Appendix to Cambridgeshire Community Services NHS Trust (CCS NHS Trust) Intravenous Therapy Policy 2.0

Version 1 Final Draft (18)

Luton Adult Services - Admission Avoidance Clinical Pathways for Primary Care

Document Owner : Tracy Fitzsimmons Programme Manager – Frailty - CCS		
Medicines : Ann Darvill Principal Pharmacist & Medicine Safety Officer **-** CCS		
Developed In consultation with :		
Name	**Title**	**Organisation**
Vicki Brookes	Nurse Specialist / Team Lead Tissue Viability	CCS
Bridget Elliot	Programme Manager Long Term Conditions	CCS
Marion Eaton	Lead Nurse Specialist Palliative Care	CCS
Russell Foulsham	Community Health Services Pharmacist	CCS
Beverley Green	Nurse Specialist Catheter Care	CCS
Penelope Gazeley	Programme Manager- Frailty	CCS
Petrina Kaye	Service Manager Rapid Response	CCS
Ann McHugh	Senior Sister Rapid Response	CCS
Maria Mclaughlin	Lead Nurse Integrated Nursing	CCS
Carly Morrison	Nurse Specialist Tissue Viability	CCS
Lisa Parrish	Service Manager Integrated Community Nursing	CCS
Susan Phillips	Nurse Specialist Heart Failure	CCS
Jo Robertson	Lead Nurse Specialist Respiratory	CCS
Abbe Robertson	Clinical & Professional Development Lead	CCS
Jacqueline Shortall	Senior Sister Rapid Response	CCS
Sally Shaw	Lead Nurse Community Liaison/CHC	CCS
Ruth Tilley	Nurse Specialist Heart Failure	CCS
Liz Webb	Deputy Chief Nurse	CCS
Lauren Yearwood	Senior Sister Rapid Response	CCS
Haydn Williams	GP – Sundon Medical Centre/Network Director	Primary Care
Baz Barhey	GP- Woodland Ave / Network Director	Primary Care
Chirag Bakhai	GP / Deputy Chair LCCG	GP/LCCG
Peter Albert	Lead Consultant for Acute Medicine	L&DNHST
Carly Blackwell	Senior Sister – Clinical Navigation	L&DNHST
Dr Kumar	Consultant Cardiologist	L&DNHST
Emily King	Transformation Lead for Integration	L&DNHST
Dr Rohinton Mulla	Consultant Microbiologist	L&DNHST
Vanda McGibbon	Matron – Navigation / Hospital at Home	L&DNHST
Dr James Ramsey	Medical Director /Respiratory Consultant	L&DNHST

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1.0 INTRODUCTION

Recent evidence and guidance recognises that patients can fare better if treated in their usual place of residence, even if the required treatment involves the administration of intravenous medicines.

The purpose of this appendix is to:

- Describe the role of CCS NHS Trust Staff within the multi-organisational pathways to provide safe, consistent pathways that support the provision of Intravenous (IV) therapy to patients outside of the acute setting requiring treatment for uncomplicated cellulitis, uncomplicated respiratory tract infections such as exacerbation of chronic obstructive pulmonary disease (COPD), urinary tract infection (UTI) or exacerbation of chronic heart failure.
- Provide evidence-based guidance to support healthcare staff to provide a safe and effective service and support service developments within the Trust.
- Provide pathways that offer an alternative to hospital admission and support early discharge.
- Provide a better experience for patients and carers, aim to ensure people receive the right, care, at the right time, by the right team and in the right place.
- Support people when their condition becomes more advanced and enable them to have a choice to remain at home.
- Describe how these pathways are designed to support primary care admission avoidance for those patients who are otherwise medically fit, and can be treated in the community as an alternative to hospital admission, while remaining under the care of their GP.
- Describe the pathway for patients who may have an acute or more complex health concern, but can be managed safely in community setting, provided the expertise of a hospital consultant is available to them.
  N.B Honorary contracts with the Trust are in place for named Luton and Dunstable Hospital consultants.
- Describe the pathway for patients who may require IV therapy, who require more intensive monitoring and specialist outreach medical management, for whom management by GP care alone is not appropriate, and who require consultant involvement.
- Describe how and when patient reviews should be undertaken by the professionals involved.
- The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

1.1 The IV team

Members of the IV team will vary from patient to patient, and may consist of the following:

- CCS NHS Trust “One Service” including the Rapid Response (RR) team, Specialist Nurses

- L&DNHS Trust Consultants – Enhanced models of care (Honorary contracts in place)
- General Practitioners
- Consultant microbiologist, Luton & Dunstable Hospital
- Designated community pharmacies

Contact details are held by the Rapid Response Team

2.0 GENERAL PRINCIPLES

- The Trust Intravenous Therapy Policy applies throughout, including the “Criteria for IV Therapy”.
- Administration of IV medicines should be performed in accordance with the Trust Standard Operating Procedure for Preparing and Administering Intravenous Medicines, MMSOP029.
- In all circumstances requiring consultant involvement, the Standard Operating Procedure for IV Therapy Initiated by Hospital Consultant, Administered by Rapid Response (5.1 in this document) should be followed.
- Choice of Antibiotic: The pathways include recommendations based on current guidelines – prescribers should always refer to the most up to date Antimicrobial guidelines seeking advice from the local hospital microbiologist as required.
- Microbiology advice can be sought by any professional within the IV team including the Rapid Response or Specialist Nurse dependent on the clinical situation and clinical discussion/ treatment plan.
- Following Referral the Rapid Response Team will undertake holistic assessment and care planning. The team will commence the prescribed treatment and ongoing monitoring as per local protocols according to the Referral Treatment Plan (5.5).
- IV antibiotics should be reviewed regularly and stepped down to oral treatment as soon as appropriate.
- When clinically indicated IV therapy in the community can be considered as part of personalised care and support planning / admission avoidance care planning ,

