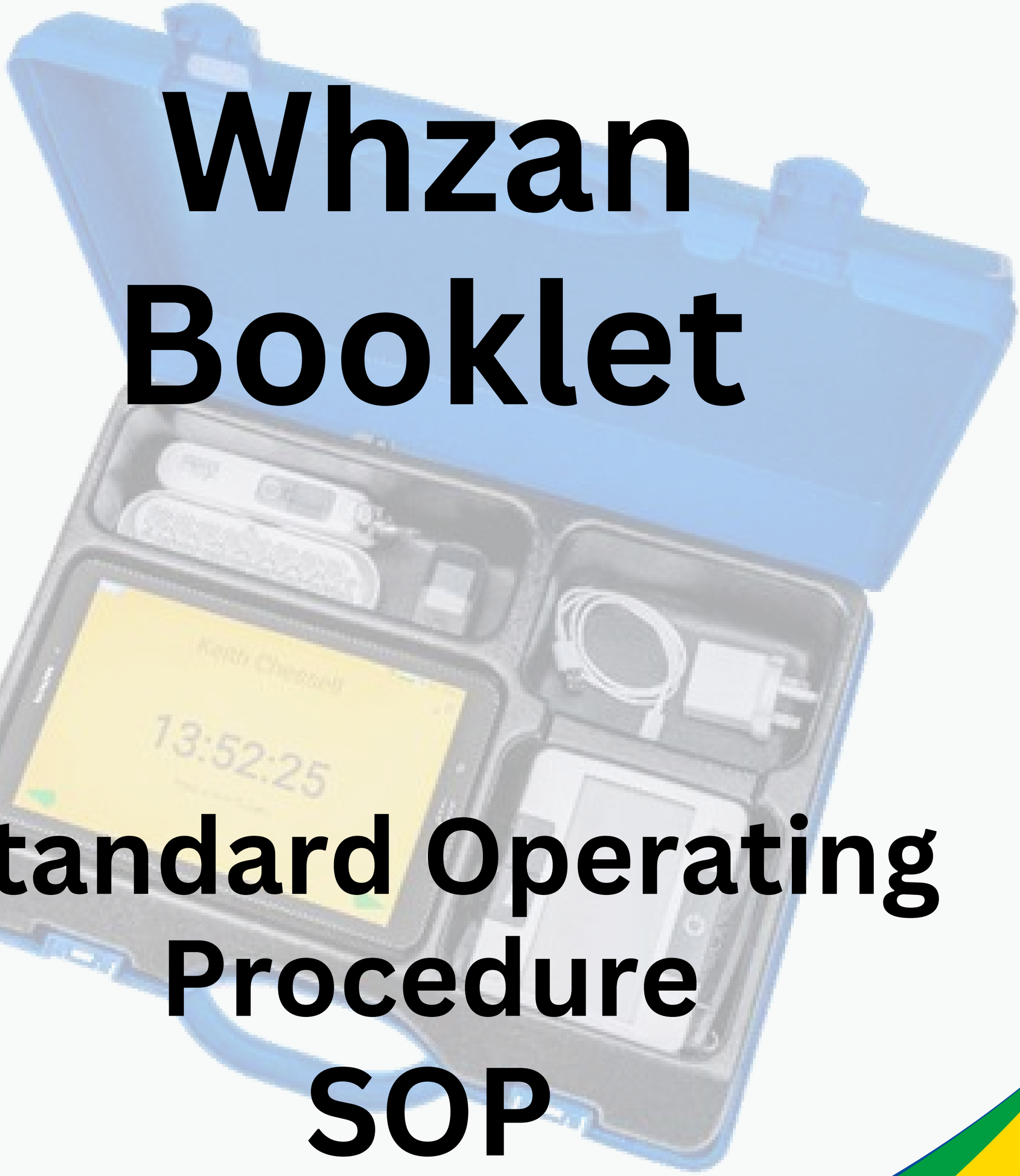
CareinLincs
Digital

Whzan Booklet



Standard Operating Procedure

SOP

LINCOLNSHIRE ICB

WHZAN

STANDARD OPERATING PROCEDURE

FOR CARE HOME

Contents

Definition of key terms:	
Care Home	Residential with or without nursing interventions.
Cloud based system	A place where shared information is stored and shared with other professionals.
Digital Tablet	A wireless portable personal computer with touchscreen.
Health and/or Care Professional	This would cover a range of health and /or care professionals across Lincolnshire including Professional Care Worker/s, GP, Nurses, Geriatrician, Dietician, pharmacist, paramedic, occupational therapist, and physio therapist.
Infection Prevention and Control (IPC)	Team to help you meet CQC requirements, reduce healthcare associated *infection* and hospital admission.
Lincolnshire Care Association (LinCA)	LinCA is a not-for-profit organisation supporting adult care providers of Domiciliary Care, End of Life Care, Learning Disabilities, Mental Health, Nursing Homes, Residential Care Homes, and Supported Living within the independent and voluntary sectors in Lincolnshire.
