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Basic Observation Training

Session will start shortly

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Learning outcomes:

>To understand why we take observations
>To be able to undertake three basic observations, blood pressure, temperature and oxygen saturation
>To understand how to use Restore 2 tool
>To be able to confidently document observation readings
>To be able to confidently handover observation readings to health care professionals

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Why do we take clinical observations?

- A set of clinical observations can give many indications of general deterioration
- Point to signs of infection
- Underlying conditions that have not yet been diagnosed
- Observations are really helpful for a clinician assessing a patient, especially via phone or video call.

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What is a blood pressure?

Blood pressure is a measure of the force that the heart uses to pump blood around the body.

There are 2 readings:

Systolic - pressure when the heart pumps
Diastolic - pressure when the heart relaxes

They are written systolic/diastolic.
The units of measurement are mmHg (stands for millimetres of mercury)

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What is a blood pressure?

For example, if your blood pressure is "140 over 90" or 140/90mmHg, it means you have a systolic pressure of 140mmHg and a diastolic pressure of 90mmHg.

Systolic = top number of a blood pressure reading

Diastolic = bottom number of a blood pressure reading

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For most of life, we want to make sure BP readings are not too high.
This will be most important for residents in MH or LD homes and fitter older residents.

In frail older age, low blood pressure can become more of a problem.

What is high blood pressure (hypertension)?

Click here to view video and visit British Heart Foundation website

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What is high blood pressure and what can cause it?

High blood pressure is considered to be 140/90mmHg or higher (**150/90mmHg or higher if you're over the age of 80**)

Risks of high blood pressure

High blood pressure, or hypertension, rarely has noticeable symptoms. If a blood pressure is too high, it puts extra strain on your blood vessels, heart and other organs, such as the brain, kidneys and eyes.

Persistent high blood pressure can increase your risk of a number of serious and potentially life-threatening health conditions, such as:

- heart disease
- heart attacks
- strokes
- heart failure
- peripheral arterial disease
- aortic aneurysms
- kidney disease
- vascular dementia

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What is low blood pressure and what can cause it?

Low blood pressure is a reading of 90/60mmHg or less. It does not always cause symptoms. It is a common problem in older residents and an important cause of falls.

Risks of low blood pressure

Low blood pressure, or hypotension, can sometimes have the following symptoms;

- Light headedness or dizziness
- feeling sick
- blurred vision
- generally feeling weak
- confusion
- Fainting

If a resident suffers with low blood pressure the following may help;

- get up slowly from sitting to standing
- take care when getting out of bed – move slowly from lying to sitting to standing
- raise the head of your bed by about 15cm (6 inches) contact appropriate healthcare professional for equipment
- eat small, frequent meals – lying down or sitting still for a while after eating may also help
- increase the amount of water you drink

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What is a normal blood pressure?

As a **general** guide in a younger person:

Normal blood pressure is considered to be between **90/60mmHg** and **120/80mmHg**

High blood pressure is considered to be **140/90mmHg** or higher

Low blood pressure is considered to be **90/60mmHg** or lower

Blood Pressure Category	Systolic mm Hg (upper #)		Diastolic mm Hg (lower #)
Low blood pressure (Hypotension)	less than 90	or	less than 60
Normal	90 to 120	and	60 to 80
Prehypertension	120-139	or	80-89
High Blood Pressure (Hypertension Stage 1)	140-159	or	90-99
High Blood Pressure (Hypertension Stage 2)	160 or higher	or	100 or higher
High Blood Pressure Crisis (Seek Emergency Care)	180 or higher	or	110 or higher

How to take an electronic blood pressure

It is really important that the person is relaxed, so:

- Sitting back in their chair
- Arm supported at chest height
- Calm and NOT talking

If in bed:

- Lying with pillows and arm by their side.

Click here to view- https://www.youtube.com/watch?v=G8QkaAyqatE

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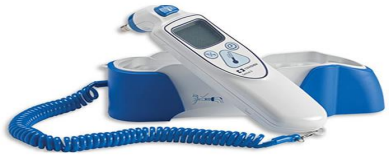
How to take a temperature using a tympanic thermometer



- Gain consent and wash your hands
- Place a cover over the probe of the thermometer, this provides infection control
- Hold the thermometer in your dominant hand
- With your non dominant hand straighten the residents external ear
- Gently pull the upper ear outward and back
- Insert the probe gently into the residents ear canal
- Seal the probe tightly without causing discomfort and wait for the beep.
- Remove the probe and discard the plastic cover
- Record the temperature as shown on the display of the thermometer.
- Clean all equipment ready for next use