2.1 Special circumstances

Any other patients requiring IV Therapy may be considered eligible and accepted onto a pathway by CCS NHS Trust after discussion with and review by the consultant or GP together with the Senior RR Nurse on duty.

2.2 Treatment location

IV therapy can be administered in the patient’s usual place of residence (including residential and nursing homes) or in an identified Step-up bed in an identified nursing or residential home.

2.3 Clinical responsibility and Review

- The patient will remain the clinical responsibility of the prescribing medical clinician. This may be the GP or consultant, following discussion, and must be documented in the patient's records.

- Relevant results will be available on ICE and monitoring support and guidance can be sought from the consultant, GP, microbiologist as needed.
- The Visiting Nurse / Professional must raise any concerns; seek advice regarding patients' response to treatment with the consultant or GP as appropriate.
- Patient reviews should be organised on initiation of treatment and as needed throughout the course of treatment. These clinical conversations can be conducted face to face or remotely depending on the clinical situation and patients' clinical needs. This can include seeking telephone advice from the patients GP or joint home visits between the consultants with honorary contracts and the CCS Nurse involved in monitoring the patient.
- IV Antibiotic therapy must be reviewed after 48hrs in conjunction with the medical prescriber – with a decision to continue or step down to oral treatment. This can be conducted remotely or face to face depending on clinical need.
- Patients will be reviewed in accordance with the relevant pathway, with the support of specialist teams as appropriate

2.4 Prescribing

- Prescriptions will be completed by the prescribing consultant, Rapid Response nurse (within their scope of practice and competence) or GP responsible for the patient's care and treatment plan.
- Medicines can be dispensed at the local designated pharmacy; four pharmacies in Luton hold an agreed stock list for IV therapy. The list of routine stock and locations are listed in the Trust Medicines Management SOP029, Preparing and Administering Intravenous Medicines (Rapid Response Team's locally completed version).
- The Rapid Response Team will liaise with the local designated pharmacy/ prescriber and patient to arrange the supply of medicines
- Any item not held as routine stock will need adequate notice to be provided to the community pharmacy.

2.5 How to refer a patient

Patients can be referred using the existing Rapid Response Referral Route –

- Contact the Rapid Response single point of contact :

  03334053000 – 8am to 6pm to discuss the referral agree the Treatment plan and confirm Rapid Response Team capacity.

3.0 MONITORING & AUDIT

- Monitoring must be conducted in accordance with the Intravenous Therapy Policy.
- In addition to this, managers must monitor and review systems to ensure compliance with these pathways.
- Where monitoring identifies deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

3.1 Review of Pathways

- Review of this Appendix at the end of the testing phase will be undertaken by the Frailty Project Team / Programme Manager.
- Ongoing responsibility for review of the pathways will be confirmed by the Frailty Project Team / Programme Manager. Following conclusion of the testing phase.

4.0 CLINICAL PATHWAYS

4.1 COPD

4.1a Factors to consider when deciding where to treat the Adult person with exacerbation of COPD

Factor	Treat at home	Treat in hospital
Able to cope at home *	Yes	No
Breathlessness	Mild	Severe
General condition	Good	Poor/deteriorating
Level of activity	Good	Poor/confined to bed
Cyanosis	No	Yes
Worsening peripheral oedema	No	Yes
Level of consciousness	Normal	Impaired
Already receiving long-term oxygen therapy	No	Yes
Social circumstances *	Good	Living alone/not coping
Acute confusion	No	Yes
Rapid rate of onset	No	Yes
Significant comorbidity (particularly cardiac disease and insulin-dependent diabetes)	No	Yes
SaO_2 <90%	No	Yes
Changes on chest radiograph **	No	Present
Arterial pH level **	≥7.35	<7.35
Arterial PaO_2 **	≥7 kPa	<7 kPa
** Can consider access to Step up Bed pathway via Rapid Response Team as alternative to hospital admission for patients requiring additional social support and not able to manage at home.*		
****** this indicator may not be relevant in community setting unless patient has been assessed in Acute setting e.g. A&E /ARAS*		

NICE (2018a). *Chronic obstructive pulmonary disease in over 16s: Diagnosis and management* Available From: **https://www.nice.org.uk/guidance/ng115**

4.1b COPD PATHWAY

Adult over 18 presents with suspected: infective exacerbation of COPD

History and examination support diagnosis
A sustained acute-onset worsening of the person's symptoms from their usual stable state, which goes beyond their normal day-to-day variations. Commonly reported symptoms are worsening breathlessness, cough, and increased sputum production and change in sputum colour. The change in these symptoms often necessitates a change in medication.

