patient record on TRAK using pt enquiry and unique CHI

    II. Click on the ‘ATD Menu’ tab

    III. Click ‘Adm’

    IV. Under hospital: Type HHED [ENTER] (Hospital at home – Edinburgh HHED)

    V. Under admission date: Type T [ENTER] (for today)

    VI. Under admission time: Type N [ENTER] (for now)

    VII. Under ward: Type Compass+

    VIII. Under Speciality: Type GA [ENTER] (for Medicine of the Elderly)

    IX. Under consultant: Type CJA [ENTER] for Carolyn Armstrong and JAH6 [ENTER] for Jenny Harrison.

    X. Under expected disch date: enter the likely date of discharge using the calendar tab

    XI. Under intended management: Type I [ENTER] (for Inpatient

    XII. Under admission type: select E (emergency admission)

XIII. Under admission from:

- Type H [ENTER] for 'home' if gp referral
- Type Trust [ENTER] for 'same health board' if supportive discharge from wards
- Type E [ENTER] for supportive discharge from A&E
- If care home resident then Type NLA [ENTER]

XIV. Under provisional diagnosis: write reason for referral in free text eg: chest infection

XV. **NB if a patient is referred to hospital at home from another hospital team please do not admit to the virtual ward until the patient has been discharged from the referring hospital team as TRAK fails when there are two simultaneous inpatient episodes and this can prevent you from ending one episode if one is ongoing**

If an advice call has been passed on to the duty consultant, the flow centre will take details and generate an entry on the expected patient list as above. If this patient is then subsequently admitted the process above should be followed. If, however, they are not admitted a note should be entered under 'comments' summarising the discussion and advice given. If further action is not required the patient can then be discharged. If the patient requires admission to hospital the consultant or GP will have to contact the flow centre thereafter. It is likely that this will fall to the GP who may need to give details regarding transport etc.

First Assessment:

Use the generic TRAK clerking, EPR: Consultation List (NEW): Catergory: Clerking (New). This will populate the clinical notes.

- Call the patient to confirm planned visit and expected time of arrival
- Review patient record on TRAK prior to visit (including ECS and KIS, recent investigations)
- Enter location of visit in diary in Hospital at home office
- Notify co-ordinating nurse that you are going on a visit – who is going, where to and when you expect to return

- Initial assessment of patient and environment: is it safe, is the patient stable. Complete risk assessment form and
- Always wear an identicom and update your location with each visit.
- Always attend patients' homes with laptop and red bag of equipment, ensuring that it is stocked and fit for use. If administering medications bring emergency drugs (adrenaline).
- Bring new patient pack including: Demographic details, NOK contact details, Home and Environmental Risk Assessment, copy of referral, , NEWS 2 chart, continuation sheets, Drug kardex, Fluid balance, Bristol stool chart, MOCA, GDS, Useful leaflets i.e delirium Vocal, Hospital at Home information leaflet and Questionnaire (to be left with patient and family)
- Observations
- Weight
- History
- Examination
- Blood tests, MOE Admission profile including CRP
- Urine test if indicated – MSU if checking for infection not dipstick
- ECG if indicated
- 4-AT, MUST and WATERLO
- Differential diagnosis
- Initial management plan
- Explain plan to patient / next of kin and leave emergency contact details for H@H service i.e. Hospital at Home information leaflet.
- Return to Liberton hub, complete clerking which was commenced on laptop in patient's home, discuss case and your plan with lead clinician (though during assessment you may have already discussed with senior clinician by phone).
- For Heart failure patients please document agreed initial assessment in problem list (see Heart failure in shared drive for details).

Further clinical evaluations:

After the initial assessment, all subsequent clinical notes and evaluations are recorded on TRAK.

- On TRAK select 'EPR'
- Then 'Clinical notes' then select the 'New' tab
- Under note type select 'progress note'
- Under care provider: remove the automatic generic code and enter your name / TRAK code
- Under specialty: leave Medicine of the Elderly
- In the text box please write your clinical note and finish by entering your name, grade and contact details
- Must, observations, waterlow, weights, venflon bundles should all be recorded on TRAK under the relevant sections
- The Problem list and medication lists should be amended with each visit. These are visible under the 'Ward round/Review' section of 'EPR'.
- Investigation results are reviewed daily, signed off and actioned by the practitioner who reviewed that patient that day.

'Ward rounds' Hospital at Home have a consultant led MDT meeting or ward round twice a week. Usually on a Monday and Friday afternoon. All members of the team are expected to attend if possible and all patients are discussed. A summary of the discussion and management plan generated is added to trak in ward rounds section.

