

Case Study

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Health Call

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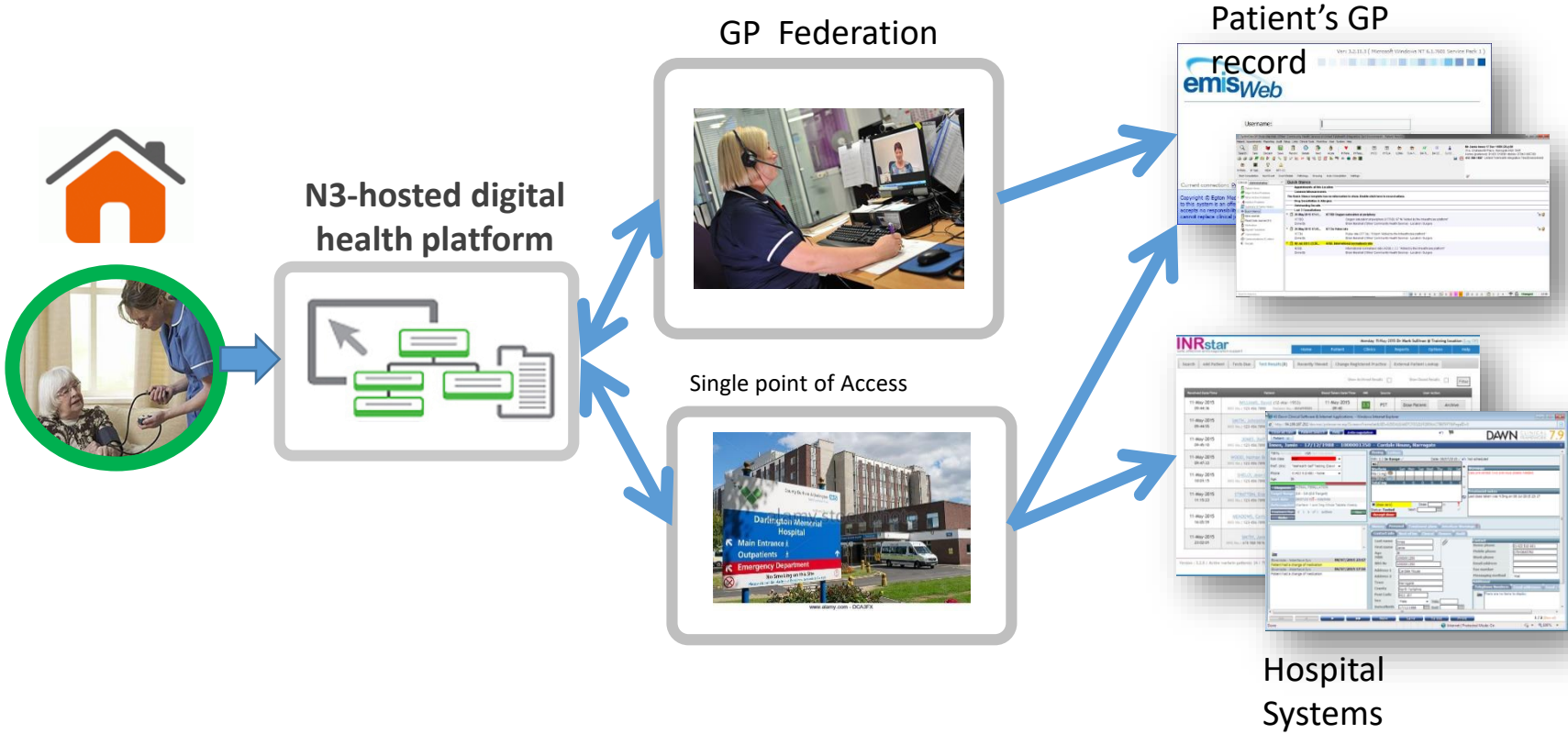


Digital Care Home

Health *Call*

County Durham
& Darlington
Community Services

Health *Call* Digital Care Home – What is it?