Ensure the following:

- Inhaler regime and technique correct
- Consider adding mucolytic, especially if chronic productive cough with sputum
- Ensure benefit-review of ongoing need
- Nutritional assessment
- Smoking cessation
- Flu and pneumococcal advice check vaccinations up to date
- Consider referral to the community respiratory nurse for review
- Consider referral to pulmonary rehab
- Provide information leaflet on COPD exacerbations

Haemodynamically Unstable / Red flags

Assess and check signs and symptoms using local NEWS 2 / SEPSIS TOOL and consider RED FLAG symptoms that may indicate same day referral to hospital e.g.

- **Profound shortness of breath**
- **Inability to complete sentence**
- **Peripheral or central cyanosis**
- **Drowsy**
- **Confusion**
- **Rapid onset of symptoms**

Admission to hospital
Mon - Fri 8.00 – 18.30
Contact GP Liaison Service
01582 297234

Or

Consider referral to the Hospital Acute Respiratory Assessment Service (ARAS) via 07535977268
Available 8am to 4pm Monday to Friday

First choice intravenous antibiotic choice if unable to take oral or severely unwell (*consider local Microbiologist review & Guidance)*

- Amoxicillin 500 mg three times a day (see BNF for dosage in severe infections)
- Co-amoxiclav 1.2 g three times a day
- Clarithromycin 500 mg twice a day
- Co-trimoxazole 960 mg twice a day (see BNF for dosage in severe infections)
- Piperacillin with tazobactam 4.5 g three times a day (see BNF for dosage in severe infections)

Second choice intravenous antibiotics:

- Consult local microbiologist (guided by sensitivities)

www.nice.org.uk/guidance/NG114

Refer to Rapid Response Team (SOP 5.1)

If IV Therapy commenced consider changing back to orals at 48 hours

Agree plan for ongoing monitoring

Haemodynamically stable / No red flags

Start first line antibiotic therapy and steroids utilising
Local Antimicrobial Guidelines
https://www.gpref.bedfordshire.nhs.uk/referrals/bedfordshire-and-luton-joint-prescribing-committee-(jpc)/jpc-guidelines/antimicrobial-guidelines.aspx

Optimise treatment by increasing short-acting Bronchodilator for the duration of the exacerbation e.g. 2-8 puffs up to 4 hourly.

No improvement 2-3 days or sooner if deterioration

Red flags

No red flags

Investigations: FBC, U&E, CRP, CXR, Sputum culture
Consider if early referral to Rapid Response indicated.
Start 2nd line oral antibiotic therapy; or
3rd line oral antibiotic therapy;
In accordance with local Antimicrobial Guidelines
https://www.gpref.bedfordshire.nhs.uk/referrals/bedfordshire-and-luton-joint-prescribing-committee-(jpc)/jpc-guidelines/antimicrobial-

MONITOR DAILY OR AS PER CARE PLAN

Red flags

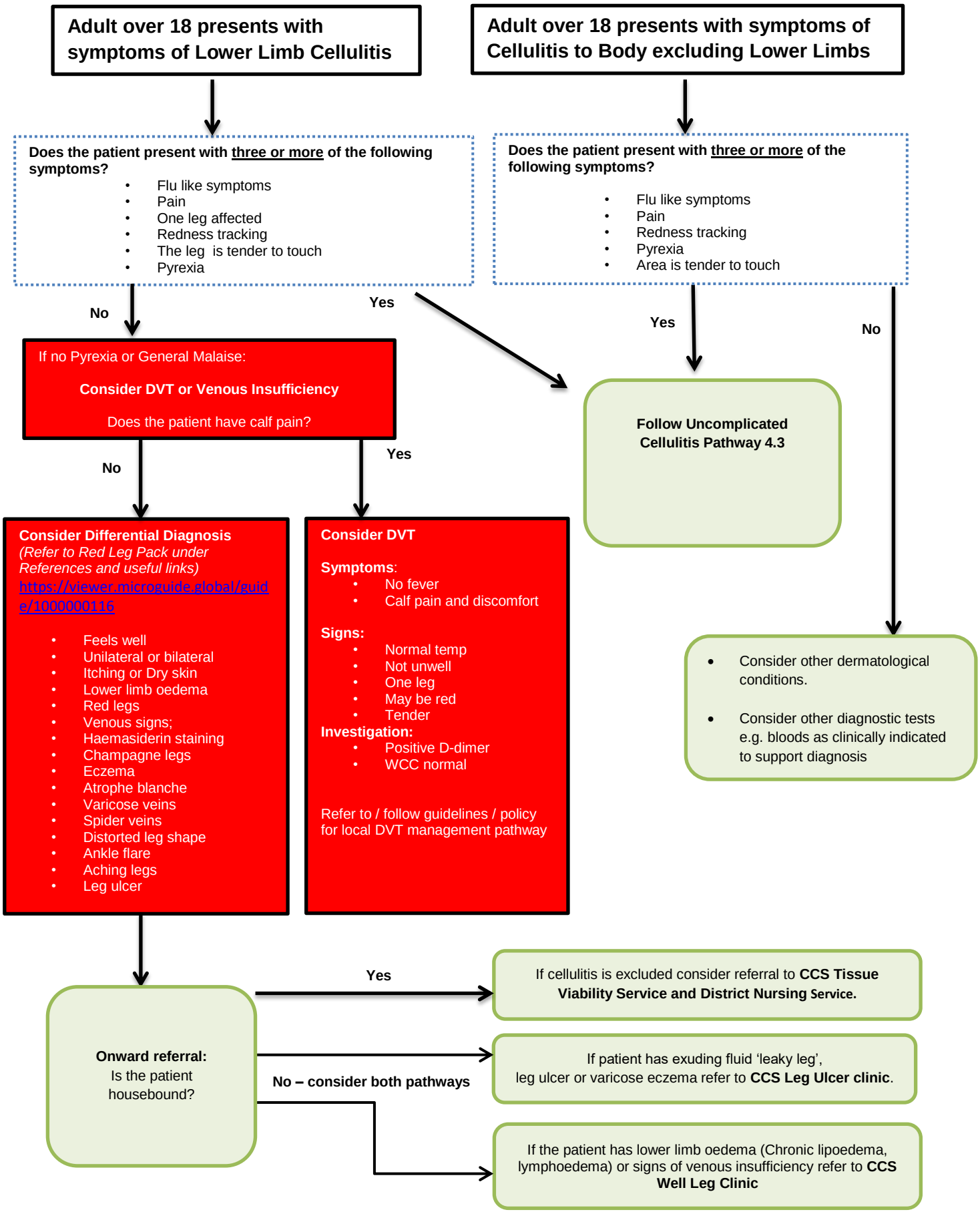
No improvement in 2-3 days or sooner if deterioration