Lincolnshire ICB - Integrated care board	An NHS organisation which commissions health services for the population of Lincolnshire.
Multi-Disciplinary Team	Collection of professionals from all sectors of health and social care to care plan patient needs from a holistic approach.
MUST– Malnutrition Universal Screening Tool	A 5-step screening tool to identify adults who are malnourished, at risk, or are obese.
NEWS2 - National Early Warning Score	A combination of 6 physiological measurements that determine clinical risk (NEWS2 table utilised)
Resident	An individual residing in the Residential/Nursing Home setting.
SBARD - Situation, Background, Assessment, Recommendation and Decision	SBARD consists of standardised prompt questions in five sections to ensure that staff are sharing concise and focused information. It allows staff to communicate assertively and effectively, reducing the need for repetition and reducing the likelihood of error.
SOLCOM	Whzan supplier.
Telehealth	A solution providing a means of collecting health information about residents using telecommunications to transmit the information. May be used to manage long term conditions.
Whzan	Name of the telehealth kit.

1. Introduction

The objective of this standard operating procedure is to provide guidance on the introduction and operational process of using Whzan, telehealth digital solution, within Care Homes and with the EHCH MDT.

The Whzan telehealth kit should be used as per the agreed pathways (see 1.2, 1.3 and 1.4).

This telehealth kit is for information and support only. If you experience a medical emergency, please contact the Clinical Advice Service for Care Homes (CASfCH) or call 999. Care Homes should refer to the Care Home Information Pack (CHIP) for more information, on when to use LCHS CAS – the Clinical Assessment Service for Care Homes. A copy of the CHIP can be found in the appendices.

Consent must always be given, where consent cannot be given mental capacity assessment must be completed.

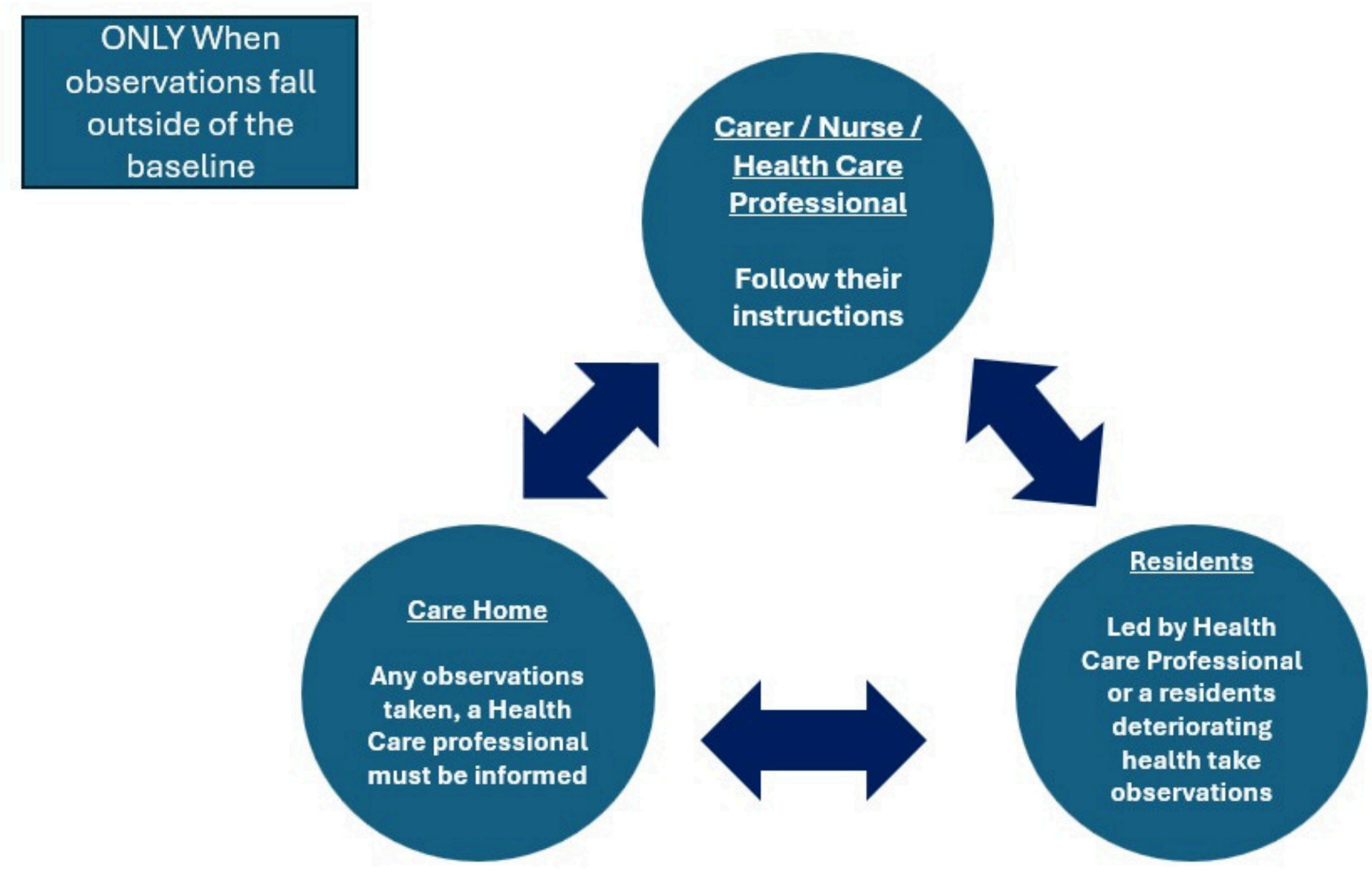
Observations may be recorded by Health and/or Care Professional under either the Baseline Pathway or the Review Pathway.

