LIVES/LCHS/LCC/ULHT/AGE UK

Policy and Standard Operating Procedures For Early Intervention Vehicle

Links
The associated policy can be found on each organisation's website:
https://lives.org.uk/
https://www.lincolnshirecommunityhealthservices.nhs.uk/
https://www.ulh.nhs.uk/
https://www.lincolnshire.gov.uk/

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1. Policy Statement / Introduction

1.1. This following document outlines the structure, role, reporting and responsibilities of LIVES HQ, Lincolnshire Community Health Services (LCHS), United Lincolnshire Hospital Trust (ULHT) and Lincolnshire County Council (LCC) staff and Responders with respect to the Early Intervention Vehicle.

1.2. In addition to the Core Activity, LIVES also delivers other secondary clinical services from time to time, on a commercial basis, the income from which is to fund and underpin that Core Activity. Such service includes non-emergency Patient Transport Services, Event First Aid or other contracts to deliver clinical services

1.3. As part of delivering secondary clinical services, LIVES, LCHS, ULHT and LCC staff, in partnership with relevant external organisations, will provide Early Intervention Services on a non-emergency response basis, using LIVES vehicles. This policy describes how all organisations previously stated will manage the Early Intervention Vehicle service.

2. Aims & Objectives

2.1. Aims of the Policy

The overriding consideration of this SOP is to promote patient safety and clinical excellence, and to ensure that best practice standards are delivered at all times for patients who require the assistance of the Early Intervention Vehicle (EIV).

2.2. Objectives of the Policy

To inform all relevant staff and third-party associates regarding the EIV operational procedures and the key requirements including essential criteria, training, equipment, activation protocols and documentation/reporting requirements.

3. Definitions

3.1. **LIVES** – Lincolnshire Integrated Voluntary Emergency Service. A voluntary charity providing an immediate response to medical and trauma emergencies within Lincolnshire.

3.2. **EMAS** – East Midlands Ambulance Service NHS Trust

3.3. **CAS** –Clinical Assessment Service – a senior clinician-led triage service for patients with unscheduled or urgent need with a range of dispositions, one of which is LIVES.

3.4. **CAT** – Clinical Assessment Team – predominantly nurse and paramedic populated team of clinicians working for EMAS

3.5. **EOC** – Emergency Operations Centre (ambulance control) which for Lincolnshire is situated at Bracebridge Heath on the southern edge of Lincoln City.

3.6. **BBH** – Bracebridge Heath. The location at Lincoln of the EMAS Lincolnshire EOC.

3.7. **LCHS** – Lincolnshire Community Health Services NHS Trust

3.8. **CFR** – Community First Responder

3.9. **MFR** – Medical First Responder

3.10. **EIV –** Early Intervention Vehicle

3.11. **Therapist –** Therapist Staff Member

3.12. **Responder** – A LIVES CFR, of Levels 1 – 4 with varying skill sets and LIVES MFR of Levels 4 – 8 with varying skill sets

3.13. **LIVES EMERGENCY call** – The type of Responder call that LIVES has responded to since the inception of CFRs. Deployed by an EMAS (EOC) and automatically backed up with an EMAS resource.

3.14. **M&H** – Moving and Handling of Persons. This refers to the training package written and delivered by LIVES and for our own insurance reasons we are unable to accept any similar qualification from outside the organisation. Training for equipment specific to this activity e.g. lifting devices may be delivered on a Train-the-Trainer basis to LIVES Trainers, but all training of LIVES personnel will be delivered directly by LIVES.

3.15. **BLS** – Basic Life Support, as defined by the Resuscitation Council Guidelines (2015)

3.16. **AED** – Automated External Defibrillator, as defined by the Resuscitation Council Guidelines (2015)

3.17. **AVPU** – A system for assessing conscious level based on **A**lert, Responding to **V**oice, Responding to **P**ain, **U**nresponsive.

3.18. **ULHT** – United Lincolnshire Hospitals NHS Trust

3.19. **LCC – Lincolnshire County Council**

3.20. **GCS** – Glasgow Coma Scale. A system for assessing conscious level that is more detailed than the AVPU scale.

4. Scope

4.1. Person

This Standard Operational Procedure (SOP) covers the Responders who wish to undertake the role of EIV Responder providing a clinical response to calls generated by the Lincolnshire CAS service. These responders will be known as LIVES EIV Responders.

4.2 Equipment & Activation / Communication
This document outlines the equipment and consumables to be carried, along with the activation and communication processes to LIVES EIV calls.

4.3 Training
This document outlines the training required for LIVES personnel to operate on the EIV.

5. Statutory Requirements

This policy takes heed of the following legislation:

5.1. Health and Safety at Work Act 1974

5.2. Management of Health and Safety at Work Regulations (MHSAW) 1999

5.3. The Manual Handling Operations Regulations (MHOR) 1992

5.4. Workplace (Health, Safety and Welfare) Regulations (WHSW) 1992

5.5. Lifting Operations and Lifting Equipment Regulations (LOLER) 1998

5.6. Provision and Use of Work Equipment Regulations (PUWER) 1998

5.7. Mental Capacity Act 2005, revised 2007

5.8. The Human Rights Act 1998

5.9. The Care Act 2014

5.10. Disability Discrimination Act

5.11. Health and Social Care (Safety and Quality) Act 2015

5.12. Safeguarding Adults and children

5.13. Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013(RIDDOR)

6. Roles & Responsibilities

6.1. Trustee Board and Trust Boards

The Trustee Board and Trust Boards have the responsibility to monitor the effectiveness of this SOP. Monitoring of this SOP will be carried out by updates to the LIVES Risk Management and Operations Committees and Trust Operational Committees.