No red flags

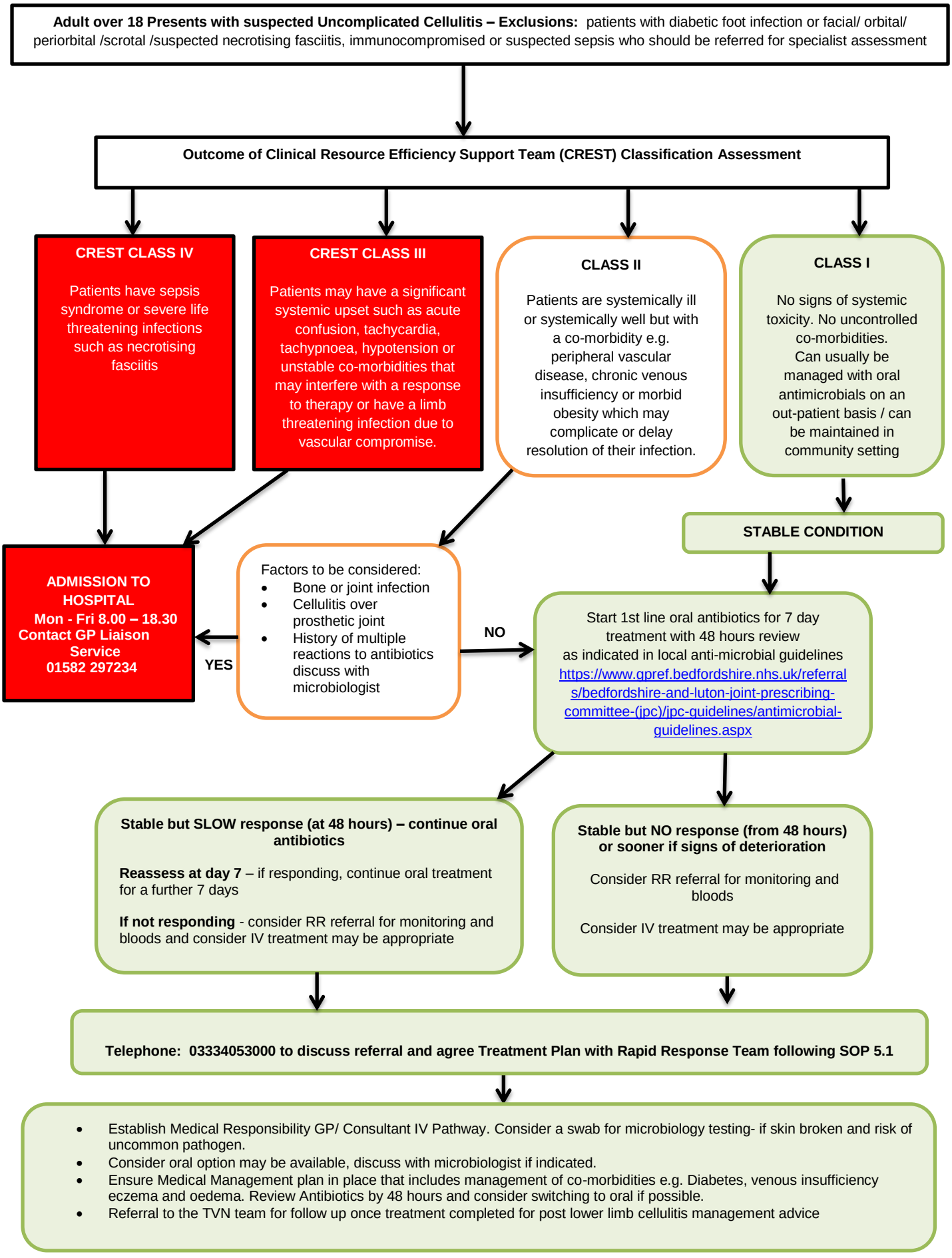
Review by consultant and respiratory nurse to consider continuing treatment in community with reference to clinical factors (4.1a)

