Bradford District and Craven
Health and Care Partnership

ACTasONE

Winter Pack for Care Homes 2023

Introduction

Bradford District and Craven Health and Care Partnership

Across Bradford district and Craven our aim is to keep people happy, healthy at home.

We have a range of services that can support people at home (including Care Homes) to avoid unnecessary hospital admissions or attendance at emergency departments

This Winter pack has been developed to raise awareness of the range of services and support that is available to Care Homes across Bradford district & Craven. **Please print the pages out and display them within your Care Home as appropriate**

There is also information on **how you can support** our wider health and social care teams to reduce lengthy hospital stays and support people to return to their usual place of residence as quickly and safely as possible.

Hospitals are not always the best places for older people

They could have worse outcomes associated with hospital admissions including increased frailty, confusion, and a decline in function of the body due to inactivity

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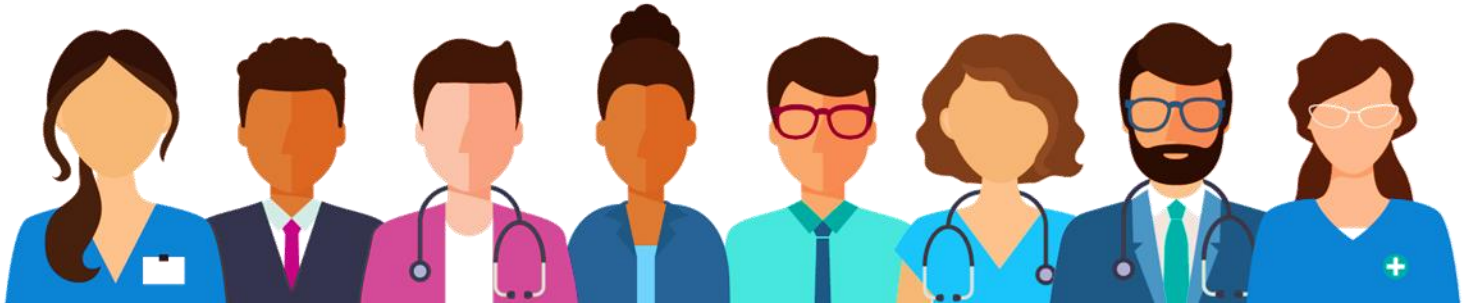
Concerned about a resident?

Accessing the right response at the right time for people living in Care Homes

Think...
Telemedicine



Telemedicine provides you with a 24/7 clinically led service that not only offers advice, support and guidance but can also directly refer you into the Urgent Community Response or Virtual Ward if required

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Think: Telemedicine

If you are thinking of calling 999, 111 or a GP. Could you use Telemedicine instead?

We're here 24/7 for any issue or concern

Check your internal policies and decision trees – do they refer to Telemedicine as the first point of contact?