Following capture, observations will be assessed against the individual's agreed parameters. Where observations fall within these parameters, no escalation is required. Where observations fall outside of parameters, or if there are concerns, appropriate escalation should be undertaken in line with the Whzan escalation pathways.

Please refer to the SBARD (Situation, Background, Assessment, Recommendation and Decision) pathway diagram (Appendix 4) for guidance on how to make a referral via the Single Point of Access for clinical triage and onward allocation to the appropriate service.

In End of Life Care, where a Registered Health Professional has assessed the individual and, following discussion with the resident and/or their next of kin, determined that routine observations would not support comfort or care, a clinical decision to omit observations must be clearly documented within the persons record and communicated with the care team.

1.1 Pathways

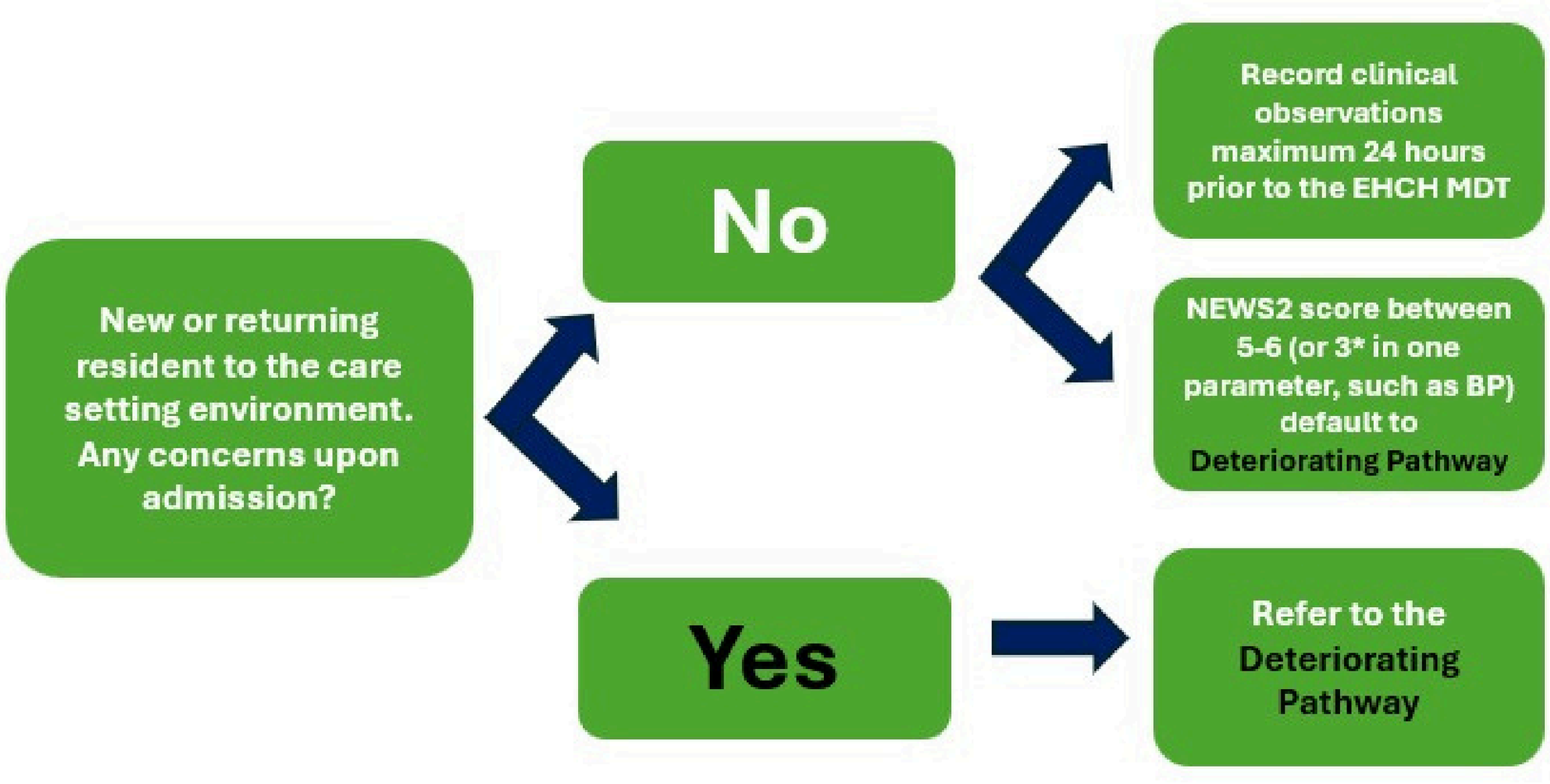


The pathway triangle can start at any point and flow in either direction.

1.2 Baseline Pathway - To record any essential health observations on a new resident or a residentreturningfromrespite or hospital. The baseline must be established maximum of 24 hours before MDT.

Any ReSPECT plan or Advance Care Plan in place must be followed.

On admission, the Baseline Pathway (below) should be initiated, during which initial observations are recorded to establish the individual's baseline. At this point, the frequency of ongoing observations will be agreed, in line with individual's care plan or care home policy.