Health *Call*

INTERNAL USE AND AUTHORISED THIRD PARTIES ONLY

Drivers

- Care homes have no direct access to NHS IT systems
- The phone is predominately used to contact the wider health care system, wasting hours and often with lots of repetition
- No ability for clinicians to remotely monitor residents in care homes
- Reduce hospital admissions, calls to 111/999
- Provide care to the right person at the right time in the right place

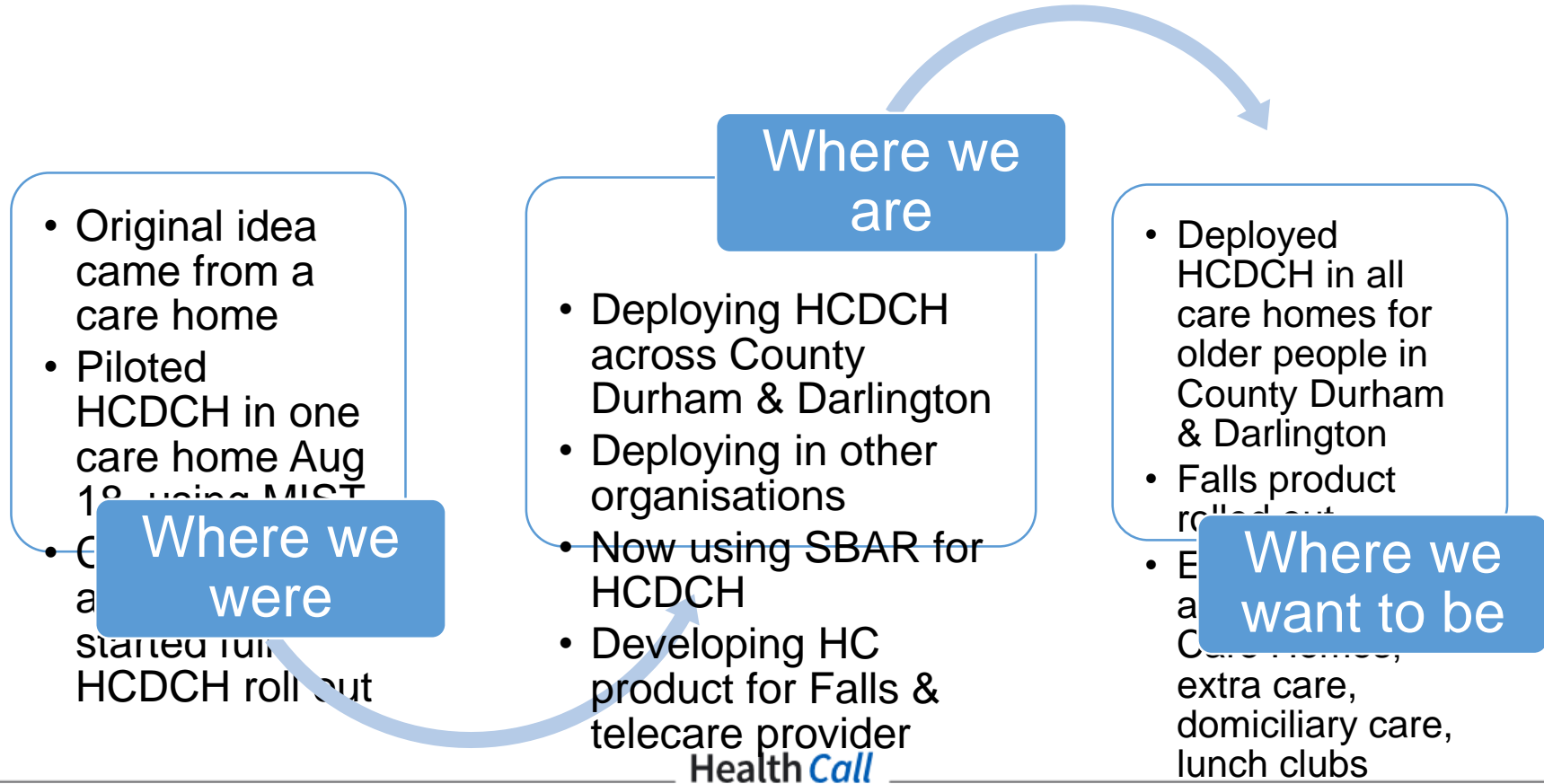


Better records
for better care



Health *Call*

Timeline



Health Call Digital Care Home – How does it work?

Patient list

A list of patients with available tasks is shown below. Click on a patient to view their individual tasks.