6.2. LIVES Chief Executive Officer

The LIVES CEO has the responsibility to ensure that the Trustee Board is kept informed of any changes to the SOP, any breaches or exceptions to the SOP, and ensure that the Clinical Director reports any changes or concerns regarding this SOP or implementation thereof to the Chief Executive.

6.3. Clinical Director

The LIVES Clinical Director has lead responsibility for overall monitoring and implementation of this policy.

6.4. Head of Operations

The LIVES Head of Operations has responsibility for the delivery of the EIV service on a day to day basis. Alongside the Clinical Director, the Head of Operations provides clinical input and has overall responsibility and accountability for the safe delivery of this SOP within the operational environment. The Head of Operations will be the escalation point for any operational or clinical concerns arising out of this activity. Together with the Clinical Director they have responsibility to conduct investigations in relation to reported untoward incidents in relation to this Policy, and report these to Operations Committee and the Trustee Board

6.5. LIVES Managers & Staff

All relevant LIVES personnel have a responsibility to familiarise themselves with the content of this SOP and associated policies & procedures. It is their responsibility to implement this SOP and ensure compliance by Responders. In particular they should report immediately to their line manager any non-compliance or untoward incidents that occur during the execution of this policy.

6.6. LIVES Responders

It is the responsibility of the Responders operating within the scope of this SOP to adhere to this procedure. All persons volunteering for LIVES to attend LIVES EIV calls must report to LIVES HQ any contraventions of this policy and any untoward incidents occurring during the execution of this policy.

6.7. LCHS Managers and Staff

All relevant LCHS personnel have a responsibility to familiarise themselves with the content of this SOP and associated policies & procedures. It is their responsibility to implement this SOP and ensure compliance by staff. In particular they should report immediately to their line manager any non-compliance or untoward incidents that occur during the execution of this policy.

7. Competences / Training Requirements

7.1. Any person carrying out activity under this SOP must be current in the following minimum skill set:

7.2. Be level 3 or level 4 CFRs, currently holding 'on-line' status

7.3. Have successfully completed the LIVES Moving & Handling course either as part of basic training (now mandatory) or as a stand-alone course if basic training done prior to the introduction of M&H & any specific training on equipment relevant to this activity.

7.4. The training to carry out the two sets of observations as referred to in Section (7.2.3) to include:

7.4.1. The measurement of Blood Pressure using a LIVES-approved, calibrated, automated electronic Blood Pressure machine.

7.4.2. The measurement of Capillary Blood Glucose using a LIVES-approved, calibrated, electronic meter.

7.4.3. Urinalysis

7.5. Have successfully completed the additional LIVES Moving & Handling training specific to this service including use of moving and handling equipment e.g. Mangar elk or similar equipment specified by the commissioning partner.

7.6. Hold the appropriate driving licence categories to drive the EIV vehicle

7.7. For staff within LCC, ULHT and LCHS trust mandatory training must be up to date and competencies tested regarding the therapy equipment listed in Appendix E.

8. Operational Procedure for EIV

8.1. Call origin

EIV calls will be generated by the Lincolnshire Clinical Assessment Service (CAS). If the CAS has identified that an EIV response is the appropriate disposition the LCHS Operations Centre will request the EIV Responder to be deployed.

All tasking **MUST** be through LCHS ONLY. Tasking from other sources **MUST NOT** be accepted and the caller should be referred to the LCHS Ops Centre

The EIV vehicle **WILL NOT** be deployed as an emergency or 'blue light' service under any circumstance.

8.2. The EIV will operate between 7.30am – 6.30pm 7 days a week including bank holidays. A phased approach will be applied gradually building to these operational hours. This may be subject to change/adjustment as the project develops and by agreement with all partner agencies.

8.3. The EIV personnel will:

8.3.1. Arrive at Johnson Hospital, Spalding, or other agreed location, no later than 0730 and collect the keys for the vehicle from the porters within the hospital.

8.3.2. Sign on for the shift using the vehicle log book which will be in the cab of the vehicle

8.3.3. Complete the pre-shift 'daily checks' as per the LIVES Safer Ambulance SOP (See folder in the cab of the ambulance)

8.3.4. Call the LCHS Ops Centre on tel: 0300 123 4868 Option 2 and book 'Ready for Duty'

8.3.5. Proceed to 'stand-by' point as and when instructed by the LCHS Ops Centre

8.3.6. Proceed to the patient location when deployed by LCHS Ops Centre

8.3.7. Undertake clinical activity as detailed in 9. Clinical Procedure for EIV.

8.3.8. Complete a LIVES A4 PRF for **EVERY** patient transported. The PRF should be annotated with **'LCHS EIV'** in the top right hand corner. Make a record on the PRF as to whether a DNACPR or other similar document exists, and is taken with the patient, if transported.