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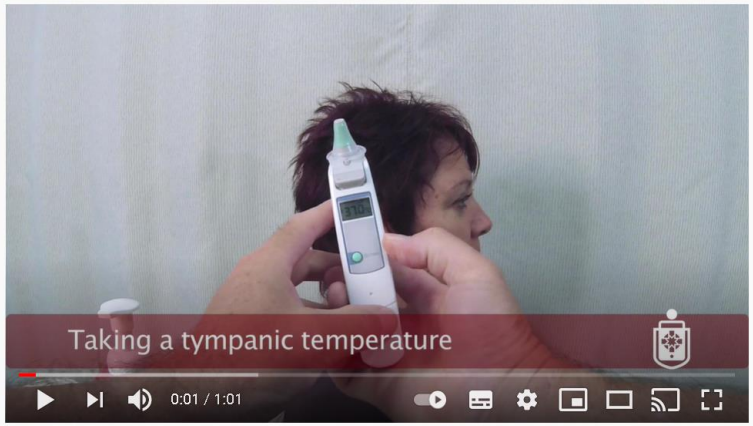
How to take a temperature using a tympanic thermometer



Taking a Tympanic Temperature

https://www.youtube.com/watch?v=W3ygP86FpOM

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Why do we take a pulse oximeter reading?

A pulse oximeter measure the amount of oxygen in the blood.
It is known as an oxygen saturation – how much is the blood “saturated” or filled with oxygen.
Called a %Sp02.
Most pulse oximeters also record a heart rate (pulse).

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How to take a pulse oximeter reading;

- Gain consent and wash your hands
- Ensure any nail varnish is removed from the finger you are preparing to use as this can give a false reading
- Place oximeter over the end of the finger with display facing up and wait for the display to confirm a %
- The oximeter display shows the percentage of oxygen in your blood. For someone who's healthy, the normal blood oxygen saturation level will be around 95–100%.
- Record as appropriate
- Clean all equipment ready for next use.

https://www.youtube.com/watch?v=u16nRuCYqBM

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Heart Rate or Pulse Readings

- The Heart Rate or Pulse is the number of times the heart beats in a minute.
- This is also measured by most blood pressure readings.
- Most pulse readings will be between 60 and 100 beats per minute.

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Recording observations

Ensure following is recorded;

- Date and time reading is taken
- Both readings are recorded
- Position of resident; sitting/standing or bedbound
- Any other concerns, that you have observed

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Recording observations

Date	Time	BP reading	Pulse	Sitting	Standing	Comments

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Key Tasks

	Performance criteria	Comments	Competence achieved (date/sign)
1	Give the individual relevant information and support in a manner sensitive to their needs		
2	Gain valid consent to carry out the task of taking an electronic blood pressure reading		
3	Check the individual's identity and confirm the planned action		
4	Apply standard precautions for infection and prevention control		
5	Use the appropriate equipment to obtain an accurate measurement		
6	Reassure individual throughout the process and answer any questions and concerns they may have within your own realm of competence		
7	Escalate any concerns from the reading to the appropriate healthcare professional		
8	Seek a further recording of the measurement by another staff member if you are unable to obtain the reading or are unsure		

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Key Tasks

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	Performance criteria	Comments	Competence achieved (date/sign)
10	Identify and respond immediately if there are any significant changes in the residents condition		
11	Recognise and report any measurement which falls outside of normal reading to the residents GP		
12	Record your findings accurately in the appropriate documentation		
13	Clean used equipment and return to usual place of storage		

