Fife Health & Social Care Partnership

Supporting the people of Fife together

NHS FIFE

HOSPITAL AT HOME TEAM (H@H)

PROTOCOL FOR COMMUNITY REFERALS

DATE: August 2021

REVIEW: August 2023

FUNCTION

To provide a service for the frail elderly population of Fife, predominantly over 65yrs, which prevents acute hospital admission or facilitates an earlier discharge where acute hospital admission has taken place.

AIMS

- To allow people to have a period of “acute” care within their own home, which will in turn allow the person to recover from a period of illness without needing hospital admission.
- To provide consultant-led alternative to hospital admission by delivering treatments at home.
- To provide multi-disciplinary comprehensive geriatric assessment (CGA) within the patient’s home.
- To facilitate prompt discharge following acute hospital admission.
- To reduce incidence of acute hospital admissions and delayed discharges.
- To reduce the incidence of admission to hospital from Care Homes.

CRITERIA

- Patient must live in Fife and be registered with a GP or be a temporary resident in Fife and registered as a temporary resident with a GP.
- Patient, or POA/Guardian if lacks capacity, must consent to admission to Hospital at Home (H@H).
- H@H cannot provide carers and thus a patient must have a safe functional level.
- Consider H@H admission for the following patients:
    - Care Home/Nursing home resident with acute illness
    - Mild frailty (Rockwood 5 – See Appendix 1) or above and an illness that can be managed in the home environment
        - This can include IV antibiotics, IV fluid boluses, O2 administration.
        - Must not need immediate imaging, immediate transfusion, fluid resuscitation, thrombolysis or be severely unwell unless hospital admission inappropriate.
    - Vulnerable (Rockwood 4) or below with a frailty syndrome including delirium, falls or acute functional decline.
    - Unexplained deterioration / worsening frailty and unable to attend assessment and rehabilitation centre or outpatient clinic.
    - Patients currently undergoing, or within 6 weeks of receiving active cancer therapy should be discussed with the Cancer Treatment Helpline. Occasionally these patients can be considered for H@H admission but this should be following a discussion with the Acute Oncology Nurse practitioner (X21588) or the H@H consultant (via the H@H team).
    - See Appendix 2 for examples of suitable and not suitable conditions.
    - Admissions for osteomyelitis must be discussed with the oncall H@H consultant.

CAPACITY

- The H@H service has a limited capacity and thus may not always be able to take appropriate patients.
- If the H@H team are reaching maximum capacity for the day then they may ask additional questions from the referrer to give advice or suggest alternative pathway for the patient if appropriate.

ADVICE FOR SUITABILITY OR APPROPRIATE PATHWAY

- If advice is required in relation to suitability of the patient then please ask to speak to the team coordinator for the day or H@H consultant of the day.
- If consultant advice is needed to discuss which pathway is correct then consider discussion with the Geriatrician of the Day via Switchboard as an alternative if the H@H consultant if cannot be contacted.
- There are some treatments that cannot be offered eg IV Vancomycin due to the time taken to administer and we can advise of this over the phone.

REFERRAL PROCESS

- **Referrals accepted Monday → Sunday, 09:00 - 17:00 hours.**
- **Patients must have been seen by a GP or other clinician (eg ANP or NP) within 24 hours of referral. This should be a FACE to FACE review and not telephone consult.**
- **If the referral comes from a NP or an AHP such as podiatrist then this should have been discussed with a GP prior to referral to the H@H service.**
- **The referrer is asked to provide a written letter following acceptance to the service with relevant medical details and current medication:-**
  - **<u>If in the patient's home</u> the letter and GP Summary (drugs and PMH print out) should be left there AND phone call to Single Point of Access (SPOA) with patient details.**
  - **<u>If back at the surgery</u> the letter & medical information can be submitted via SCI-Gateway AND phone call to SPOA to alert admin staff referral submitted.**
- **<u>A voicemail is not acceptable for referral as there may not be capacity for the patient. In addition a SCI-Gateway referral must be accompanied by a phonecall.</u>**
- The details will then be passed to an Advanced Nurse Practitioner (ANP) or Nurse Practitioner for further triage, GP will be asked if they wish to speak to H@H clinical staff directly.
- If accepted to H@H GPs must make a "special notification" against patient record to alert staff of H@H involvement.
- PCES OOHs will be notified of H@H involvement, if patient accepted by the H@H team.

RESPONSIBILITIES

Referrer:

- The referring doctor is expected to phone the relevant referral point and provide verbal information which enables an episode of care to be initiated quickly.
- A GP or member of the team should have seen the patient within 24 hours and observations been taken.
    - If the patient has not been seen within 24 hours then please ask to speak to the senior medical staff to decide whether appropriate.
- Referral information should include current medical problems (+/- working diagnosis), whether patient is safe at home and whether supplemental oxygen is required (there must be no smokers in the house).
- If the patient is under 65 year of age the case may need to be discussed with a H@H clinician prior to referral being taken by administration staff.

D&WF	K&L	G&NEF
D&WF PACT Queen Margaret Hospital	K&L ICASS Whyteman's Brae Hospital	G&NEF Adamson Hospital
☎: 01383 674006 (x24006) 🖷: 01383 674174 (x24174)	☎:01592 648129 (x28129) 🖷: 01592 648079 (x28079)	☎: 01334 651305 (x51305) 🖷: 01334 651340 (x51340)

Care by H@H team:

- Medical and nursing care will be provided by the H@H team by the Consultant, GP with a specialist interest, clinical fellows, FY2s, ANP, NP and the nursing team.
- The Advanced Nurse Practitioner or Nurse Practitioner will take the details from the administration staff and triage as to whether appropriate to H@H.
- Out of hours: Primary Care Emergency Services (PCES) provide medical cover between 22:00hrs and 08:00hrs weekdays and 22:00hrs and 08:00hrs weekends.
- The medical Consultant or medical Registrar on-call, at Victoria Hospital, Kirkcaldy is available for the Nursing team to contact should they need advice out of hours.

DISCHARGE PROCEDURE FROM HOSPITAL AT HOME TEAM

- Throughout the H@H admission the patient will be regularly assessed and reviewed by the team and predicted date of discharge set.
- The H@H team will liaise with all appropriate agencies to enable future care provision.
- The H@H team will email GP to inform of discharge date & send a eIDL as final discharge document within 24 hours of discharge.
- H@H team will inform district nurses of patient's discharge.
- H@H will inform PCES of discharge from H@H.
- A minimum of a one week supply of medication will be provided.

Appendix 1 – Rockwood Clinical Frailty Scale

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Appendix 2 – Example of Suitable Conditions

Suggested suitable conditions:-

- Infection, e.g. chest, urine, cellulitis
- Delirium
- Falls – no lower limb fractures
- Exacerbation of chronic disease, e.g. COPD, heart failure
- Reduced mobility related to illness / accident
- Dehydration
- Frailty –acute decline of uncertain cause
- Care Home resident with acute illness

Exclusion Criteria:-

- Acute Stroke/TIA
- Cardiac event
- Lower leg fracture
- GI bleed
- Head injury (loss of consciousness)
- Acute abdomen
- DVT
- Social crisis or unable to be left alone overnight
- Patients with cancer currently receiving or within six weeks of active anti-cancer therapy*