INTEGRATED URGENT CARE SERVICE DELIVERY UNIT

Home Visit Dispatching Workbook

V1.4

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THE SHIFT MANAGER BASED AT HEADQUARTERS WILL HOLD A HARD COPY. AN ELECTRONC COPY OF THIS DOCUMENT CAN ACCESSED VIA UC24 INTRANET.

Document Change History

Version	Date	Date of release	Changed by	Reason for Change
V1	November 2020		S. Bennett C. Krelle	Document Created
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V1.4	January 2021		G. Kearns	Content Amendment

Contents:

1. Introduction:

This Workbook forms an integral part of the management and governance arrangements of the Home Visit Dispatching procedure. The workbook procedures will ensure compliance with statutory requirements and best practice.

2. Purpose:

The purpose of this workbook is to support the IUC Department by providing instruction and guidance to staff, which will ensure that robust processes are in place and consistently followed by staff

- To ensure consistency in respect of patient's requiring a home visit, ensuring all patient's needs are met
- To ensure prompt commencement without loss of visiting time
- To ensure liaison between the Driver and Home Visiting Urgent Care Coordinator/ Shift Manager regarding the arrival and completion time
- To ensure prompt communication regarding patient information/deterioration

3. Guidance:

This workbook will offer support and guidance to operational staff to ensure:

- Patients are visited by their clinical priority/needs and **NOT by Geographical Area.**
- Operational staff fully understand call prioritisation and National Quality Requirements (NQR) timescales
- This process is to ensure that the control of the visits is maintained and multiple calls are not dispatched to the Med Cars
- All home visits (except deaths) must be prioritised by PC24 clinicians .Home visits cannot be passed without a clinical prioritisation

4. Administration Procedures:

It is important to ensure that calls placed in the "Home Visit Dispatch pool" are dealt with in-line with the National Quality Requirements (NQRs). **In all instances, actions should be recorded and documented within the patient's record.**

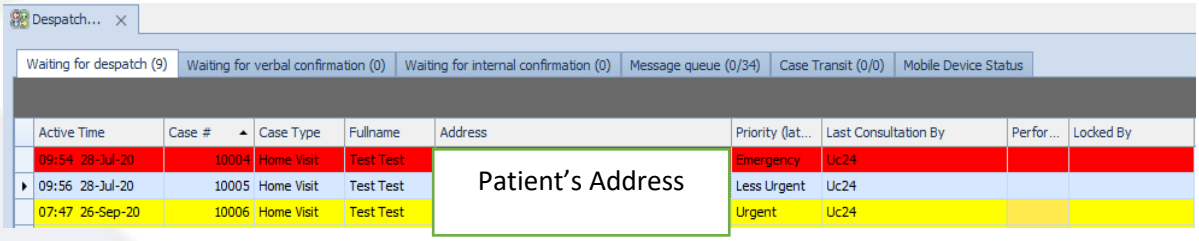
- A robust handover is to be taken from the previous Urgent Care Coordinator or Shift Manager identifying any calls awaiting in the dispatch screen
- Resources are checked in line with the rotas, such as – The allocation of Med cars, Clinicians and Drivers
- Identify short falls within the rota and plan accordingly with the Operational Team
- Prepare Home Visiting Dispatching guide sheet **(Appendix 1)** and Home Visit Tracking Sheet V4 **(Appendix 2)**

- Log onto Adastra and Fleet Tracking Software.
- Open Contact Sheet for Health Care Professional list and Chemist lists located in:
  - **Shared Drive (S) – Operations – Out of Hours (OOHs) – Contact**
- Allocate the Driver resources as assigned by the rota:
  - Med Car
  - Laptop
  - 2 phones – Driver and Clinicians

5. Identify Home Visit awaiting dispatch

- From Adastra select the Dispatch Tab
- Open up the Dispatch Screen and select 'Home Visits' from the drop down menu on the top right hand side of the screen.
- The Dispatch Screen will show the Clinical Prioritisations of each Home visit:

Emergency	To be completed within **one hour** from triage consultation finish time
Urgent	To be completed within **two hours** from triage consultation finish time
Less Urgent	To be completed within **six hours** from triage consultation finish times



6. Setting up the Drivers:

Under normal circumstances the Driver and Clinician are expected to have left base within a maximum of 15 minutes of commencement of the shift – if visits are available