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Restore 2

Deterioration and escalation tool for residential and nursing homes

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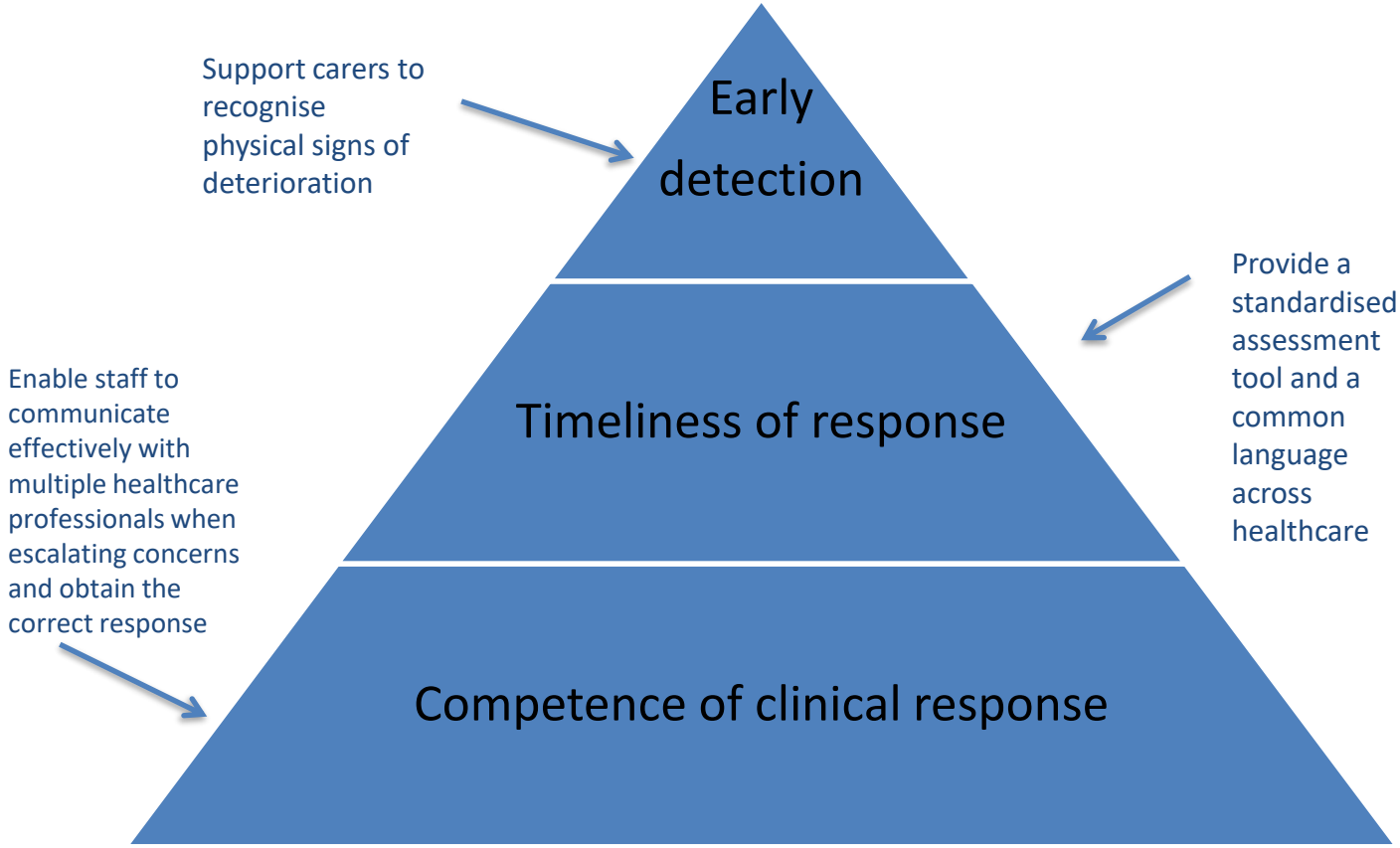
What is Restore 2?

Restore 2 is a deterioration and escalation tool for residential and nursing homes. This approach allows care home staff to communicate with outside healthcare professionals including GP's by;

- Using evidence based methods to help care home staff recognise and communicate concerns about early deterioration in a resident
- By using these tools care homes are able to speak the same language, using proven techniques such as NEWS 2 and SBAR.

Restore 2


Support carers to recognise physical signs of deterioration
Early detection
Provide a standardised assessment tool and a common language across healthcare
Enable staff to communicate effectively with multiple healthcare professionals when escalating concerns and obtain the correct response
Timeliness of response
Competence of clinical response