Changes to medications:

We often stop or start medications for patients within the ward. All medication changes should be documented in the 'Ward round/Review' section of 'EPS' after every visit. This is the responsibility of both the visiting practitioner and the prescriber. It is vitally important that we communicate with GPs about this clearly and in a timely manner. Medication changes should be made clear in the discharge letter to the GP but you should also notify the practice using the clinical inbox email or by calling the surgery directly if this is required before discharge. Any correspondence/email/telephone conversation should be copied into a clinical note and the discharge letter updated.

Discharge procedures:

When discharging a hospital at home patient this should be a team decision. It is important to clearly communicate with the patient, their carer and the GP surgery about the planned discharge if necessary. In addition to the discharge letter on TRAK which once approved is sent to the GP, it may be necessary to call the surgery or email the clinical inbox to ensure a timely update on the patients care and plans for discharge. Again there is a template that can be utilised, this can be found in the shared drive: **F: Drive Lib Int Older People Service: Letter Templates: H@H Discharge Email Template.** A copy of the email should then be inserted into the patient's TRAK record as a clinical note.

Patient Name –

Patient CHI –
Date –
Time –

Dear GP,

The above patient has been discharged today from the Hospital at Home team. A discharge letter will follow as soon as possible.

If you have any questions in the meantime, please call 07989 170 797.

Kind Regards,

Edinburgh Hospital at Home Team

Once the discharge letter has been completed on trak a patient sticker should be added to the discharge board (usually found in DH beside white board). It is the responsibility of the senior members of the medical team to check this regularly, check and update any discharge letters and authorise them to go to GP. This should occur daily Mon – Friday to allow the timely communication with GPs.

If patients have outstanding results they should be added to the H@H pending list within the shared drive. This is reviewed regularly by senior medical team. Results will be reviewed, signed off and actioned appropriately.

Referrals to other teams:

We sometimes need to refer patients to other clinical teams. This is best done by dictating a letter on G2 or starting a new "correspondence" on TRAK and notifying the secretaries that a referral has been typed or dictated.

Out of hours:

IOPS nurses currently work from 8am until 20:30 Monday to Sunday. The IOPS doctors work from 9am until 5pm Monday to Friday. Clinical work out with 9-5 should as far as possible be planned and discussed with a senior clinician ahead of time. If a clinical query arises during the period of extended nursing cover, advice can be sought from the MoE consultant on call for South Edinburgh (contactable via switchboard 0131 536 1000). Ideally, new patients will be accepted by IOPS before 5pm. However this can be reviewed on an individual basis. If staffing allows and patient needs can be met, then patients may be accepted out with these hours. Flow centre will stop accepting GP referrals at 3PM, any referrals thereafter will be discussed with the team and judged on a case by case basis.

All patients / carers should be left with an information leaflet containing contact numbers for our service. They should also be instructed on worsening statement and who to call for help out of hours ie 111 or 999 depending upon situation.

It is imperative to maintain good communication with GP surgeries when we are caring for their registered patients. This is particularly important if the Hospital at Home team is supporting a recent discharge from hospital. An email should be sent to the GPs of all supported discharges accepted for review by Hospital at Home, a template can be found in the shared **F: Drive Lib Int Older People Service: Letter Templates: H@H Supported DC GP Email**

Patient Name –
Patient CHI –
Date –
Time –

Dear GP,

The above patient is under the care of the Hospital at Home Team as a supported discharge from hospital.
We are currently responsible for their medical care and any calls you receive from family or carers should be directed to us on 07989 170 797.
We will be back in touch on discharge from the service.

Kind Regards,

Edinburgh Hospital at Home Team

During Hospital at Home involvement, any significant clinical change would necessitate an email being sent to the appropriate clinical inbox found in the shared drive: **F: Drive Lib Int Older People Service: GP: GP clinical inbox addresses** (or the GP should be spoken to directly by phone). If appropriate it may be necessary for the GP to adjust a dosette box or amend the patients' KIS summary to reflect ongoing changes in their care plan. However, hospital at home should take full responsibility for the medical care of the patient during their admission/ District nurses may still need to attend, e.g. for dressings, insulin, EPO injections etc.

Oxygen Therapy:

Hospital at home can now provide oxygen therapy to prevent admission to hospital or support early discharge. We can provide up to 2 litres oxygen for a reversible cause following a risk assessment being completed.