- Driver is to report to the Urgent Care Coordinator at the start of the shift to confirm assigned Med Car and Clinician

- If driver is being sent straight out they are to sign out the corresponding laptop with the Shift Manager and report any damages

The signing out of the laptop is only completed once a visit has been assigned to the Med Car

- The Urgent Care Coordinator and Driver to enter the Meds Room to collect/return and sign in/out equipment on the "Medicines and Equipment Access Form (**Appendix 3**)

- The Urgent Care Coordinator is to sign in/out the following Bags and Boxes:

    - Medication Boxes A & B
    - Resus Bag
    - Defibrillator
    - Nebuliser

Once the Driver has completed all the Med Car checks (as per the Drivers Workbook), the first call can be dispatched from the dispatch pool to the Aremote.

7. Dispatching of Home Visits:

- Home visits are to be passed to the visiting team **one at a time;** this is to enable the Urgent Care Dispatching Coordinator to have control over their workload
- It is important that each Driver contacts the Dispatching Coordinator with the following:
    - ❖ Arrival time at the visit
    - ❖ Departure time on leaving the patient's address
    - ❖ **THIS PROCEDURE MUST BE FOLLOWED FOR EACH HOME VISIT**

The only deviation to the above is if there is more than one visit to the place of residence

Procedures:

- ❖ The Urgent Care Coordinator to sign in/out prescriptions and Clinician's medical bag with the assigned clinician before commencing home visits
- ❖ The Driver to inform Urgent Care Co-ordinator to send the Clinician to the med car and the first call can be passed to the Adastra Aremote
- ❖ The Urgent Care Coordinator to liaise with the Driver to ensure the driver is aware of the logistics/patient details and any changes/further information regarding the home visit
- ❖ When the visit is completed the Driver must inform the Urgent Care Coordinator of the completion time and the priority and move onto the next visit as soon as possible

8. Completion of Home Visits:

- If a dispatched home visit cannot be completed, the driver is to inform the Urgent Care Coordinator, who will then return the case to the dispatch screen with full documentation on the reason why and amend the home visit tracking sheet.

Procedures:

- ❖ Select the call/Med Car required, right click on the Med Car selected and there will be two options:
- ❖ Return to Dispatch List
- ❖ View Case Details

Press "Return to Dispatch list" and the call will be removed and returned to your main list, ready to be dispatched to another Med Car

9. Failure of Adastra Aremote (Calls to be completed at Base)

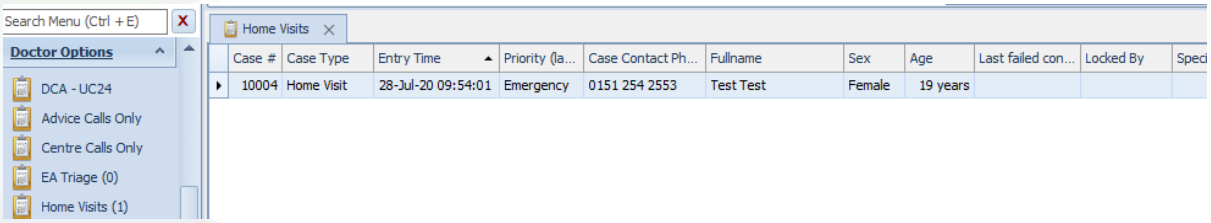
- When a Clinician requests that a call is to be completed once the clinician has returned to base, or the Aremote has failed the following guide should be followed:

Procedures:

- ❖ Right click on the call in case transit and return the call to the dispatch list
- ❖ Dispatch the call again, but **DO NOT ASSIGN** to the Med Car
- ❖ Click the enable secondary destination
- ❖ Select the Med Car required
- ❖ Double click “Verbal/OLC”
- ❖ Click passed

The call will now sit in the Clinician’s Options under home visits. The Clinician can now complete the call in the normal manner.

Please remind the Clinicians to complete the call with the real time for the arrival and completion and not the times the call has been completed back at Wavertree HQ or at a centre so it is a true reflection of the Home Visit in accordance with the NQRs.



How to contact the Driver’s Phone:

- No outside line is required
- Press *
- Followed by the Med Car Number
- ***101** (Med Car 1), ***102** (Med Car 2)

10. Setting up the Clinician:

- If no visits are available, the Urgent Care Coordinator should inform the Senior Care Coordinator that the Clinician is available for triage whilst waiting to be assigned a home visit.
- The Urgent Care Coordinator must give adequate warning to the Clinician and Senior Care Coordinator that the Clinician is requested to go out, to allow calls to be completed in a timely manner in the DCA pool.