Patients

Status key
★ Tasks to do ⏸ Not synced ❌ Error

Patient details

| Name | Date of Birth | Tasks |
|-----------------------|-------------------|-------|
| BURTON, Belinda (Mrs) | 19-Sep-1960 (59y) | 1 |
| BURTON, Jonathan (Mr) | 31-May-1959 (60y) | 2 |
| SMITH, David (Mr) | 25-Apr-1947 (72y) | 1 |
| SMITH, Gail (Miss) | 25-Aug-1968 (51y) | 1 |
| SMITH, John (Mr) | 23-Feb-1940 (79y) | 1 |
| SMITH, Paul (Mr) | 15-Apr-1952 (67y) | 1 |
| SPEIGHT, Aaron () | 19-Mar-1995 (24y) | 1 |

Patient

SMITH, John (Mr)
23-Feb-1940 (79y)

A list of tasks to complete is shown below. Select a task to view its details and complete it.

Tasks

Status key
★ Tasks to do ☆ Ad hoc ☑ Draft
⏸ Not synced ❌ Error

Task details

SBAR for 6.1
Assessment

Task

SMITH, John (Mr)
23-Feb-1940 (79y)

SBAR for 6.1
Assessment

CARE HOME SBAR ASSESSMENT

Who is the patient known to?

- District nurses
- Advanced nurse practitioners or CSPs
- VAWAS (Durham Dales only)

Are you able to complete the observations?

- Yes
- No

Reason you are unable to complete the observations

District Nurse referral

SITUATION

Carer's name

Catherine

The problem is

skin tear

App
(for offline & online use)

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Health Call Digital Care Home – How does it work?

Task

SMITH, John (Mr)
23-Feb-1940 (79y)

BACKGROUND

Relevant medical history

poor mobility

How long have they been unwell?

one day

Do they have an active DNACPR decision?

Yes

No

Do they have an EHCP?

Yes

No

Do they have an Advanced Directive?

Yes

No

Are they EOL?

Yes

No

Task

SMITH, John (Mr)
23-Feb-1940 (79y)

ASSESSMENT - AIRWAY

Is the airway clear? (optional)

Yes

No

Respiratory rate (breaths/min) (optional)

14

SpO2, Scale 1

Air or oxygen? (optional)

Air

Oxygen

Are there any added noises? (optional)

Yes

No

ASSESSMENT - CIRCULATION

Systolic BP reading (mmHg) (optional)

147

Diastolic BP reading (mmHg) (optional)

Task

SMITH, John (Mr)
23-Feb-1940 (79y)

Systolic BP reading (mmHg) (optional)

147

Diastolic BP reading (mmHg) (optional)

69

Pulse rate (BPM) (optional)

65

Temperature (°C) (optional)

36.9

Oxygen saturation (%) (optional)

96

When did they last pass urine? (optional)

this morning

When did they last have their bowels opened? (optional)

yesterday

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Health Call Digital Care Home – How does it work?

Task

SMITH, John (Mr)
23-Feb-1940 (79y)

ASSESSMENT - DISABILITY

Level of consciousness (optional)

- Alert
 Confusion (new)
 Voice
 Pain
 Unresponsive

What is the patient's blood glucose? (mmol/L) (optional)

Answer

Are they in pain? (optional)

- Yes
 No

ASSESSMENT - EXPOSURE

Have they got a new rash or any skin changes that you are concerned about? (optional)

- Yes
 No

ASSESSMENT - SUMMARY OF CONCERNS

What are you concerned about?

Task

SMITH, John (Mr)
23-Feb-1940 (79y)

ASSESSMENT - SUMMARY OF CONCERNS

What are you concerned about?

pressure check

RECOMMENDATION

Things I have already done to help the individual

applied cream

NEWS2 CLINICAL RISK

NEWS2

0

The NEWS2 score was derived from the following values:

Respiratory rate
14 breaths/min (score 0)

Oxygen saturation
96 % (score 0)

Air or oxygen
Air (score 0)

Task

SMITH, John (Mr)
23-Feb-1940 (79y)

The NEWS2 score was derived from the following values:

Respiratory rate
14 breaths/min (score 0)

Oxygen saturation
96 % (score 0)

Air or oxygen
Air (score 0)

Temperature
36.9 degrees Celsius (score 0)

Systolic blood pressure
147 mmHg (score 0)

Pulse rate
65 BPM (score 0)

Level of consciousness
A (score 0)

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The relevant clinical team pick up the reading, review and then action as appropriate. The patient's electronic record is also updated.