Consider referral to Rapid Response Team for monitoring and /or IV Therapy provision

4.2 Suspected Cellulitis Pathway



4.3 Uncomplicated Cellulitis Pathway



4.4 Urinary Tract infection Pathway for Community teams

DO NOT DIAGNOSE UTI USING URINE DIPSTICKS - Urine Dipsticks become more unreliable with increasing age over 65 years. Up to half of older adults, and most with urinary catheter, will have bacteria present in the bladder/urine without an infection. This is "asymptomatic bacteriuria" is not harmful, and although it causes a positive urine dipstick, antibiotics are not beneficial and may cause harm (N.B. when indicated urine dipstick can support differential diagnosis).

THINK SEPSIS – CHECK FOR SIGNS & SYMPTOMS USING LOCAL NEWS 2 /SEPSIS TOOL

Are there any symptoms suggestive of non-urinary infection?
Gastrointestinal: Nausea/vomiting, new onset of abdominal pain, new onset diarrhoea
Respiratory: Productive cough/ new pleuritic chest pain, SOB
Soft tissue/Skin: purulent discharge, swelling, new redness, warmth, clear urine

YES → **UTI unlikely seek / refer for medical guidance as appropriate**

If NO - Is the patient catheterised?

NO CATHETER

Does the patient have TWO OR MORE of the following symptoms?
- Dysuria
- Urgency to pass urine
- New urinary incontinence
- Frequency
- Flank/suprapubic pain
- Frank haematuria
- New onset or worsening of previous agitation / delirium
- Hypothermic/fever (>37.9°C)/ Rigor
- Consider all unexplained falls as possible symptom

YES CATHETER

Does the patient have ONE OR MORE of the following symptoms?
- Rigors
- Flank/suprapubic pain
- New onset or worsening of previous agitation / delirium
- Hypothermic/fever (>37.9°C)
- Consider all unexplained falls as possible symptom

No symptoms → UTI is unlikely – Give self-care and prevention Advice – PHE TARGET leaflet. Ensure patient knows who to contact for new or worsening symptoms.

No symptoms → UTI is unlikely. Give Self Care and Prevention Advice – PHE TARGET leaflet. Ensure patent knows who to contact for new or worsening symptoms

Yes / Yes → **Likely UTI**

IMMEDIATE ACTION REQUIRED NOW - Apply and follow UTI Care Plan
- Obtain MSU/CSU for culture sensitivity before starting antibiotics
- If urinary catheter has been in for more than7 days, replace now & take specimen from new catheter
- Patient to start 1st line oral antibiotic therapy according to local Anti-microbial Guidelines https://www.gpref.bedfordshire.nhs.uk/referrals/bedfordshire-and-luton-joint-prescribing-committee-(jpc)/jpc-guidelines/antimicrobial-guidelines.aspx
- Give self-care advice to patient and /or carers - Prevention Advice PHE TARGET leaflet

FOLLOW UP REQUIRED WITHIN 24 HOURS
- Contact patient to review / assess progress to include signs and symptoms using News 2 / Sepsis tool (this may be required sooner according to individual need). Check and confirm antibiotics have been started.

Stable or improved

Continue to monitor progress which may be remotely or face to face as clinically indicated.

AFTER 48 HOURS
- Review MSU/CSU results on ICE
- Change antibiotics if indicated by results
- Continue to monitor progress / Review signs & symptoms using News 2 / Sepsis tool as appropriate

Patient improving
Arrange any further follow up as required.
Clearance MSU / CSU IS NOT REQUIRED. Discharge to usual care.

No improvement or deteriorated

- Face to Face Assessment / Review to include Signs and Symptoms using NEWS2 /Sepsis Tool escalating as appropriate
- Seek Medical Advice / GP Review
- **Consider Referring to Rapid Response Team for monitoring and consideration for IV Therapy**
- For Consultant / Microbiologist input for IV Therapy under Rapid Response Team – Follow SOP 5.1

AFTER 48 HOURS
- Review MSU / CSU results on ICE - Change antibiotics if indicated by results
- RR Team to continue to monitor progress /review signs & symptoms using News 2 / Sepsis tool / Deliver agreed Treatment Plan and Reviews accordingly.

4.5 Chronic Heart Failure IV Diuretic Pathway – Adults

Patient has been diagnosed with heart failure by a consultant cardiologist

Patient is not a known heart failure patient or previously has not had diagnosis of Heart Failure by a cardiologist to be referred for Assessment & Diagnosis following local processes

Patient under care of Heart Failure (HF) team previously discussed at HFMDT meeting and identified as suitable for home treatment.
Plan in place for IV Diuretic treatment at home to be initiated if and when clinically indicated

GP/ Senior Nurse sees patient at home and refers direct to Rapid Response team to consider for the administration of IV Diuretics following SOP (5.1)

Patient attends Ambulatory Care / Acute In-patient ward or OPD and identified as suitable to consider for early discharge / home treatment following SOP (5.1)
(Consider assessment by in reach cardiologist)