8.3.9. Completed PRFs should be placed in the A4 envelope provided (in the cab of the ambulance) and deposited in the LIVES letterbox at the end of each shift

8.3.10. Ensure that the vehicle is cleaned between each patient and restocked as necessary as detailed in the LIVES Safer Ambulance SOP

8.3.11. Ensure that the vehicle is thoroughly cleaned, restocked and refuelled at the end of each shift as detailed in the LIVES Safer Ambulance SOP. This should include replacing any therapy equipment from peripheral stores in the local area.

8.3.12. Complete the 'consumables used' form in the folder and deposited in the LIVES letterbox at the end of the shift (if relevant)

8.3.13. Upon returning the vehicle to LIVES HQ the Responder should ensure that it is ready for the following day, securely locked and the keys must be returned to the key safe

9. Clinical Procedure for EIV

9.1. On arrival at the address the Responder and therapist will dynamically assess for danger and only proceed if the scene is safe. If the scene is not safe they will withdraw and report to Police via 999.

9.2. The Responder and therapist will then proceed to a Response – ABC primary survey. They will also take a basic initial history of the outline of the problem.

9.3. If the initial Primary Survey or clinical presentation indicates an immediate life-threatening situation, the Responder will telephone 999, ask for ambulance and inform the call taker of the situation. The EMAS CAD number must be recorded on the PRF.

9.4. In the event of 9.3 above, the Responder and therapist will stay on scene and the responder will administer appropriate care to the highest level to which they are trained as a LIVES Responder (including AED if available and necessary).

9.5. If the primary survey and clinical presentation does not identify an immediately life threatening situation, then the Responder will take and record an initial set of observations*

9.6. *The initial set of observations will be:

- AVPU or GCS (if trained to do – Appendix A)
- Tympanic temperature
- Respiratory Rate (breaths per minute)
- Oxygen Saturation
- Pulse Rate (beats per minute)
- Blood Pressure using LIVES-approved electronic monitor
- Capillary Blood Glucose – using LIVES-approved device
- Urinalysis (if requested by CAS clinician)

9.7. If any of the parameters are outside the ranges detailed in Appendix B, the Responder will discuss with the therapist and decide if they need to contact the LCHS Ops Centre and ask for the clinician to speak to them as soon as possible or if it safe for the therapist to carry out their assessment

9.8. If the LIVES Responder feels able to do so, they should use the chart in Appendix C to calculate a National Early Warning Score (NEWS) to pass to the CAS clinician in their report.

9.9. If the parameters ARE within the ranges in Appendix B the Therapist, with the support of the Responder will then consider whether the patient is in an acceptable position for further assessment (i.e. are they safe and comfortable without the risk of getting pressure sores such as in bed or in a chair).

9.10. If the patient is NOT in an acceptable position, the Therapist, with the support of the Responder will assess whether the patient can be **facilitated / enabled** to get back into bed or into a chair. Therapists and Responders should use approved techniques and follow their Moving & Handling training.

9.11. If the patient cannot move themselves into a safe and comfortable position, the Responder and Therapist must risk assess if it's appropriate and safe to do so utilising appropriate equipment.

9.12. A second set of observations will be taken by the responder when asked by the therapist with the exception being that if the initial CBG was between 5 – 11 and there is no change in the clinical presentation then it does not need to be repeated. Urinalysis does not need to be repeated.

9.13. The second set of observations will be assessed and recorded not sooner than 15 minutes but no later than 20 minutes after the initial set unless guided otherwise by the Therapist.

10. Communication

10.1. On completion of the patient assessment the therapist will develop and agree a management plan with patient and other health / social care providers if required.

10.2. If the therapist feels that they need clinical advice from CAS they will call the Ops centre on 0300 123 4868 and ask that the CAS practitioner calls them back as soon as possible.

10.3. The LCHS Ops Centre will send an instant screen message to the CAS practitioner with the EIV contact number and ask them to call the EIV. The message should be sent to the practitioner who activated the EIV

10.4. The CAS practitioner should call the EIV as soon as possible to prevent delays.

10.5. Following discussion a plan will be agreed between the CAS practitioner and the therapist. The therapist will document the agreed plan on mobile S1. If it has been agreed that a home visit is required by the day time home visiting team then therapist should close the case on mobile S1 as decision deferred, If no action is required from CAS or the day time home visiting team then the therapist should mark the case as requires closing on mobile S1.

10.6. The CAS clinician and the Therapist may jointly decide that the patient needs other input such as attending Accident and Emergency, Urgent Care centre, home visit or GP surgery. The CAS practitioner will arrange an ambulance, if required, using the agreed dx codes if this has not already been done..

10.7. The Therapist and Responder can leave the scene once they have explained what actions are to the patient or their representative and have given advice to call 111 or 999 if their condition worsens while waiting for the visit.

10.8. The CAS clinician may feel that the patient is unstable from the reported observations and will arrange an ambulance response using the approved DX codes. If this is the case, the CAS clinician will ask the Responder to stay on scene and administer appropriate care

to the highest level to which they are trained as a LIVES Responder (including AED if available and necessary).