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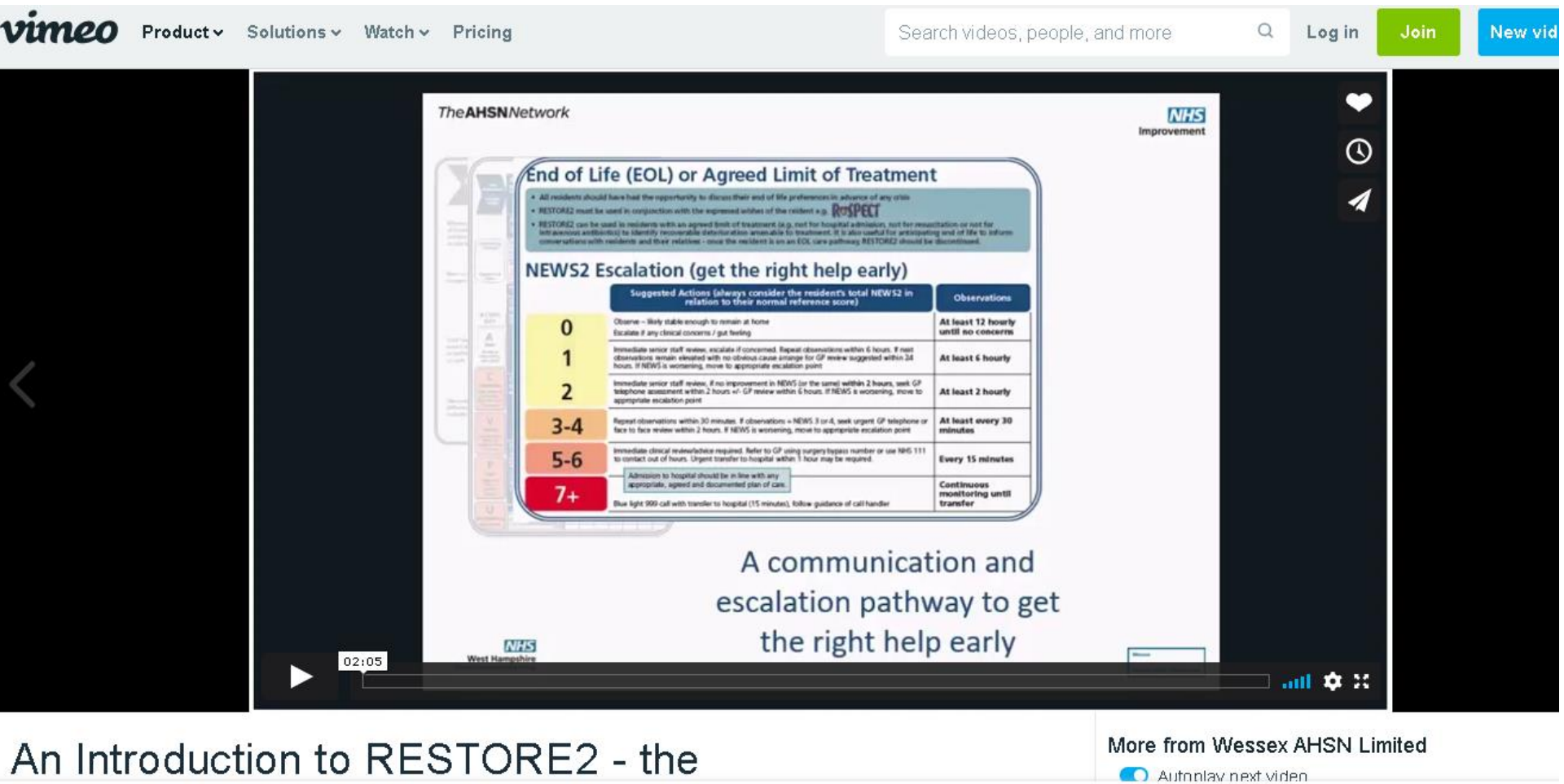
Restore 2

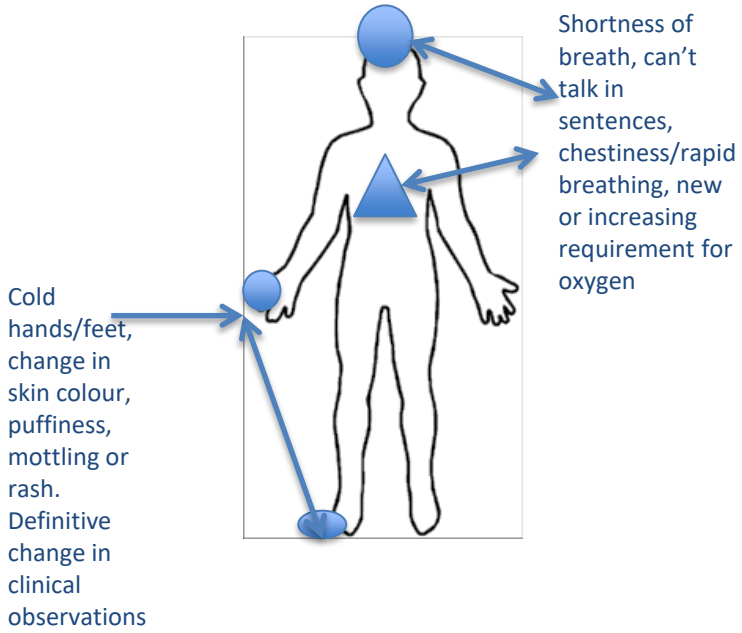
Click here to view - https://vimeo.com/368051959



Restore 2

Signs of deterioration provide relevant prompts for staff and an entry point into NEWS2 observations

Does your resident have signs/symptoms?