Prescriptions:

- The Urgent Care Coordinator is to issue the Clinician with prescriptions.
- The scripts must be signed out noting the first number in the sequence and the last number.
- The Clinician **must** sign the scripts out and on return
  The Urgent Care Coordinator must ensure that the scripts are returned after all completed visits
- The last number in the sequence should match the denoted number on the signing out sheet
- If there is a discrepancy, it should be clarified with the Clinician before the Clinician leaves the site
- If any scripts have been lost or stolen – this should be reported immediately to the Shift Manager on duty.

Clinicians Bags:

It is the responsibility of the Clinician to collect an Equipment Bag prior to leaving the site.

- Clinicians should check the contents of the bag against the Clinician's Equipment Bag Check List (appendix 4)
- The Urgent Care Coordinator to replenish any further equipment from the spare equipment box in the Meds Room

PPE Equipment - COVID-19 – (Clinicians responsibility)

The Urgent Care Coordinator must ensure that the Clinician has adequate PPE on their visits. The Clinician must take the following out on HVs

- Masks
- Visors/Helmets (if available)
- Aprons
- Gloves
- Clinical waste bags (yellow/orange)

On return, any **used** PPE **must be** placed securely in a yellow clinical waste bag and deposited in the appropriate clinical waste bin. Used PPE items should not be placed into a bin without being placed into a yellow clinical waste bag.

Any **unused** PPE to be returned and made ready for the next Clinician

All Med bags are to be sprayed and wiped down by the Clinician in the Medical Bag Spraying Area, made ready for the next Clinician

11. Additional Information:

In order to support the Clinician and Driver on the road it is useful to have the following information:

- Contact numbers for other Health Care Providers

- Pharmacy Lists
- Medication list for Box A (Appendix 5)
- Medication list for Box B (Appendix 6)
- Resus Bag Equipment (Appendix 7)
- Resus Contents (Appendix 8)

12. Patients Not at Home

Should the patient not be at home or their current place of residence further investigations are to be followed to ensure that the patient's safety is of the highest priority
For guidance and process, please see Appendix 7 – Patients Not at Home flow chart

13. Procedure for the Provision of Care for Patients based at Her Majesty's Prisons (HMP)

On occasions Primary Care 24, may get a visit for a Patient who is based in one of Her Majesty's Prisons. If the call is passed for a home, the following **MUST** be observed by the Driver and Clinician out on the visit and for the Urgent Care Coordinator to make sure they are aware of the Procedure.

- Driver and Clinician are both to have their Primary Care 24 ID Badges with them.

Admittance to the Prison will not be permitted without Valid ID.

- The Driver should contact the Prison prior to the visit with an expected time of arrival. It is essential that the Driver communicates with the Prison if this time changes. This is to avoid being kept waiting to enter the prison.

- Once inside the Prison, the Primary Care 24 Clinician will be accompanied at all times whilst they are inside the Prison premises.

- Any concern in regards to patient safety and care should be brought to the attention of the PC24 Shift Manager, Manager on Call and Director on Call.

- Once the case is completed on Adastra, a copy of the patient's demographics and outcome of the encounter is sent via Adastra directly to the prison, allowing the PC24 encounter to be filed with the Patient's prison medical record.

14. Comfort Calls for Home Visits awaiting to be dispatched

At times of escalated or increased activity home visiting times to patients may fall beyond the expected National Quality Requirement (NQR) timeframes, which may be 60 minutes, or 6 hours. It is important to ensure that patient safety is not compromised during periods of increased activity.

At these times, the Shift Manager or Senior Urgent Care Coordinator will be responsible for making a timely decision to instruct the Urgent Care Coordinators to inform patients that home visits times may take longer than original anticipated.

It is the responsibility of the Urgent Care Coordinator to manage the home visits awaiting dispatch in a safe manner which does not compromise Patient's safety

Process:

- The Urgent Care Coordinator will contact the patient/representative awaiting a home visit
- The comfort call will be carried out in an empathic and caring manner and will inform the patient/representative of the renewed anticipated timescale for the arrival of the Clinician, identifying any new or worsening symptoms and to identify if any ILTC symptoms, using the following script:

Operational staff comfort call script within the call centre

'Good morning/afternoon/evening, my name is (say name) from Primary Care 24, we have your call on our system. I wish to apologise for the delay in our clinician visiting you today. Please may I ask if you are experiencing any deterioration in your condition or any new symptoms?'