Patient is symptomatic despite maximum tolerated doses of oral therapy (adherence confirmed), any reversible causes for deterioration in symptoms have been considered, there is absence of pulmonary oedema and patient's kidney function has been reviewed by prescriber.
Renal stability (CrCl ≥ 30ml/l/min) and stable for the preceding 2 months

- Patient determined for IV Diuretics for administration in the Community and can be managed utilising SOP (5.1) including prescribing of medication – dosage and diluent.
- The Prescriber provides an Individual Referral Treatment Plan (see 5.5) so that clear identification of Treatment goals and escalation points are considered and shared with Practitioners. These must include:
  - Expected symptomatic improvement and/or; acceptable BP range and /or; Maintain renal function and/or ;
  - Weight loss; and/or Target weight and the Duration of Treatment being planned ,

Prescribing responsibility will remain with the doctor who is medically responsible for the patient during the treatment which will mainly be with the named hospital consultant (this can be the GP if appropriate)
To refer for Consultant Care under Rapid Response Team Follow SOP (5.1)

Day 1 - Assessment by Rapid Response (RR) Nurse according to agreed Individual Referral Treatment Plan (5.5)

- If patient meets criteria for home treatment, IV Diuretic (Furosemide) prescribed at equivalent or higher than the oral dose. Advise patient not to take oral diuretics on the day of IV administration
  Prescription to specify administration as intermittent infusion as a single daily or twice daily dose including length of time of infusion, with rate not to exceed 4mg per minute
- Cannulation and Administration as a once daily or twice daily administration in accordance with prescription using appropriate method

Day 2 onwards - Daily assessment, treatment & review undertaken according to agreed Individual Referral Treatment Plan

Administration of IV Diuretic therapy following agreed Treatment Plan , record observations of BP, pulse, weight, symptoms, cannulation site, U&E etc. as per CCS Intravenous Policy

- Refer to guidelines/escalation points in Individual Referral Treatment Plan (see 5.5)
  - Review with Medical prescriber as clinically indicated – this may be daily and will need to consider electrolyte supplementation
- Dose of IV Furosemide to be titrated (up or down) by medical prescriber according to response to treatment.
- The product licence for furosemide allows doses to be increased by increments of 20mg, and the maximum recommended daily dose in adults is 240mg over 60mins if remains stable – this will depend on individual prescription / treatment plan
- Specialists may practice outside the terms of the product licence.

Patient has achieved treatment goal: Determined following review by the prescriber in consultation with the nursing team. **Stop IV Diuretics** and resume oral diuretics at dose equivalent to IV dose, follow up / supervision as identified in discussion with medical prescriber.

Refer back to Heart Failure Team

Refer to other services e.g. palliative care, community matron, GP

For medical advice 9.00 – 17.00 Monday to Friday RR team contact L&D consultant via GP Liaison on 01582 297234, outside these hours follow Medical advice pathway on 5.3

Advice from Medical Consultant (Honorary contract with CCS / or cardiologist and/or GP should be sought if there are any concerns or as clinically indicated throughout episode of care.

5.0 IV Therapy Initiated by Hospital Consultant Administered by Rapid Response

5.1 Standard Operating Procedure

Criteria
Patient on the Frailty Cohort requires medical management under L&D consultant for IV therapy due to acute health concern that cannot be managed by patients own GP but care can be managed safely in community setting.

Rationale
Some patients requiring IV therapy cannot be managed by GP care alone due to complex drug regimens and or complex medical conditions requiring more intensive monitoring and specialist outreach medical management (Consultant honorary contracts in place).

Patients for IV therapy under this SOP to be treated under care of the Rapid Response (RR) team.

Visiting Senior Nurse and or GP identifies that patient requires Consultant assessment for medical review / consideration for IV therapy, (this could come via daily Safety Huddle or weekly MDT discussions), GP to be kept up to date by Senior Nurse.

Senior Nurse / GP to discuss with RR team on **0333 405 3000.** the referral for IV Therapy. (if not already under RR care)

Senior Nurse contacts Consultant via GP liaison service and decision made where and when to review the patient either over the phone, on joint domiciliary visit or at hospital (clinic /ambulatory care).

Housebound patients –a domiciliary visit from the consultant may be appropriate. A joint visit should be planned with RR Nurse in attendance – RR Nurse to contact consultant and agree home visit details.

Consultant & Nurse undertake the assessment visit –

Consultant provides the Referral Treatment Plan 5.5 to ensure clear communication of the diagnosis, investigations required or pending results, the treatment plan, escalation points for consultant review, and any relevant instructions in relation to safety parameters e.g. blood results etc.

Patient kept up to date, consent gained/Mental Capacity Assessment completed if appropriate by RR Nurse.

Consultant completes community FP10 prescription for medications to be obtained from community pharmacy provision.
Paper Copy of Prescription and Referral Treatment Plan to be kept in patient's home notes (Pink Folder)

Consultant to update clinical record onto system1

RR Team manage and treat patient according to the treatment plan, escalating as necessary according to the patient's condition utilising medical advice pathway (5.3) as needed and escalation points as agreed in the Treatment Plan

RR team manage and support discharge from consultant care ensuring RR discharge summary letter sent to GP at completion of treatment plan and follow up / step down arranged.