How to use Telemedicine

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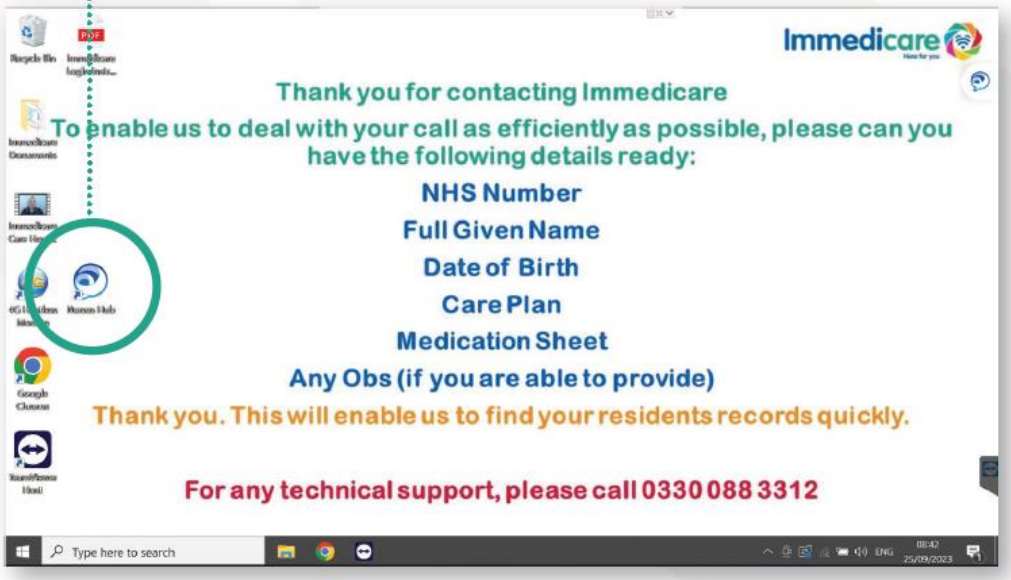
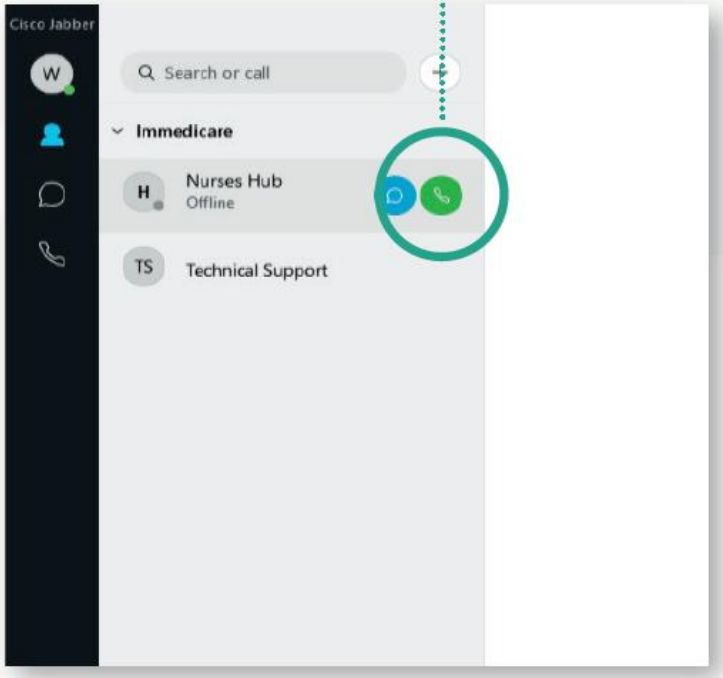
Ensure your care home laptop is fully charged and staff know where to find it when needed!

For technical support please call 0330 088 3312

To make a call, click the Nurses Hub icon on your deskop



Next, select the green button to start the video call



If your resident has a fall…

Think: Telemedicine

If you are thinking of calling 999, 111 or a GP. Could you use Telemedicine instead?

Even if someone has already dialled 999, you can still contact Telemedicine as they could take-over before an ambulance arrives!

88% of residents remain in their care home post-fall when being assessed through the Telemedicine Service

Telemedicine provides you with virtual face-face access to a team of senior nurses, based within the Digital Care Hub. Assessments of residents who have fallen and the development of a falls risk assessment and prevention plan can be carried out remotely.

If the person has suffered a minor injury from the fall and requires treatment that can be carried out within the Care Home, the Telemedicine service will be able to **refer you onto other services** such as **Urgent Community Response.**

Our Urgent Community Response (UCR) service provides a **two-hour** response to people who are at risk of admission (or re-admission) to hospital due to a 'crisis' and are likely to attend hospital within the next two to 24 hours without intervention to prevent further deterioration and to keep them safe at home.

We also have established pathways in place with YAS where any calls received from Care Homes that are classified as **Category 3 or Category 4 will be routed from 999 to the Telemedicine Service** to see if we can support residents and avoid an unnecessary attendance to hospital.

Save time, contact the Telemedicine Service before calling 999, unless it's an emergency (e.g. fracture or severe bleeding).

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Benefits of using Telemedicine

Have a question you can't answer?

- Prompt referral to other services including **Urgent Community Response** teams where face-to-face multi-disciplinary assessments and interventions may be offered within the Care Home.

- Reduction in onward referrals and hospital attendance:
  - Sending a resident into hospital can have a detrimental effect as it can increase confusion, increase infection risks, result in delays in treatment, increase the risk of deconditioning and increased falls
  - No requirement to release staff to escort residents to hospital

Worried about a resident and need support?

What is an Urgent Community Response service?

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Our Urgent Community Response (UCR) service provides a **two-hour** response to people who are at risk of admission (or re-admission) to hospital due to a 'crisis' and are likely to attend hospital within the next two to 24 hours without intervention to prevent further deterioration and to keep them safe at home.

Nursing and residential homes will need to **contact the Telemedicine Service (TMS) in the first instance** for triage/advice/support/guidance regarding referral into the UCR service and if required the TMS will refer directly into the UCR service

The person is:

- ✓ Over 18 years
- ✓ Registered with a GP in Bradford district & Craven
- ✓ Experiencing a crisis which can be defined as a sudden deterioration in their health and wellbeing
- ✓ Require an MDT approach
- ✓ Able to have a health and social care needs met safely within 2 hrs at home

Interventions will be time limited between 24-72 hours and will cover a range of elements:
(Step up to **Virtual Ward** if ongoing interventions required post 72hrs.)
Including:

- Comprehensive Geriatric Assessment
- Diagnostics point of care testing e.g., bloods, urine
- Medical/nursing/therapy interventions
- Prescription and/or administration of medication for pain or symptoms relief
- Catheter care to relieve immediate discomfort
- Medication review
- Social care support (BEST)
- IV therapy

What is a Virtual Ward?