10.9. Under NO circumstances must the Responder attempt to make any diagnosis or give any advice other than that which they are trained to do as a LIVES Responder (as per the Responder handbook). The main role of the Responder is to support the Therapist and the CAS clinician who will be taking ultimate clinical responsibility.

10.10. The exception to this is when the CAS Responder is a health care professional engaged as a MFR for LIVES and can give advice within their scope of practice.

10.11. Calling clear – Once the Responder is clear to leave the scene they should telephone the LCHS Ops Centre on tel: 0300 123 4868 Option 2 who will mark you clear and available to attend further calls.

11. Record-keeping

Keeping concise and accurate medical records is mandatory for all patients attended by EIV teams.

11.1. A concise record of events and findings should be made at the time of the call. The LIVES Clinical Directorate requires a clear and accurate record to enable a robust defence of any Responder from scrutiny and to ensure any training or support needs are identified.

11.2. If the Responder is cleared from the scene, then they will leave the top copy of the PRF with the patient and will take the bottom copy to return to LIVES HQ. If a further response is being arranged by the CAS that will arrive after the Responder has left, the Responder will ask the patient or their representative to give the PRF to the further resource when they attend

11.3. The therapist will document the assessment and plan using mobile S1.

11.4. If a further resource is arranged to arrive and the Responder is requested to stay on scene until that resource arrives then the top copy of the PRF will be given to the additional resource and the bottom copy is returned to LIVES HQ

12. Risk Assessment

12.1. This Standard Operating Procedure is written in conjunction with our Risk Management Policy and will be reviewed on a regular basis by the Risk Management Committee.

13. Incidents

13.1. Requests for deployment from any source other than the LCHS Ops Centre must be referred to the Ops Centre

13.2. Any safeguarding concerns should be raised at the first possible opportunity through the agreed LCC, ULHT and LCHS pathways.

3.1.1. In the event of the EIV being involved in a RTC or any other transport related incident the LIVES Responder should call the LIVES Head of Operations on 07785 444857and a LIVES IR1 form should be completed and handed in to LIVES HQ at the earliest convenient time

14. Safeguarding procedure

14.1. LIVES, LCHS, ULHT and LCC observes best practice with Safeguarding of Adults and Children. It is possible that Vulnerable Older Adults in particular may be identified as a result of the EIV assessment

14.2. Should there be any concerns regarding the safeguarding of any patients who are seen whilst carrying out an EIV call LCHS / ULHT / LCC staff should ensure that this is reported. Using the agreed LCHS, ULHT or LCC pathways.

14.3. Identification of Vulnerable individuals

Vulnerability may present in many ways and it is essential to read the policies on Safeguarding Adults and Children. Examples include; lack of food in the house, lack of heating, emotional abuse, verbal abuse, physical abuse, physical safety within a house (multiple fall hazards and frail person for example). If you have ANY concerns, Therapists and Responders have a Duty of Care to report their concerns using agreed pathways.

15. Consultation

15.1. This SOP has been written in consultation with the service designers at Lincolnshire Community Health Services NHS Trust and other partner agencies.

16. Measuring Compliance and Effectiveness of this Procedure

16.1. Monitoring of this Standard Operating Procedure will be undertaken, jointly by Lincolnshire Community Health Services NHS Trust, United Lincolnshire Hospitals NHS Trust, Lincolnshire County Council and LIVES Clinical Director and the LIVES Head of Operations in his/her place.

17. Explicit Statements

17.1. There are no explicit statements with this Standard Operating Procedure

Appendix A

Glasgow Coma Scale

The Glasgow Coma Scale was originally devised 40 years ago and there was a recent update to simplify the terminology used and improve the suitability for use by Community First Responders.

The Glasgow Coma Scale at 40 years: standing the test of time

Prof Graham Teasdale, FRCS, Prof Andrew Maas, MD, Prof Fiona Lecky, MD, Geoffrey Manley, MD, Prof Nino Stocchetti, MD, Prof Gordon Murray, PhD

The Lancet. Volume 13, No. 8, p844–854, August 2014

The Current Glasgow Coma Scale supplements the AVPU assessment of conscious level by giving a numerical value to the level of consciousness. This allows an assessment of whether a patient is improving or deteriorating.

*Notes on Stimulation to produce "Pressure"

The technique of stimulation to be used to elicit responses was not tightly specified in the original 1974 report. A year later (Teasdale Nursing times, 1975) a more detailed description of practical use of the Glasgow Coma Scale referred to locations for stimulation being finger nail bed, trapezius muscle and supraorbital notch.

The assessment of motor responses in people not obeying commands continues to take account of information from finger pressure and trapezius / supraorbital sites. In practice the sequence will usually be in that order, fingertip pressure having been used first it when eye opening does not occur spontaneously or to sound. Some concerns have been expressed that undue force exerted repeatedly on the finger nail bed can produce damage (albeit very rarely); pressure on the side of the finger has been proposed as an alternative. In the absence of evidence about the equivalence of the responses to the different sites, the fingernail continues to be recommended, peripherally rather than proximally, with variation over time in the finger stimulated in any given patient.