SBAR for 6.1 Alert

The 'Process alert' button will assign the alert to you and start the alert consultation process.

| | |
|---|--|
| <i>Patient name</i> BURTON, Anthony (Mr) | <i>Created date</i> 09-Feb-2020 13:26 |
| <i>NHS No.</i> 926 572 5621 | <i>Assigned to</i> Unassigned |
| <i>Severity</i> 1 - Urgent | <i>Respiratory rate</i> 16 breaths/min (score 0) |
| <i>Service</i> SBAR for 6.1 | <i>Oxygen saturation</i> 96 % (score 0) |
| <i>Description</i> Alert - District nurses | <i>Air or oxygen</i> Air (score 0) |
| | <i>Temperature</i> 38.9 degrees Celsius (score 1) |
| | <i>Systolic BP</i> 156 mmHg (score 0) |
| | <i>Diastolic BP</i> 89 mmHg |
| | <i>Pulse rate</i> 67 BPM (score 0) |
| | <i>Consciousness</i> A (score 0) |
| | <i>Care facility</i> SBAR Care Home |

Notes

There are no notes for you to view.

Exit Process alert Assign alert View patient



systemone
ONEPATIENTONERECORD

emis

VISION



HealthCall

INTERNAL USE AND AUTHORISED THIRD PARTIES
ONLY

Care Home

- More empowered staff
- Information going directly to a clinician
- Less time on the phone
- Reduced admissions and escorting residents
- More time with residents
- Quicker access to health care

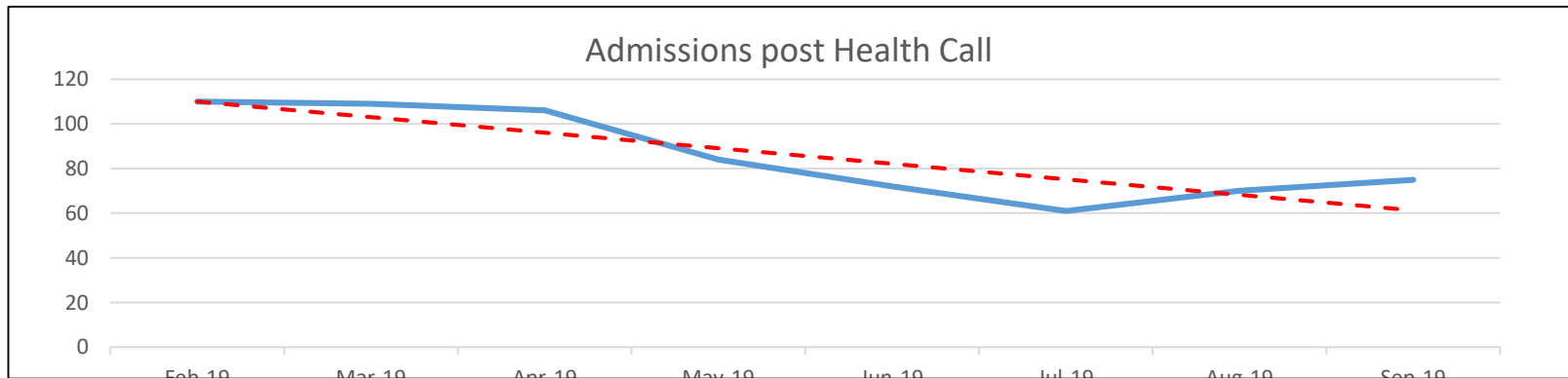
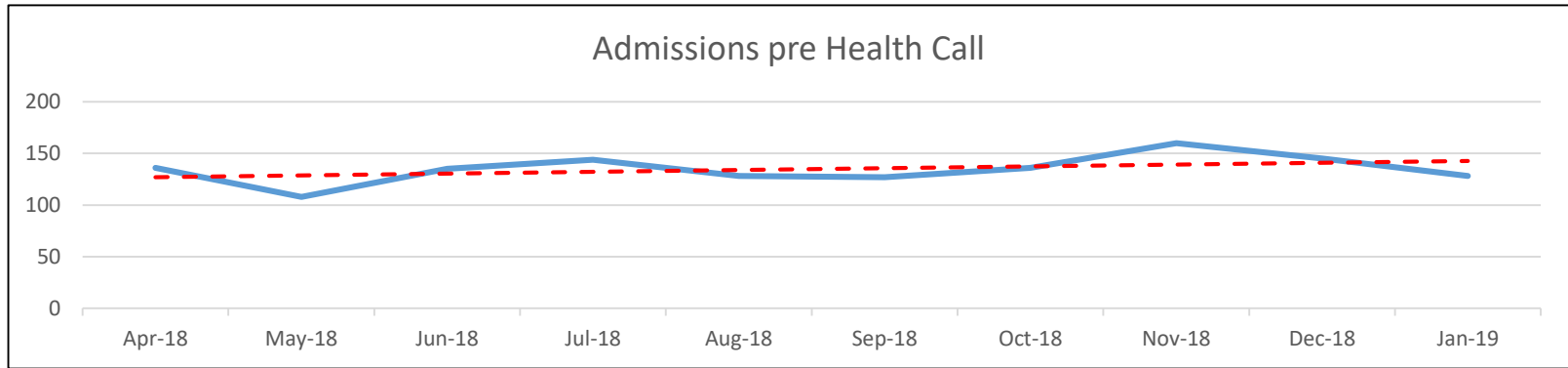
Residents