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After a period of **up to 72 hours** a person may be discharged from Urgent Community Response (UCR) with no further interventions needed or referred into wider community teams for some additional support.

If there is a need for ongoing treatment that can still be provided in their usual place of residence, they could be stepped up into our **Virtual Ward service.**

Our Virtual Wards support patients, who would otherwise be in hospital, to receive the acute care and treatment they need in their own home (including Care Homes). This includes either preventing avoidable admissions into hospital or supporting early discharge out of hospital.

Nursing and residential homes will need to contact the Telemedicine Service (TMS) in the first instance to seek triage/advice/support/guidance regarding referral into a VW service and if required the TMS can refer directly into the VW service.

Virtual Wards
Happy Healthy at Home

Benefits of using Virtual Ward:

- Increased **patient choice** and **personalised care**, allowing patients to be treated in a more comfortable home environment.
- Caring for people in their **own homes** can contribute to fewer hospital-acquired infections, falls and complications.
- **Reduced emergency department (ED) presentations and hospital admissions** through the provision of timely multidisciplinary care.

What actions can we take to be more pro-active with the care of our residents?

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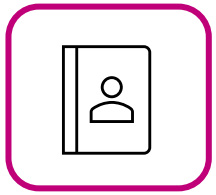
Ensure all residents are up to date with immunisations and non are missed such as Flu / Covid



Ensure all resident's contact details are up to date

Work with your PCN/GP practices to ensure long term condition checks and medication reviews have occurred in the last 12 months

Ensure all residents have ReSPECT plans in place and you have the most up to date version

What if my resident is deteriorating?

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Deterioration is when a resident moves from their normal clinical state to a worse clinical state.

This increases their risk of illness, sepsis, organ failure, hospital admission, further disability and even sometimes death.

To improve resident outcomes, it's important to focus on:

Recognition – Spot the early signs that a resident is deteriorating

Response – Think what actions do I need to take?

Communicate – Escalate your concerns and ask for help from other healthcare staff **Think: Telemedicine**

Why do we need to spot deterioration early?

- Responding early will ensure that the resident receives '**The right care, at the right time by the right person'**
- Prompt treatment and care will enhance the resident's **comfort and promote recovery**
- We can **avoid some hospital admissions** which may not be in the resident's best interest or wishes

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Moving between hospital and home (including care homes)

It is recognised that there will be times when it will be appropriate for your resident to attend an emergency department or be admitted into hospital.

Good communication is essential when residents are moving between hospital and their usual place of residence.

Without it, people can experience:

Unmet care and support needs

Avoidable hospital readmissions

Unnecessary long stays in hospital which can lead to further deterioration and risk of infection.

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What you can do to support the transfer of residents in and out of hospital

Before admission:

- Please prepare any relevant care plans and ReSPECT documentation, equipment, medication, glasses, dentures, hearing aids etc.
- Please make this information/items easily accessible to the health and care staff involved in the transfer to hospital and that they are identifiable to avoid them getting lost.

If you have a **Red Bag**, make sure it's readily available

At admission:

- Please provide the admitting team with all the information/equipment as above

Discharge:

- Please stay connected with the hospital to understand when your resident will be ready to come home
- Once your resident is medically fit for discharge or if you are taking a new admission from hospital into your Care Home, please complete any assessments and arrange transfer to the Care Home in a timely manner
- This will help to minimise any risk of harms to your resident, avoid any unnecessary delays and free up a bed for someone with a more urgent need.

What we are doing to support you…

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Care Home Handbook

We are undertaking work to refresh the Care Home handbook which is a resource that provides information on the local practices, top tips, useful links and contacts across Bradford District.

You can access the handbook here: Care Home Handbook

If you're a Care Home in Craven, there'll also be a similar resource available to you shortly.

Hospital Discharge

We are developing a standard operating procedure for the Hospital Discharge process which will define clear roles, responsibilities and expectations across the health and care system to ensure safe transfers of care.

Medications

We are exploring ways to improve how we check medications on discharge and ensure people leave with the right information about their prescriptions.

Telemedicine

There is continuous work around how the Telemedicine Service can support you and your residents to ensure they receive the right care, at the right time in the right place.

We're keen to build on effective working relationships between Hospitals and Care Homes to improve understanding around different roles and pressures experienced.