Both trapezius and supraorbital sites are recommended for central stimulus in a standard sequence of graded intensity. Information about the relative performance of these two different stimuli would be a useful topic for future research. Pressure behind the jaw,(retromandibular / styloid process) is difficult to apply accurately and is not recommended for routine use. **Stimulation by rubbing the knuckles on the sternum is strongly discouraged; it can cause bruising and responses can be difficult to interpret.**

Teasdale G. Acute impairment of brain function-1. Assessing 'conscious level'. Nursing Times.1975 71(24):914-7

Teasdale G, Allen D, Brennan P, McElhinney E, Mackinnon L. The Glasgow Coma Scale: an update after 40 years. Nursing Times 2014; 110: 12-16

A patient who is fully conscious will score 15 on the GCS
A patient who is fully unconscious will score 3 on the GCS. It is not possible to score less than 3
Three parameters are measured for a Glasgow Coma Scale score – Eyes, Verbal Response and Motor Response.

GCS Score = EYES score (1-4) + VERBAL score (1-5) + MOTOR score (1-6)

Scoring is done as follows:

EYES

SCORE	DESCRIPTION	EXPLANATION
4	Spontaneous	The patient has their eyes open spontaneously
3	To sound	The patient opens their eyes in response to being spoken to
2	To pressure	Eyes open to pressure stimulation – see following notes*
1	None	The eyes do not open at all to any stimulation

VERBAL

SCORE	DESCRIPTION	EXPLANATION
5	Orientated	You can have an sensible conversation with the patient
4	Confused	A conversation may be possible, but 'mixed up'
3	Words	The patient can say words but not string them into sentences
2	Sounds	Such as groans and other noises, not amounting to words
1	None	There is no verbal noise being made

MOTOR

SCORE	DESCRIPTION	EXPLANATION
6	Obey commands	The patient will following instructions such as pointing to nose
5	Localizing	On pressure stimulation, the patient will make a move to that point (such as trying to move off the stimulating hand)
4	Normal flexion	On stimulation with pressure on the finger for example, the patient tries to remove their hand by flexing the arm away
3	Abnormal flexion	The patient spontaneously adopts a posture of flexing the arms and wrists
2	Extension	The patient spontaneously adopts a posture of extending the arms and wrists
1	None	No movement whatsoever

Appendix B

Acceptable Normal Parameters / Triggers for Observations

These levels do not give immediate alarm in adult patients:

Physiological Parameter	**Acceptable Range**
GCS / AVPU	=15 / A
Tympanic (ear) Temperature	36.1 C – 38 C
Respiratory Rate	10 - 20
Fingertip Oxygen Saturation	> 94% on air
Pulse Rate	41 - 110
Systolic Blood Pressure	101 - 219
Capillary Blood Glucose	4.0 – 11.0

Appendix C

National Early Warning Score (NEWS)

National Early Warning Score (NEWS)*

PHYSIOLOGICAL PARAMETERS	3	2	1	0	1	2	3
Respiration Rate	≤8		9 - 11	12 - 20		21 - 24	≥25
Oxygen Saturations	≤91	92 - 93	94 - 95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥39.1	
Systolic BP	≤90	91 - 100	101 - 110	111 - 219			≥220
Heart Rate	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Level of Consciousness				A			V, P, or U

NEW scores	Clinical risk
0	Low
Aggregate 1–4	
RED score* (Individual parameter scoring 3)	Medium
Aggregate 5–6	
Aggregate 7 or more	High

Appendix D
EIV patient criteria

The following criteria should be used to assess the suitability of the EIV.

Patients over the age of 18 with a PE11 post code who are suffering with an acute decline in function and mobility that might result in that patient being at risk from falling or further decline that might result in admission to hospital/accident and emergency.

This may be due to;

- Worsening of their dementia
- Possible Urinary Tract Infection
- Reduced fluid intake that might be leading to dehydration
- Head Injury once the following has been excluded through the telephone consultation;