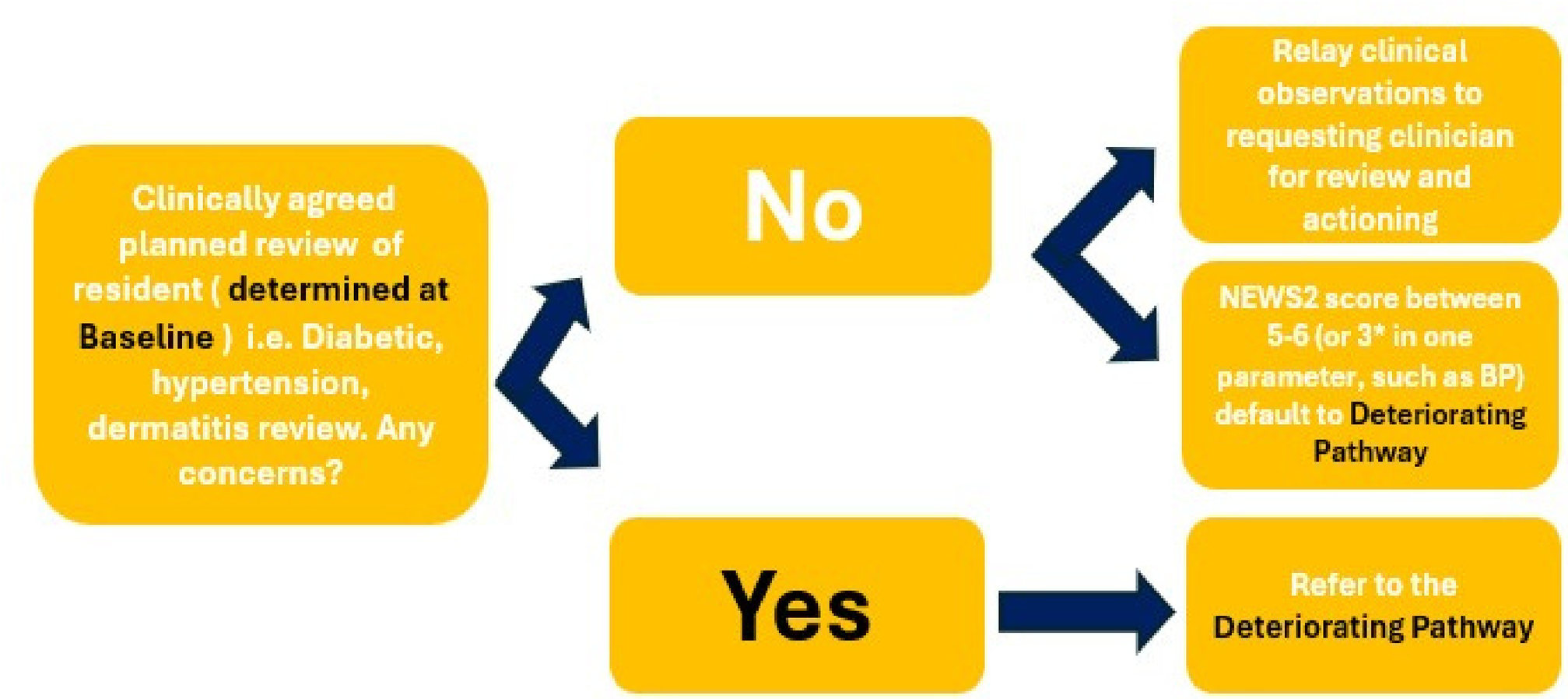


**Note locally agreed bespoke parameters for residents defined by Health and/ or Care Professional which will exclude them from escalation to Deteriorating Pathway i.e. COPD patients*

Any ReSPECT plan or Advance Care Plan in place must be followed.

1.3 Review Pathway, clinically agreed review between the Care Home and PCN. For example, annual diabetic review, newly commencing medication, hypertension review

Carer to advise Health Care Professional clinical observations are to be reviewed remotely as part of SBARD discussion.



Examples: Health and/or Care Professional request daily BP to enable reviewing potential hypertension or monthly BP to monitor as proactive care and monitoring where a resident has been commenced on regular hypertension medication.

CAS for Care Homes (CASfCH) operatives (clinical staff) have access to the Whzan Dashboard and can access observations taken by Care Home staff, access historical data, support clinical decision-making and monitor resident outcomes.

*Note locally agreed bespoke parameters for residents defined by Health Care Professionals which will exclude them from escalation to Deteriorating Pathway i.e. COPD patients

Any ReSPECT plan or Advance Care Plan in place must be followed.

1.4 Deteriorating Pathway To seek clinical advice if a Care Home resident's health is showing signs of deterioration, using SBARD and Whzan to provide information to support the reviewing clinician's decision. For example, CAS, 999.

As part of the deterioration pathway, care home staff should escalate concerns by advising the relevant Health Care Professional that clinical observations are ready to be reviewed remotely, to support an SBARD discussion.

*Note locally agreed bespoke parameters for residents defined by Health Care Professional which will exclude them from escalation to Deteriorating Pathway i.e. COPD patients

CASfCH clinical staff have access to the Whzan dashboard, enabling them to view care home recorded observations and access historical data trends. This facilitates informed clinical decision making and supports the delivery of appropriate and timely resident outcomes.

Any ReSPECT plan or Advance Care Plan in place must be followed.

1.5 The use of Whzan should not replace existing escalation protocols or the Care Home Information Pack for unwell residents who require urgent attention.

Ensure that the clinical observation parameters of each person are reviewed and set to meet their own personalised care and support plan in the management of their long-term condition(s). The plan will be devised as part of their initial admission to the care home under pathway one, in conjunction with the relevant specialists involved i.e. Heart Failure/Respiratory Nurse Specialists.

Any ReSPECT plan or Advance Care Plan in place must be followed.