We have 3 oxygen concentrations (1 portable, 2 larger machines) which can be used. All supplies and information required to commence therapy are in grab boxes to aid speed of delivery. All patients requiring oxygen should be discussed with the consultant prior to being accepted.

See policy, risk assessment and information leaflets in shared drive under 'oxygen'.

Intermediate Care

Who

People admitted to Interim Care wards, currently at Liberton Hospital

What

Nurse Practitioner or Advanced Nurse Practitioner supports GP team in the ongoing management of these patients.

Where

Interim Care wards currently at Liberton Hospital. Site may change in future.

When

A NP/ANP from the IOPS nursing team which operates from 8am until 20:30pm Monday to Sunday, is allocated to the Interim Care wards. This is their main responsibility but they may also provide support for the H@H patients if required.

Why

To provide support for GP team managing patients admitted to Interim Care whilst awaiting discharge from hospital.

Prescribing

Prescribing for IOPS

Non urgent amendments to patients' medications are requested by IOPS prescriber via email to patients GP's clinical inbox.

If an urgent prescription is required for an IOPS Patient the below methods are available:

Option 1 (particularly helpful for dosette):

1. Prescriber to use Hospital Based Prescription (HBP)_ pad to prescribe medication.
2. Prescription to be dispensed by community pharmacy.
3. Patient relative or carer to collect medication. Where this is not possible, liaise with community pharmacy to organise delivery or team can arrange make arrangements to collect in sealed red bag (avoiding controlled drugs).

Option 2:

1. Prescriber to use Outpatient prescription pad to prescribe medication.
2. Prescription is emailed to Royal Edinburgh Pharmacy.
3. Phone Royal Edinburgh Pharmacy to ensure they have received email copy of prescription
4. Medication will be delivered to Liberton Hub once available (unless urgent and agreed plan discussed with Royal Edinburgh pharmacy to collect from there)
5. Member of staff to take medication to patient in sealed tamper evident container/bag.
6. Store copy of outpatient prescription in patient notes and patient carbon copy to be given to patient/carer.

Option 3:

1. If hospital pharmacy non-contactable, dispense o over labelled to take out (TTO) medication by a registered Nurse Practitioner Following the TTO policy below

   The prescription for medicines to be provided from Day Hospital via TTO supply should be written on an A4 Outpatient Prescription and check that the prescription contains the following

   •Patient's name
   •Patient's address
   •CHI number
   •Ward or department
   •Prescriber's signature

   Check the following details on the Outpatient Prescription against the over labelled TTO medication stocked from the agreed list
   • medicine name and form
   •dosage instructions
   •quantity to be provided

   If any of these details differ from the instructions on the over labelled TTO medication, the prescription must be dispensed from a pharmacy and not at ward level

Select the medicines to be issued. Check that the expiry date is appropriate. Check that each medicine is labelled to include the following information

•the correct quantity, name, form and strength of the medicine
•the correct dosage instructions and cautionary labels
•the address of the Division

Complete the 'Issued by' section of the Outpatient Letter. Ensure that a practitioner authorised to administer medicines checks each detail described above, and signs the final 'Checked by' by section on the prescription.

Distribute the copies of the Outpatient Letter as follows
•the white copy to pharmacy
•the pink copy to the GP usually via the patient
•the blue copy to the patient's notes

Out with pharmacy opening hours

Contact the on call pharmacist for the Royal Edinburgh Hospital via switchboard who will advise/supply medicines

Returning Patient Medication for Hospital at Home Patients:

1. Patient relative or carer to return to community pharmacy.
2. If patient relatives or carers are unavailable to return medication, practitioner to risk assess on case by case basis.
3. No patient medication to be returned to hospital pharmacy.
4. If medication dispensed by hospital pharmacy has not left hospital premises and is no longer required, return to hospital pharmacy.

Hospital at Home Out of Hours Prescribing

This is to cover unexpected prescribing out of hours for patients currently under the care of hospital at home teams and covered by the on call MOE consultant based at RIE (including IOPS, Merrit and ELSIE). This would only apply when a prescribing ANP is not available or the medication required is out with the prescribing ANPs competency and not on their individual core formulary.

It is expected that all teams will prescribe as required medications for more predictable events that may occur on a Friday as part of weekend planning.