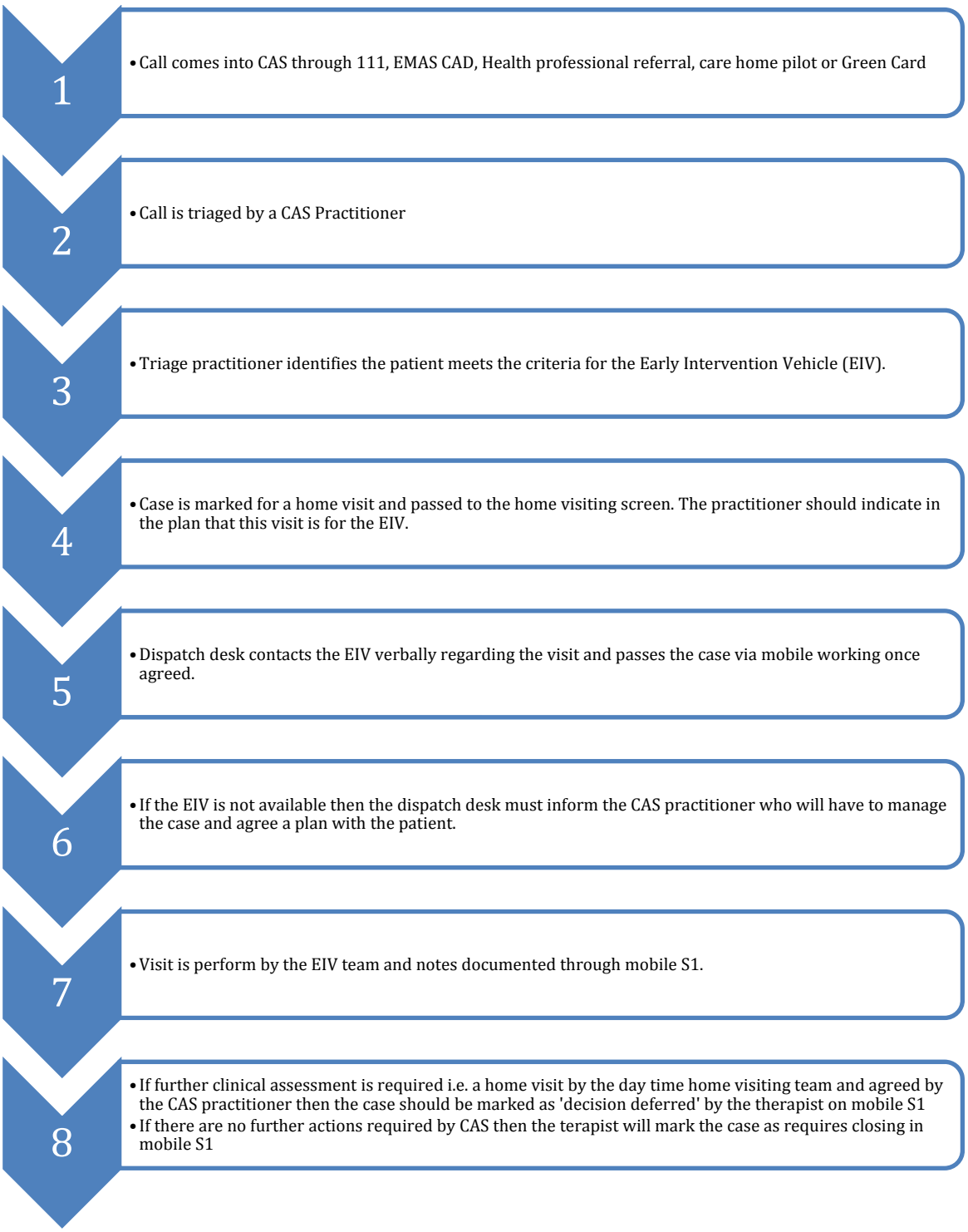
  - Unconscious or lack of full consciousness
  - Any focal neurological deficit since the injury i.e. difficulties understanding speech
  - Any suspicion of a skull fracture or penetrating head injury
  - Any seizure since the injury
  - High energy injury i.e. a fall from higher than 1 metre or more than 5 stairs
  - Any loss of consciousness from which the person has now recovered
  - Amnesia of events before or after the injury
  - Persistent headache since the injury
  - Any vomiting since the injury
  - Any previous brain surgery
  - Any history of bleeding or clotting disorders
  - Current anticoagulant therapy such as warfarin
  - Current drug or alcohol intoxication
  - Altered behaviour

Fall once the following has been excluded

- FAST positive
- Reduced level of consciousness
- Possible fracture
- Uncontrolled Haemorrhage
- Head injury – see above for head injury exclusion
- Amnesia of events pre or post fall
- Possible arrhythmia – fluttering in chest, clamminess
- Possible postural hypotension with symptoms of dizziness
- Possible medical event leading to fall
- High energy injury i.e. a fall from higher than 1 metre or more than 5 stairs

Appendix E

EIV Process Map



Appendix E
Equipment List

- Mangar ELK lifting chair and compressor + additional battery / car charger
- Slide sheets (including additional single patient use slide sheets)
- 3 x zimmer frames (Small/Medium/Large)
- Wheel kits
- Ferrules
- ETAC Turner
- Mobile Commode
- Pressure relieving equipment (Propad and Roho cushions)
- Free standing toilet frame
- Raised toilet seat (4”)
- 1 pair elbow crutches
- 2 x walking sticks

Appendix F

Accessing Transitional Care Beds

Difficulties which may indicate the need for a Transitional Care Bed:

- Person's needs cannot be met by care package and/or family support
- Poor cognition mean that the person may engage in risky behaviour in between health and/or care visits
- There is a significant moving and handling risk that cannot be mitigated by the provision of appropriate equipment
- There is a risk of significant pressure damage
- The person requires 24 hour supervision
- The person has medication needs with surpass the support which carers could provide e.g. they need medication administering
- The person has nursing needs which cannot be met by the community nurses

(N.B. This list is not exhaustive and decisions to admit or not should always be based on clinical reasoning)