Referral for home treatment indicated

Treatment advice by phone – for some patients it may be clinically appropriate to commence IV therapy without prior face to face consultant consultation e.g. stable patient who requires specific antibiotic as result of culture & sensitivity results. Decision will be dependent on clinical presentation and made on a case by case basis, with follow up face to face review by consultant agreed and arranged between senior nurse / RR nurse, consultant and the patient.

Patient suitable for ambulatory assessment

Non - Housebound patients or OOH – Senior Nurse / GP / Consultant to consider ambulatory assessment in clinic setting or ambulatory care , to contact GP liaison service and follow pathway for access to urgent hot clinic or ambulatory care assessment. Patient can be discharged to usual home residence to commence treatment by RR Nurse following the' L&D H@H referrals to RR for IV therapy under consultant care pathway'- 5.4

Patients on the Frailty Cohort presenting in A&E /EAU on the frailty cohort can be considered for home treatment utilising the 'L&D H@H referrals to RR for IV therapy under consultant care pathway' (5.4)

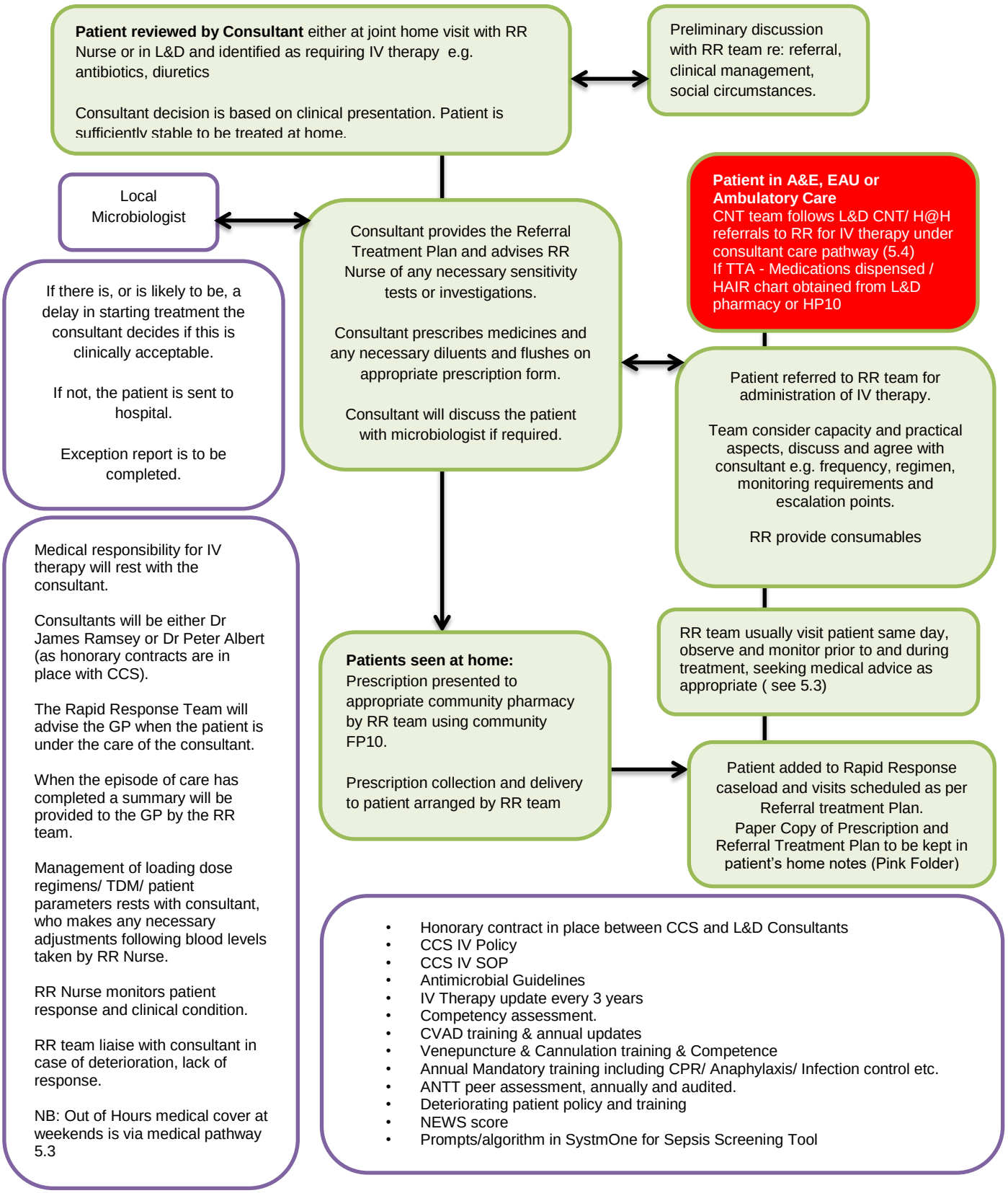
Unable to arrange timely review/ unable to meet immediate need / patient declines

Arrange hospital admission
Mon - Fri 8.00 – 18.30
Contact GP Liaison Service 01582 297234

For help and advice regarding the patient, if any change in condition Rapid Response Team can be contacted 24 hours a day on tel. no: 0333 405 3000.