2. Purpose and Vision

2.1 The purpose of this Whzan SOP is to introduce Whzan into the Health and Social environments to enhance collaborative working; to ensure a standardised assessment of people to manage deterioration; to improve clinical outcomes and support decision making.

2.2 To provide guidance on how to implement Whzan, to standardise delivery and audit in the following areas:

- User training and maintenance of competencies
- User remote access and responsibility to review data
- Governance i.e., IPC
- Use and maintenance of equipment
- Assessment tools i.e., NEWS2
- Escalation pathways

3.Outline of the digital tablet and cloud-based software

3.1 The Whzan digital tablet incorporates software that can be used to monitor people's health and wellbeing. The tablet is provided with observational equipment and the hardware is supported by Knox mobile secure software, enabling remote support access and tracking, including the following:

- Sp02 Monitor (Oximeter) including Heart rate
- Blood pressure monitor including Heart rate
- Thermometer (requests for additional thermometer caps can be made to- LinCA or Solcom) _

3.2 Whzan has Bluetooth capability that transmits the readings directly to the tablet. Respiration rate observations need to be carried out manually; or automatically using the new Oximeter, with relevant training provided by SOLCOM and/or LinCA (section 6).

The tablet has the following elements incorporated within it:

- SBARD - Situation, Background, Assessment, Recommendation and Decision

- NEWS2 - National Early Warning Score
- MUST - Malnutrition Universal Screening Tool

Other tools could be used, as clinically required, E.g. Abbey Pain Score, Is My Resident Unwell. Please contact the Remote Monitoring Lead for further details on these tools.

3.3 SBARD: Situation - Identify yourself, Identify the resident/client by name and the reason for the call, Describe your concern. Background - What long-term illness does the resident/client have? Provide a list of current medication. Assessment - What are the resident/clients' vital signs, NEWS2 score and other relevant information? What actions (if any) have you taken already?

Recommendation - Explain what is needed – be specific about request and time frame.

Decision - What, When and How any decisions have been agreed based on the S-B-A-R, write down any instructions and remember to add a time and date when they had been requested, document any actions undertaken. SBAR-Implementation-and-Training-Guide.pdf

3.4 NEWS2: Uses six physiological measurements to determine the level of risk, as follows:

1. Respiratory Rate
2. Oxygen Saturations
3. Systolic Blood Pressure
4. Pulse Rate
5. Level of Consciousness or new confusion
6. Temperature

NHS England » National Early Warning Score (NEWS)

A score is allocated to each parameter as they are measured, with the magnitude of the score reflecting how extreme the parameter varies from the norm. The score is then aggregated and uplifted by 2 points for people requiring supplemental oxygen to maintain their recommended oxygen saturation.

This is a pragmatic approach, with a key emphasis on system-wide standardisation and the use of physiological parameters that are already routinely measured in NHS hospitals and in prehospital care, recorded on a standardised clinical chart.

This score is shared with a Health Care Professional so that early recognition of a deteriorating resident is established, and the appropriate support is given.

Further detail on the National Early Warning Score (NEWS) 2 scoring process and escalation thresholds can be accessed via the Royal College of Physicians website via the link below:

National Early Warning Score (NEWS) 2 | RCP

3.5 MUST: MUST Is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan and can be used by all care workers.

Clinical Outcomes of MUST: promotes multidisciplinary care and responsibility, with consequent improvements in clinical outcomes. Early recognition of malnutrition risk, or deterioration in nutritional status and appropriate care pathway to ensure risk factors are acted upon.Better nutritional care for patients, resulting in reduction in the health risks associated withmalnutrition.
Malnutrition Universal Screening Tool (MUST) :: Blackpool Teaching Hospitals

3.6 Once all information is uploaded to Whzan cloud-based system, Care Home staff andprimary care / PCN colleagues responsible for the person's care can access the information by loggingonto the web-based portal using their log in details and a secure password provided.

Login details are provided by LinCA, along with training guides, as part of the initial induction.

4. Roles and Responsibilities

4.1 The Derby & Derbyshire, Lincolnshire, and Nottingham & Nottinghamshire (DLN) ICB cluster provide oversight of the Whzan Programme, including ongoing support to enable delivery of remote monitoring objectives.