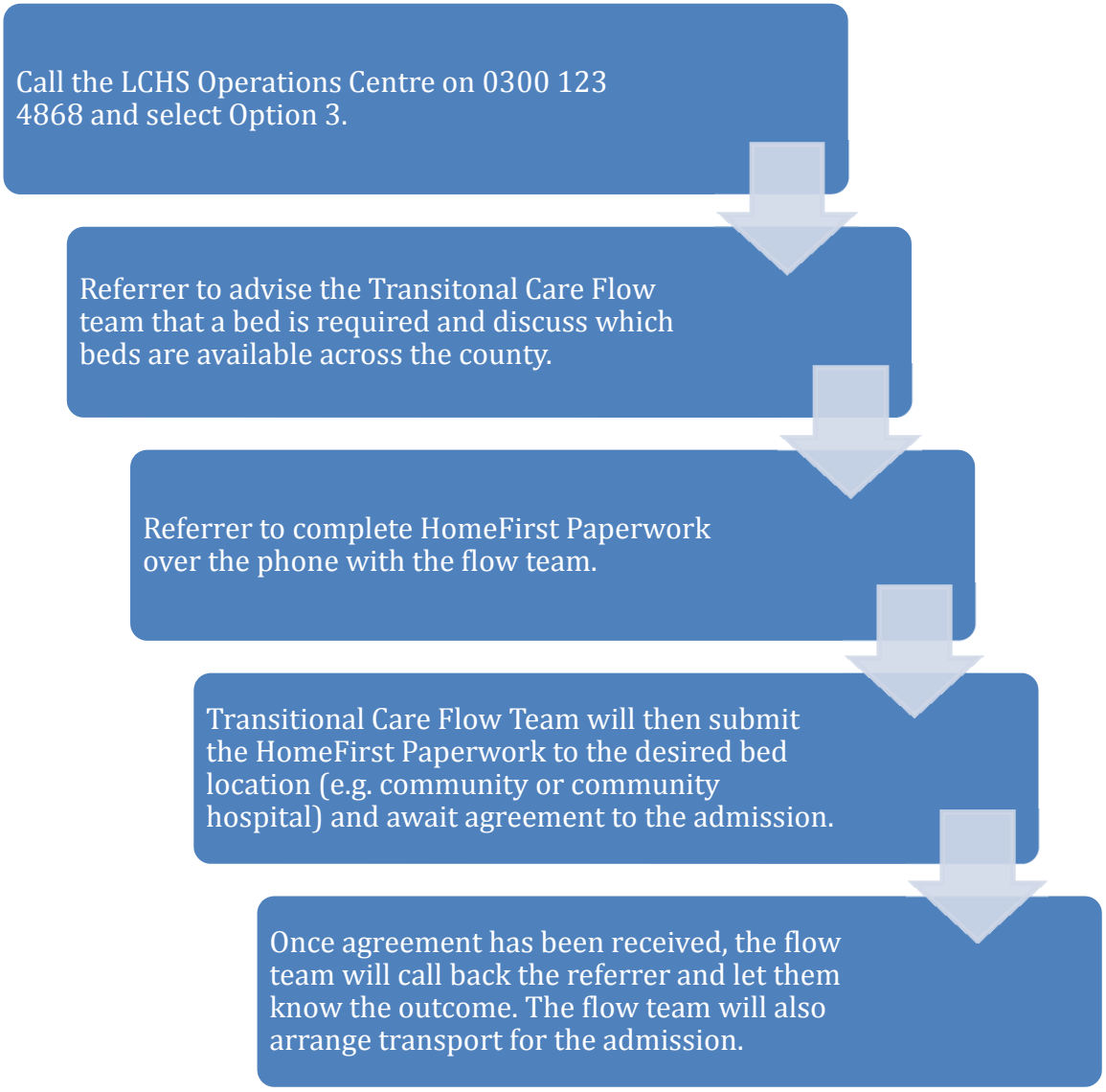
Transitional Care Bed Locations:

Location		Care Home Name	Number of Beds	Nursing or Residential?
Community	Gainsborough	Saxilby House	2	Residential
		Grosvenor House	2	Nursing
	Lincoln	Homer Lodge	13	9 x Residential 4 x Nursing
		Eccleshare Court	10	Nursing
	Wolds & Louth	Madeira House	3	Residential
		Nettleton Manor	3	Residential
		Fir Close	1	Residential
		Orchard House	2	Residential
	Skegness	The Old Rectory	3	Residential
	Grantham	Harrowby Lodge	4	Nursing
		Kings Court	2	Residential
	Sleaford	Roxholme	3	Residential
		Welbourne Manor	3	Residential
		The Five Bells	1	Residential
	Welland	Chevington House	3	Residential
		Digby Court	5	Residential
		Abbey Court	1	Residential
	South Holland	Holbeach Hospital	6	Nursing

Location		Ward	Number of Beds
	Louth Hospital	Carlton	22
	Skegness Hospital	Gloucester	24

	Skegness Hospital	Scarborough	12
	Gainsborough (John Coupland Hospital)	Scotter	21
	Johnson Community Hospital (South Holland)	Welland	20

Process for accessing Transitional Care Beds:



Appendix G

ADDITIONAL ACTIONS TO CONSIDER FOLLOWING THE COMPREHENSIVE ASSESSMENT

What is important to the patient?
What was the patient like two weeks ago? Is this normal for the patient or is this new?
Are they under any specialist services?
Do I need any prompt cards e.g. FOPS folder