For medical advice 9.00 – 17.00 Monday to Friday RR team contact L&D consultant via GP Liaison on 01582 297234, outside these hours follow Medical advice pathway on 5.3

5.2 Governance - IV Therapy initiated by Hospital Consultant under Rapid Response



Key:
Stages in the process **Governance**

5.3 Pathway for Medical Advice for Patients under Consultant Care

Patient in community is under the care of the named Hospital Consultant and review of patient is required

Monday to Friday
9am to 5pm

RR team can contact L&D consultant via GP Liaison on **01582 297234** for telephone advice or to arrange home visit

Ambulatory Care able to accept patients* for clinical review, but patients need to arrive latest by 7pm

Saturday/Sunday
9am to 5pm

Ambulatory Care Centre (ACC) can be contacted for telephone advice on **01582 718341 or 497302.**

Ambulatory Care able to accept patients* for clinical review, but patients need to arrive latest by 3pm

Overnight
5pmto 9am
7 days a week

5pmto 9pm
Ambulatory Care can be contacted for consultant telephone advice on **01582 718341 or 497302.**

After 9pm contact medical Registrar on call

Communication of Information:

- Rapid Response Team to ensure that a copy of Prescriptions and Referral Treatment Plan (5.5) kept in patient's home notes (Pink Folder) is sent to the Ambulatory Care Centre with the Patient.
- Reason for review to be provided to Ambulatory care staff by RR team by telephone or by completion of Transfer of Care Form
- Clinical Navigation Team (on site in L&D) are able to access Systm0ne information if required
- Ambulatory Care staff can contact Rapid Response Team for any queries 24 hours a day on **03334053000**

* Also note i) that wheelchair patients will need a carer with them
ii) Ambulatory care centre **cannot** accommodate bed bound patients.

5.4 Pathway for L&D Clinical Navigation Team (CNT) or Hospital at Home (H@H) Referrals to Rapid Response for IV Therapy under Consultant Care.

Patient is seen by CNT or (H@H) – from A&E / EAU / Ambulatory Care

Call Rapid Response Team 0333 405 3000 (option 2)

Speak to Referral Management Nurse and or RR Coordinator of the Day

Referral accepted by Rapid Response Team

CNT / H@H – from A&E / EAU / Ambulatory Care

CNT/ H@H Nurse to:

1. Ensure provision of RR Referral Treatment Plan (5.5) documentation and patient consent/care agreement and email both forms to RR on: **ccs-tr.lutonrmsreferrals@nhs.net**
2. Ensure Discharge letter, TTA's and HAIR Chart are sent with patient on discharge or HP10 supplied for community dispensing.
3. Contact RR to confirm receipt of documentation and to update/inform RR when patient is ready for discharge.

RR Team: Complete Holistic Assessment and agreement of patient goals at first visit. Deliver treatment according to patient's Referral Treatment Plan.

PATIENT UNDER CARE OF HOSPITAL CONSULTANT following SOP (5.1)
(Honorary contract with CCS in place)

For help and advice: 9.00 – 17.00 – Monday to Friday –

CCS Senior RR Nurse can access Consultant telephone advice by contacting GP Liaison on 01582 297234.

Outside these hours follow Medical advice pathway on 5.3

5.5 Rapid Response Referral Treatment Plan for IV Therapy

Patient's Name: **NHS Number** **Date of Birth** **Address:** **Telephone N^{o}**	**GP Name:** **Address:** **Telephone N^{o}**
MEDICAL DETAILS	
Diagnosis **(include patient infectious status):**	
Reason for Referral:	
Current Medication:	
Relevant Past Medical History:	
Planned Initiation of Treatment in Community : (date of hospital discharge if applicable)	
Details of Current Hospital Admission (if applicable):	
TREATMENT PLAN including Goals, Follow up, Monitoring & Escalation arrangements	
Intravenous therapy to be administered including dose, frequency, method and duration (***Please include & send prescription signed by prescribing doctor)***	
Microbiology advice if sought:	
For hospital discharges- date and time IV therapy commenced:	
Date and time IV therapy to be completed:	
Treatment Goals e.g. Symptom improvement, vital signs, blood results, weight etc.	
Escalation Parameters related to Goals e.g. symptom deterioration, vital signs, bloods, weight etc.	
INVESTIGATIONS PENDING /PLANNED MONITORING	
Is blood monitoring required? **Yes / No** If yes, state requirements and frequency	
Any other monitoring required?	
Date treatment to be reviewed / follow-up arrangements and by whom	
IV ACCESS (for hospital discharges)	
Type Date of Insertion Any complications with line / poor venous access	
ANAPHYLAXIS RISK ASSESSMENT	
Known Allergies or Sensitivities	
If the patient has had a previous allergic reaction, what happened?	
Has the patient had the prescribed medicine before (orally or intravenously)? **Yes / No**	
PRESCRIBER'S DETAILS Name of Prescriber / medical team responsible for the patient, to be contacted for advice:	
Prescriber Name (PRINT):…… Prescriber signature …… Date…… Telephone No: ……..	

6.0 REFERENCES

General

Bedfordshire and Luton Joint Prescribing Committee antimicrobial guidelines: https://www.gpref.bedfordshire.nhs.uk/referrals/bedfordshire-and-luton-joint-prescribing-committee-(jpc)/jpc-guidelines/antimicrobial-guidelines.aspx

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COPD Pathway

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