4.2 Care Home Staff

It is the responsibility of Care Home staff to:

- Care Home Manager is responsible for ensuring the necessary staff have access to a log in and training to use the Whzan toolkit
- Book staff onto training with SOLCOM and or LinCA
- Maintain professional care competency
- Adherence to the pathway escalation process
- Ensure the kit is maintained, preventing avoidable damage and PAT test as required
- Complete necessary IPC audits
- Should follow their incident reporting process as and when required.

4.3 Clinical Health Care Professional

It is the responsibility of clinical Health Care Professionals whether as part of the MDT or as the triaging clinician of which a Whzan pathway is be utilised to:

- To discuss new residents admitted to the Residential Home setting via the EHCH MDT
- Review the resident's baseline Whzan clinical readings
- Complete medication review accordingly
- Make appropriate onward referral to maintain resident's needs/wishes

- To negotiate agreed reviews with Care Home colleagues for ongoing Whzan monitoring
- Set bespoke parameters for Resident's clinical observations i.e., COPD Resident's
- Provide clinical guidance on Resident's who can be excluded i.e., End of Life
- Review the Whzan data remotely for confirmation of reading and calculate NEWS2 score to assist in clinical judgement and escalation. It's not the HCP's responsibility to regularly monitor the dashboard (although they may choose to do this). It's their responsibility to review readings when they alerted that they need to be reviewed.

4.4 LinCA (in line with the agreed MOU)

It is the responsibility of LinCA to:

- Act as a single point contact for non-clinical Whzan enquiries via the Helpdesk Team at CareinLincs Lincolnshire Care Association. Contact details as follows: Telephone: 01522 581073. Email: helpdesk@linca.org.uk Website: www.careinlincs.co.uk www.linca.org.uk
- Organise training and support providers where required
- Assist with the delivery and onboarding of Whzan

5. Governance

5.1 The equipment and operational aspect of the tablet have been quality and risk assessed by SOLCOM - The equipment is calibrated, and CE marked demonstrating adherence to quality standards. It comes with a 12-month statutory guarantee.

5.2 Care of the Whzan Telehealth Kit

For details on how to clean the kit see appendix A3

5.3 It is essential that the data collected is stored in a safe manner, in accordance with the Data Protection Act 1998.
5.3.1 The Whzan cloud-based system is built, in accordance with this Act and provides a secure portal for all resident information.
5.3.2 Information should only be shared with those authorised to receive that information including the Health Care Professional listed in section 4 of this document.
5.4 Compliance in using the Whzan kit will be monitored periodically via Whzan training and support sessions.

6. Training

6.1 A suite of training resources has been developed and incorporates how to onboard, train and use the Whzan kit to support and manage deterioration.

6.2 LinCA and Solcom provide a blend of face to face and virtual training from induction to more advanced support in the use of Whzan. Booking can be made via LinCA, see section 4.4 for contact details.

6.3 The employer must ensure that staff who are using Whzan must be sufficiently trained with proven competencies in recording observations.

6.4 If Whzan observations fall outside the person's agreed parameters, follow the deteriorating pathway in section 1.4.

6.5 Staff should use the equipment every 28 days to ensurethat their competence is kept up to date, this can be done by staff taking other staff members readings as part of the "Know your numbers" program (Website links below), if a resident's observationisnot required.
https://www.nhs.uk/conditions/blood-pressure-test/

~~Know your numbers (Blood pressure UK)~~

7. Managing Equipment

7.1 Delivery of equipment to Care Homes and support to all stakeholders is provided by SOLCOM and LinCA.

7.2 Equipment should be stored, when not in use in the blue storage case, in the nominated secure area, dry and not damp, preferably a locked room, and plug the external power cable into the case to ensure the tablet is charged for the next use, only use the power connector provided.

7.3 Always store or transport the instruments in the blue storage case, avoid dropping or heavy impact, avoid direct sunlight and high humidity, once a reading has been taken, please return the instrument to the case

7.4 Equipment should be cleaned in line with infection control detailed in section 5.2 of this document, and appendix A3.

7.5 Equipment faults and breakages – this must be reported directly to LinCA. Care Homes that cause damage to any equipment provided through mishandling are liable for repair/replacement costs which vary depending on the part damaged.

7.6 Battery life – medical devices require replacement batteries (AA and AAA). These need to be supplied at the cost of the Care Home.

Resources

[Whzan Guides Version 2]
[Whzan Guides Version 3]
[Digital Guides]
[LinCA Events]
[LinCA Training]
[LinCA Webinars]

Email helpdesk@linca.org.uk for more information and support