- Log if **ILTC symptoms** have developed, follow the ILTC protocols, including **calling an ambulance for the patient if required**. Log the details and inform the Shift Manager or Senior Ugent Care Coordinator. If an ambulance is identified and the caller or patient refuses 999, the Urgent Care Coordinator must inform the Shift Manager, Senior Urgent Care Coordinator immediately who must instruct a clinician to action the call as a priority.
- **Log if any symptoms have worsened or deteriorated**, inform the Shift Manager or Senior Urgent Care Coordinator immediately and close the call advising if any further change or deterioration in condition to call NHS 111
- For every comfort call completed, a note on the Adastra record should be recorded within "Case Edit" as follows:
- "Comfort call – no change in symptoms – advised to call 111 if any change or deterioration - recorded by (name) date and time"
- "Comfort call – patient worsened – informed (name) recorded by (name) date and time"
- "Comfort call – patient worsened ILTC ambulance called – informed (name) recorded by (name) date and time"

REMEMBER TO ALWAYS LOG AND INFORM

- In cases where the anticipated National Quality Requirement timeframes are not going to be reached, the above procedure is to be followed for all calls whether in the ‘DCA’ pool, ‘Advice’ pool or home visits.

Contact Made Through Comfort Calls, NHS111, Health Care Professionals

If contact with a patient is made through a comfort call, or a call back from NHS111, or another Health Care Professionals, the person receiving the call **MUST** enquire as to whether the patient’s condition has deteriorated.

If the patient meets the criteria of an ILTC, operational staff must follow ACPP. **Under no circumstances may you offer the patient or their representative the choice of calling the ambulance themselves**

The Urgent Care Coordinator will inform the Shift Manager or Senior Urgent Care Coordinator who will edit the case type to ‘Doctor Advice’, ambulance called and forward to the ‘Advice’ pool for safety-netting by a clinician.

If a patient’s condition has deteriorated but does not fall into ILTC criteria, the Urgent Care Coordinator should document deteriorating symptoms and alert the Shift Manager Senior Urgent Care Coordinator immediately. They will then alert a triaging clinician of the changes.

Appendix 1

Home Visit Dispatching Guide

Home Visits Dispatching Guide

Covid and Non-Covid Deaths (At least 4-6 hours ater death)					Emergency/Urgent				Less Urgent			
Postcode	Call No	Start	4 Hours	End	Postcode	Call No	Start	Finish	Postcode	Call No	Start	Finish

Appendix 2

Home Visit Tracking Sheet v4

Home Visit Tracking Sheet						
Date:						
Dispatcher:						
Med Car No:		**Driver Name:**			**Shift:**	
Laptop No:		**Location:**				
Med Phone No:		**Doctor Name:**			**Shift:**	
Postcode	**Call Number**	**Time In**	**Urgency**	**Term Time**	**Arrival**	**Finish**
Med Car No:		**Driver Name:**			**Shift:**	
Laptop No:		**Location:**				
Med Phone No:		**Doctor Name:**			**Shift:**	
Postcode	**Call Number**	**Time In**	**Urgency**	**Term Time**	**Arrival**	**Finish**

Appendix 3

Accessing the Medicines and Equipment Room

Details of Access					Med Mags taken / Returned					
DATE	TIME	1ST PERSON NAME	2ND PERSON NAME	In / Out (please indicate)	A BAG NO.	B BAG NO.	Resus Bag No.	Nebuliser Bag No.	Med Car Using	Reason for use / Entering

IF an A or B Bag has a yellow tag or has been opened untagged on return please place on floor. If the red tag is still in-tacked please place back on the appropriate shelf.

Appendix 4

Clinician Med Bag Check Form

Med Bag No.:		GP Name		Date:	

PLEASE RETURN COMPLETED FORM WITH PRESCRITIONS (WAVERTREE) TO DRIVER (HALTON

Equipment Check	Start of Shift	End of Shift
Auriscope		
Stethoscope		
Ear Thermometer		
BP Machine		
Glucose Monitor		
Pulse Oximeter		
DRs Paper work Folder	**PLEASE REMEMBER TO PLACE BACK IN BAG**	

For Information

Other items in bag:

Multistix / Tongue depressors / Gloves / Urine Bottles / Peakflow & Mouth pieces / Digital Thermometer / Hand Gel / KY Jelly sachets / Pregnancy test (in an Envelope) / Spare Batteries / Needles & Syringes / Steret Swabs / Cotton wool balls.