- Feeling better cared for
- Reduced admissions
- Residents more involved in their health
- Reassured residents

Health and Social Care

- Reduced admissions
- Better quality of referral
- Data pulled into the electronic patient record
- Data available to all appropriate health care staff
- More informed clinicians
- Less phone calls to DN's
- Better quality of care

Outcomes



Health Call

Health *Call* Lumley Court

- Most of the feelings the staff went through before Health *Call*
- After training referrals were smooth and seamless basic observations updated in real time
- Equipment was fit for purpose
- Staff can escalate if needed and seek advice
- 24-hour use
- Helped staff understand what is normal for that person
- Staff became interested
- Relevant to person centered care



Health *Call*

Is my resident well?

Step 1: Recognise and record the changes

| Am I worried enough to want a review? | | Am I worried enough to want a review? | |
|---------------------------------------|--|---------------------------------------|--|
| | YES | NO | |
| | Are they becoming restless or agitated? | | |
| | Are they flushed, sweating hot or cold, or clammy? | | |
| | Are they more or less mobile than usual, or unsteady? | | |
| | Is there new, or worrying, pain? | | |
| | Are there changes in skin colour or condition? | | |
| | Are they short of breath or breathing harder than usual? | | |
| | Are they more confused or drowsy? | | |
| | Do they have cold hands or feet? | | |
| | Are they feeling sick, or being sick? | | |
| | Are they off their food or drinking less fluid? | | |
| | Any changes in urine colour or smell? | | |
| | Any changes in bowel habits? | | |

What does the resident say about how they feel?
If the resident is able to express how they feel please tell us what they say.

Step 2: Take a set of observations

NEWS2. Please record

Date: _____ Time: _____

| Temperature | Pulse | Respiration | Blood pressure | Sa or oxygen | SpO2-1 | SpO2-2 | Consciousness (see key below) |
|-------------|-------|-------------|----------------|--------------|--------|--------|-------------------------------|
| | | | | | | | |

Consciousness ACVPU key
 A = ALERT - awake and responding, eyes open
 C = CONFUSED - new onset of confusion (do not score if chronic)
 V = VISIBLE - moves eyes / limbs or makes sounds to voice
 P = PAIN - responds only to painful stimuli
 U = UNRESPONSIVE - unconscious

Residents NEWS score is... _____

Does your resident have an end of life plan or anticipatory

Does your resident have a DNACPR (Do Not Attempt Cardio-pulmonary Resuscitation)