RESTORE2

Recognise Early Soft Signs, Take Observations, Respond, Escalate

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Adult Physiological Observation & Escalation Chart

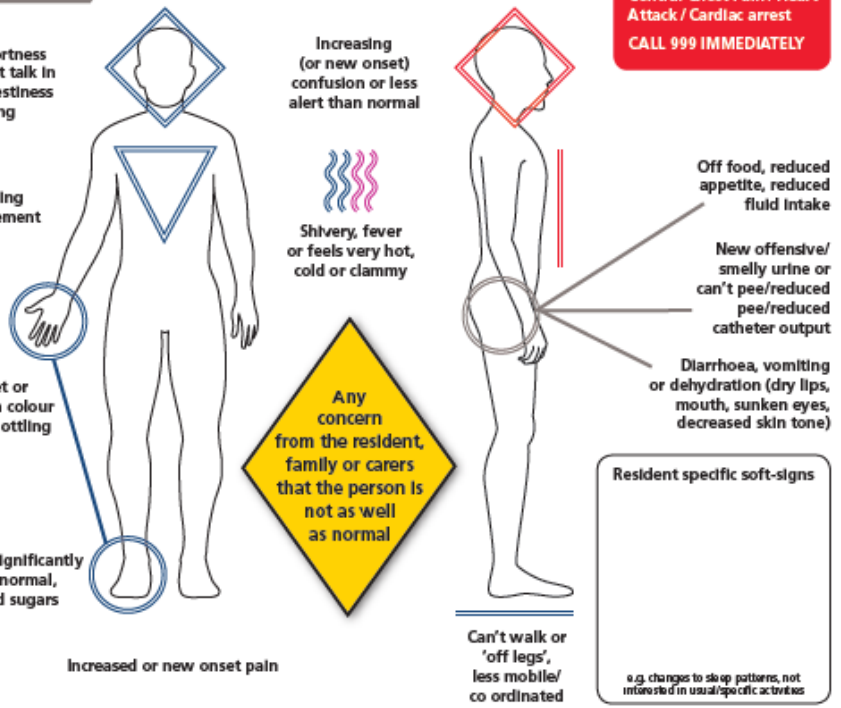
Full Name:			
NHS No.			
DOB:		Room No.	

Does Your Resident Have Soft Signs of Possible Deterioration

NEW ONSET OF:

- Stroke (facial / arm weakness, speech problems)
- Central Chest Pain / Heart Attack / Cardiac arrest

CALL 999 IMMEDIATELY



If you answer YES to any of these triggers, your resident is at risk of deterioration

RECOGNISE SOFT SIGNS OF POSSIBLE DETERIORATION → TAKE COMPLETE SET OF OBSERVATIONS AND CALCULATE NEWS → ESCALATE USING ESCALATION TOOL AND SBARD COMMUNICATION

Page 1 of 6 - All pages must be present when printing

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Full Name: NHS No.

How to use RESTORE2

RESTORE2 which includes the National Early Warning Score (NEWS2) promotes a standardised response to the assessment and management of unwell residents. It is not a replacement for clinical judgement and should always be used with reference to the persons care/escalated plan and any agreed limits of treatment. If you are concerned about the resident or if one observation has changed significantly ALWAYS ACT ON YOUR CONCERNS AND SEEK ADVICE from a competent clinical decision maker e.g. GP, Registered Nurse or AHP.

- This chart uses aggregated (total) NEWS - it is important that you understand the residents normal NEWS (the score when they are stable and as well as usual) to support appropriate escalation. You should try and establish what is normal for residents on admission with a member of the multi-disciplinary team (e.g. General Practitioner, frailty practitioner).
- **Only a Medical Professional can authorise use of the hypercapnic respiratory failure scale for residents who normally have low oxygen levels as part of a diagnosed condition (e.g. COPD)**
- Use this chart for all your routine observations as per your local policy. If your resident shows ANY of the soft signs of deterioration, record their observations and NEWS immediately on the chart and follow the escalation tool as appropriate, using SBARD to communicate
- There may be a need to re-consider what is normal for the resident following any sustained improvement in their condition or non-acute deterioration.