It is also suggested that the SRP policy could be used to allow symptoms management as is routine practice in hospital patients. (Please take care with checking ECS for potential double prescribing – eg Paracetamol exceptions etc)

The on call consultant group in general feel uncomfortable with the use of community prescription pads so this leaves 2 options for prescribing out of hours:

1 For those drugs that can be accessed from current supply (ie in the cupboard):

These medications can be administered by the team and prescribed on the Kardex. Prescribing should follow the current remote prescribing policy. In

addition, each team will have a process for listing these prescriptions so paper prescribing can occur as soon as possible. Medications being administered as a TTO will need an outpatient prescription completed (first dose can be administered by team and then prescription collected from RIE asap ie the following morning)

2 For those drugs that are not available in stock (ie not in cupboard):

The H@H practitioner would discuss by telephone the need for the prescription with on call consultant. If prescription required, practitioner will bring Outpatient prescription pad to prescriber for completion. This will then be scanned and emailed to REH and discussed with on call pharmacist. Medication will then be issued from REH and taxied to destination.
In the event that consultant is not on site at RIE, they will need to consider if an alternative prescriber is available (eg STR/Spec Dr) or if the patient requires admission to facilitate management of symptoms.

Administering Intravenous Medications to People Out With a Hospital Setting

The most up-to-date IV policy is available on the IOPS shared drive.

- 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. Where possible this should be in conjunction with the IOPS 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 and were we deviate from this a discussion with Microbiology is required.
- 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.
- For each course of treatment, an up-to-date IV Monograph should be accessed from the UK Injectable Medicines Guide (available on the NHS Lothian intranet). ?are we

doing this

- 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.
- Medication will be stored securely either in the patient's home or in The Day Hospital Liberton Edinburgh.
- 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, your line manager or employer (according to local policy) and document your actions through Datix.
- If a patient experiences an adverse drug reaction, you must take prompt action to treat this. You must 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 and PVC (VIP) Bundle is updated on TRAK

Medications should be administered in line with:

- NHS Lothian (2015)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 IOPS 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.

Medicine Administration by Registered Nurses from Community or Hospital at Home service in Secondary Care:

There may be occasion where Community Nurses, Community Psychiatric Nurses or Hospital at Home Nurses are required to come into hospital to administer medicines to patients under their care. This may include oral, intravenous, depot or palliative care medicines

Medicines administered in hospital must be prescribed on the Hospital prescription and administration record. The nurse/s administering the medicine/s must sign the hospital prescription and administration record

When administering an intravenous therapy medicine or setting up a McKinley syringe driver two registered nurses (or a nurse and a doctor) who are competent must follow the procedure through. Both registered nurse (or the nurse and doctor) must sign the prescription and administration record and supplementary chart where appropriate.

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 Police

Lone Worker Policy

All staff should adhere to Lone Working Policy available on intranet and local lone working procedure available on shared drive and in induction packs. 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 can be reviewed in the Liberton QI meetings, which are currently fortnightly, H@H QI meetings and/or at the quarterly IOPS M&M meeting.

Service development

A fortnightly QI meeting will take place weekly on a Monday (first and third of month) at around 15:30. Minutes will be circulated. A designated Hospital at Home QI meeting will take place on a Wednesday at around 09:30 every 2 to 3 weeks.

Quality improvement

As a new service 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.

An induction talk is in place for all rotating medical trainees, in addition to the general MOE induction provided at RIE. Regular support and teaching, including the completion of WPBAs is carried out by senior members of the team.

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 will be produced in a weekly BOXI report. Weekly reports also sent for MUST, 4AT, Waterlow and use of identicoms. Reports of rates of investigation sign off are also generated and reviewed regularly.

H@H CMT

Lead consultant and management team attend the recently formed H@H CMT. This is a quarterly meeting involving all 4 H@H teams currently active within NHS Lothian. The aim is to compare services to better understand similarities and differences streamline and benchmark data and support clinical governance and group learning.

Future Directions

Work is underway to expand the service to the remainder of North West Edinburgh. We are continually developing our service through a QI process. This includes development of how the service communicates and interacts with other community services.

References & Documents:

Reference 1 Shepperd S, Iliffe S, Doll HA, Clarke MJ, Kalra L, Wilson AD, Gonçalves-Bradley DC. Admission avoidance hospital at home. Cochrane Database of Systematic Reviews 2016, Issue 9. Art. No.: CD007491.

Document 1 IOPS CGA medical prompts (Induction/shared drive)

Letter 1 Initial Assessment letter (Letter templates/shared drive)

Letter 2 Update letter (Letter templates/shared drive)

Letter 3 Discharge letter (Letter templates/shared drive)

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