How concerned are you? (tick appropriate box)

| 0 | 1 | 2 | 3 |
|------------|---|---|---|
| No concern | | | |

Any extra information you think might help
 i.e. fluid chart, medication chart

BACKGROUND
 Relevant medical history
 poor mobility

How long have they been unwell?
 one day

Do they have an active DNACPR decision?
 Yes
 No

Do they have an EHC/P?
 Yes
 No

Do they have an Advanced Directive?
 Yes
 No

Are they EOL?
 Yes
 No

Step 3: Pass on your concerns

SBARD Escalation and Communication Tool and action tracker

| SBARD Escalation and Communication Tool and action tracker | | Notes (including date and time of escalation) |
|--|--|--|
| S | SITUATION Briefly describe the current situation and give a clear concise overview of relevant issues. • Provide address, direct line contact number • I am... from... (say if you are a registered professional) • I am calling about resident... (Name, DOB) • The residents present NEWS score is... (reference/ baseline NEWS score is...) • I am calling because I am concerned that... (think about the signs you ticked on page 2 or the part of the NEWS score which is concerning you) | |
| B | BACKGROUND Briefly state the relevant history and what got you to this point. • Resident XX has the following medical conditions... • The resident does/does not have a DNACPR or ReDPRCT form / agreed care plan with a limit on treatment/hospital admission. • If the person is approaching End of Life and they on a palliative care register. Do they wish to be treated at home. • They have had... (GP/other health professional involved recently, see review, investigation, medication) • Resident XX's condition has changed in the last XX hours. • The last set of observations was... (state and time) &... Their normal condition is... | |
| A | ASSESSMENT Summarise the facts and give your best assessment on what is happening. • I think the problem is... • And I have... (e.g. given pain relief, medication, sat the patient up etc.) OR • I am not sure what the problem is, but the resident is deteriorating OR • I don't know what's wrong, but I am really worried | |
| | | Actions I have been asked to take (initial 6 times when actions completed) |
| R | RECOMMENDATION What actions are you asking for? What do you want to happen next? • I need you to... • Come and see the resident in the next XX hours AND • Is there anything I need to do in the meantime? (e.g. repeat observations, give analgesia, escalate to emergency services) | |
| D | DECISION What have you agreed? • We have agreed you will visit/call in the next XX hours, and in the meantime, I will do XX. If there is no improvement within XX, I will take XX action. | |
| Name: _____ Date: _____ Time: _____ Signature: _____ | | |
| | | ASSESSMENT - SUMMARY OF CONCERNS What are you concerned about? pressure check |
| | | RECOMMENDATION Things I have already done to help the individual applied cream |
| | | NEWS2 CLINICAL RISK NEWS2 0 |
| | | The NEWS2 score was derived from the following values: Respiratory rate 14 breaths/min (score 0) |
| | | Oxygen saturation 96 % (score 0) |
| | | Air or oxygen Air Flowing |

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Health Call – Not just SBAR, not just care homes

Patient list

7 Patients

Status key
★ Tasks to do ✉ Not synced ⊗ Error

Patient details ★ ✉ ⊗

| | | | | |
|--|---|---|---|---|
| BURTON, Anthony (Mr) 03-Oct-1960 (59y) | 1 | - | - | > |
| BURTON, Belinda (Mrs) 19-Sep-1960 (59y) | 2 | - | - | > |
| BURTON, Jonathan (Mr) 31-May-1959 (60y) | 2 | - | - | > |
| SMITH, Chloe (Miss) 13-Jul-2003 (16y 6m) | 1 | - | - | > |
| SMITH, David (Mr) 25-Apr-1947 (72y) | 1 | - | - | > |
| SMITH, Gail (Miss) 25-Aug-1968 (51y) | 1 | - | - | > |
| SMITH, Paul (Mr) | | | | |

Patient list **Patient**

BURTON, Jonathan (Mr)
31-May-1959 (60y)

A list of tasks to complete is shown below.
Select a task to view its details and complete it.

2 Tasks

Status key
★ Tasks to do ☆ Ad hoc 📄 Draft
✉ Not synced ⊗ Error

| Task details | Status |
|---|--------|
| SBAR for 6.1 Assessment | ★ > |
| Undernutrition Care Home BPMN Readings collection | ★ > |

Patient list **Patient**

MCSHANE, Catherine ()
01-Jan-2000 (20y)

A list of tasks to complete is shown below.
Select a task to view its details and complete it.

2 Tasks

Status key
★ Tasks to do ☆ Ad hoc 📄 Draft
✉ Not synced ⊗ Error

| Task details | Status |
|--|--------|
| Falls Assessment_V1.1 FallsAssessQuestionnaire | ★ > |
| Wound Management Demo Initial assessment | ★ > |

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Thank you

For further information:

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www.nhshealthcall.co.uk

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