Cognition	- Does the GP need to make a CPN referral? - Does the person have reduced insight into risky behaviours that could impact on their safety at home? - Will they remember to take their medication, drink enough fluid without prompt change position regularly, follow therapy recommendations etc? - Would any equipment be beneficial, e.g. keysafe, lifeline etc?
General Health	- What are the basic observations, NEWS etc? - How many admissions/contact with out of hours have they had this year? - Does Web V and care portal hold any valuable information? - What other co-morbidities have they got? - Who else are they know to? - What's the existing care an support planning? - Do they have EPaCC's - Identify any prognostic indicators, SPICT, Admissions in last year, Karnofsky or Bartel Score? - What's the phase of illness (see LCHS pathways)
Social Support	- Are there any family or friends that could provide support? - Do family friend need carers assessment are they coping are they frail? - Could another service provide support, e.g. the Wellbeing Service, Age UK etc? - Would 72 hours support from HART be appropriate, e.g. to collect medications, food, encourage fluid intake provide care etc? - Would they benefit from a referral to the Neighbourhood team?
Functional Independence	- Do they need a referral to social services (for long term care assessment and/or Occupational Therapy assessment of long term needs), Allied Healthcare (for short term care at home when person has rehabilitation potential) or HART (for an acute episode which requires up to 72 hours care)? - Could family/significant other support with care needs? - Do they need a referral for LCHS Community Therapy (see inclusion and exclusion criteria)? - Do they need information about private care or domestic support agencies? - Is there any Social care prescribing in the area or Neighbourhood team?

Functional Performance	- Are they taking any prescribed analgesia regularly? Could reduced pain improve their mobility? Can they verbalize Pain, Abbey pain score? - Are there any continence issues? - If there are any falls relating to substance abuse, would they benefit from a referral to the DART service? - Would they benefit from provision of a more supportive walking aid, e.g. they currently use a walking stick but would be steadier with a wheeled zimmer frame? - Would any other equipment be beneficial, e.g. chair raisers, toilet frame etc? - If the person is unable to follow prompts around safe transfers, could they realistically be managed safely by a care package at home? - Prompt cards? Eightsight , Hearing etc
Nutrition	- Does the GP need to make a community dietician or SALT referral? - Would a referral to the community nurses be beneficial? - Could you provide any advice about nutrition? - Food First
Mood	- Does the GP need to make a Community Mental Health Team referral? - Is there an element of social isolation which the Wellbeing Service or voluntary agencies could support with?
Continence	- What is normal for them? - Prompt cards? Look for constipation , how do the verbalize pain, - Caffine intake etc (Continence basic training) - Would a referral to the community nurses for a continence assessment be appropriate? - Is this a new problem? Could there be an acute infection causing incontinence? - Can they mobilise to the toilet? - Do they need equipment, e.g. commode, urine bottle etc? - Could you provide any advice about fluid intake?
Medication	- How many, needs review, Stop start, where is the nearest clinical pharmacist (falls prompt card)
Falls	- Could they be dehydrated? - Is an infection causing reduced balance, increased confusion etc? - Have we checked their ears for ear wax? - Do they need a referral for LCHS Community Therapy (see inclusion and exclusion criteria)? - Do they need a referral to social services for an Occupational Therapy assessment of long term needs? - Is the patient making risky choices and would benefit from advice and discussion around these? - Do they need a more supportive walking aid? 17.2. See falls prompt card?
Environmental Assessment	- Is there evidence of hoarding? Would a referral to social services or the Lincolnshire Fire and Rescue Service be appropriate?

	- If the person is struggling to manage their finance and pay their bills, would they benefit from a referral to Age UK or the Citizens Advice bureau? - Do they need a referral to social services for an Occupational Therapy assessment of long term needs? - Are there changes you can make while you're there to reduce trip hazards? E.g. removing trailing wires, loose mats, clearing walkways etc (with patient consent). - Would they benefit from provision of any equipment, e.g. toileting equipment, commode, bed lever etc?
Physical Examination	- History taking is 80% of your assessment 20% is physical examination - Baseline observations NEWS , lying standing B/P - See attached do or do not admit flow chart - What co-morbidities does the person have follow NICE guidance - Head to toe examination - What is normal for them? - Know your RED flags (Symptom sorter) - Who else is involved is this new

Appendix H

Referral Details

Organisation	Services Available	Contact Details/ Referral Process
HART	Short Term care (up to 72 hours)	01522 308969
Lincolnshire Reablement Service (Allied)	Short term care where there is rehabilitation potential	01775 760283
Lincolnshire Customer Services Centre (Lincolnshire County Council)	Assessment for long term care needs. Occupational Therapy input for long term needs.	01522 782155
Lincolnshire Community Health Services Operations Centre	Adult Community Therapy (Physiotherapy and Occupational Therapy)	0300 123 4868
Lincolnshire Partnership Foundation Trust Single Point of Access (SPA)	Mental health triage and assessment	0303 123 4000
Wellbeing Service	Service to enhance wellbeing, delay escalation to statutory services and provide support to access community resources inc. small aids and adaptations.	01522 782140
Neighbourhood Teams (Spalding)		
Neighbourhood Team (Boston)		
Carers First	Provides emotional and practical support, advice, information and guidance for carers.	0300 303 1555