Paperwork in Folder:

BNF / Hospital referral forms / Declined admission forms / UC24 Phone Directory / Blank letterhead / Patient not at home forms / Guidance sheet for prescribed palliative care drugs for syringe driver / Hoof Forms / DN prescription sheet / Guidelines for setting up syringe driver / Syringe driver prescription sheet / Envelopes / What to do next sheet / Reportable incident forms / Bereavement / Dolls sheet.

Appendix 5

A Box - List of Medications

A BAG – Medication List		
		Paracetamol Susp 250mg
		Nitrofurantoin 100mg Tabs
	Codeine Phosphate Tabs 30mg	
Loperamide Cap 2mg	Chlorpheniramine Tabs 4mg	Prochlorperazine Tabs 3mg
	Diazepam Tabs 5mg/2mg	
	Clarithromycin Tabs 500mg	
Prednisolone Tabs 5mg	Flucloxacillin Caps 500mg	Salbutamol Inhaler
Prednisolone 5mg Vails	Amoxicillin Caps 500mg	GTN Spray
		Penicillin Tabs 250mg
	Diclofenac Inj 75mg/3ml	
	Metoclopromide Inj 10mg/2ml	
Amoxicillin Susp 250mg		
This antibiotic requires water for reconstitution, please use the cylindrical measure provided.		
Directions are on the bottle or the box.		

Appendix 6

B Box Medication Contents

B BAG – Medication List		
		PALLIATIVE CARE
Doxycycline Caps 100mg	Fletchers Enema	Midazolam Inj 2mg/ml
Trimethoprim 200mg Tabs		Levomepromazine Inj 25mg
Levonel	Volumatic	Cyclizine 50mg/1ml
Glycerol Supp 4g	Cefalexin Caps 500mg	Hyoscine Butylbromide 20mg
	Cefalexin Liq 250mg *This antibiotic requires water for reconstitution Please use the cylindrical measure provided.* *Directions are on the bottle or the box*	Hyoscine Hydrobromide 400mg
Trimethoprim Liq 50mg/5ml		
Lansoprazole Caps 30mg		Chlorpheniramine Liq 2mg/5ml
Flucloxacillin Liq 125mg/5ml *This antibiotic requires water for reconstitution, Please use the cylindrical measure provided.* *Directions are on the bottle or the box.*		

Appendix 7

CONTENTS OF RESUSITATION BAG –including Emergency Drugs

RESUSITATION BAG		
CONTENTS OF RESUSITATION BAG		**List of Emergency Drugs**
Emergency drugs - Listed Below		Salbutamol Inhaler
Oxygen Bottle		Hydrocortisone Inj
Adult single patient use resusitator bag		Benzylpenicillin Inj
Peadiatric single use resusitator bag		Water for inj
First Aid Mask		Adrenaline
Guedel airways		Aspirin Tabs 300mg
Volumatic Spacer		Chlorpheniramine Inj
Adult oxygen mask		
Child oxygen mask		Diazepam Rectal 5mg
Adult non rebreathing mask with head strap and tubing		Diazepam Rectal 10mg
		Frusemide Inj
		Glucogel
		GTN Spray
		Naloxone Inj
		Sodium Chloride

Patients Not at Home

Visiting Team arrive at the Home Visit

Is there no reply at the address or any supplied telephone number?

Yes

Home visit continues as normal

No

Further investigations

Home Visiting Driver to contact Urgent Care Coordinator to check that the service has the correct demographics?

Urgent Care Coordinator to check:

A&E Departments to see if the patient has attended?

NWAS to see if an ambulance has been called?

Call to be made to the contact numbers provided on adastra

If confirmation has been received that the patient has attended or has been conveyed to hospital, request the Clinician to complete the call from the car

Where possible, the visiting team to check around the patient's property. If the patient incapacitated an immediate 999 call to be placed to NWAS and the Police

If contact cannot be made a last resort is for the visiting team to contact the Police and request access to the patient's residence. This last action should be taken at the discretion of the visiting clinician