What's normal for this resident

Print name: Date: Signature:

What is the resident normally like? What observations and NEWS are reasonable and safe for them? When would their GP want you to call them? What escalation has been agreed with the resident (or their advocate)?

End of Life (EOL) or Agreed Limit of Treatment

- All residents should have had the opportunity to discuss their end of life preferences in advance of any crisis
- RESTORE2 must be used in conjunction with the expressed wishes of the resident e.g. treatment escalation plans or advanced care plans.
- RESTORE2 can be used in residents with an agreed limit of treatment (e.g. not for hospital admission, not for resuscitation or not for intravenous antibiotics) to identify recoverable deterioration amenable to treatment. It is also useful for anticipating end of life to inform conversations with residents and their relatives - once the resident is on an EOL care pathway, RESTORE2 should be discontinued.

NEWS2 Escalation (get the right help early)

	Suggested Actions (always consider the resident's total NEWS2 in relation to their normal reference score)	Observations
0	Observe – likely stable enough to remain at home Escalate if any clinical concerns / gut feeling	**At least 12 hourly until no concerns**
1	Immediate senior staff review, escalate if concerned. Repeat observations within 6 hours. If next observations remain elevated with no obvious cause arrange for GP review suggested within 24 hours. If NEWS is worsening, move to appropriate escalation point.	**At least 6 hourly**
2	Immediate senior staff review, if no improvement in NEWS (or the same) **within 2 hours**, seek GP telephone assessment within 2 hours +/- GP review within 6 hours. If NEWS is worsening, move to appropriate escalation point.	**At least 2 hourly**
3-4 (Single Observation 3)	Repeat observations within **30 minutes**. If **observations = NEWS +3 or more**, seek urgent GP telephone or face to face review within 2 hours. If NEWS is worsening, move to appropriate escalation point.	**At least every 30 minutes**
5-6	Immediate clinical review/advice required. Refer to GP using surgery bypass number or use NHS 111 to contact out of hours. Urgent transfer to hospital within 1 hour may be required.	**Every 15 minutes**
7+	Admission to hospital should be in line with any appropriate, agreed and documented plan of care. Blue light 999 call with transfer to hospital (15 minutes), follow guidance of call handler	**Continuous monitoring until transfer**

Full Name: _____ **NHS No.** _____

		Date / Time												
Take observation + calculate NEWS	**A+B** Respirations Breaths/min	≥25												3
		21-24												2
		18-20												
		15-17												
		12-14												
		9-11												1
		≤8												3
	A+B SpO_2 Scale 1 Oxygen saturation (%)	≥96												
		94-95												1
		92-93												2
		≤91												3
Authorising clinician Signature & Date	SpO_2 Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92%, e.g. in hypercapnic respiratory failure *ONLY use Scale2 under the direction of a qualified clinician	≥97 on O_2												3
		95-96 on O_2												2
		93-94 on O_2												1
		≥93 on air												
		88-92												
		86-87												1
		84-85												2
		≤83%												3
	Air or Oxygen?	A = Air												
		O_2 L/min												2
ACVPU KEY	**C** Blood pressure mmHg Score uses systolic BP only	≥220												3
		201-219												
		181-200												
		161-180												
		141-160												
		121-140												
		111-120												
		101-110												1
		91-100												2
		81-90												3
		71-80												
		61-70												
		51-60												
		≤50												
A Alert awake & responding, eyes open	**C** Pulse Beats/min	≥131												3
		121-130												2
		111-120												
		101-110												1
		91-100												
		81-90												
		71-80												
		61-70												
		51-60												
		41-50												1
		31-40												3
		≤30												
C Confusion New onset of confusion (Do not score if chronic)	**D** Consciousness Score for NEW onset of confusion (no score if chronic)	Alert												
		Confusion												3
		V												
		P												
		U												
V Verbal moves eyes / limbs or makes sounds to voice	**E** Temperature °C	≥39.1												2
		38.1-39.0°												1
		37.1-38.0°												
		36.1-37.0°												
		35.1-36.0°												1
		≤35.0°												3
P Pain responds only to painful stimuli	NEWS TOTAL													
U Unresponsive unconscious	Next observation due (Mins/Hrs)													
	Escalation of care Y/N													
	Initials													

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Full Name: NHS No.

												Date	
												Time	
3												≥25	A+B Respirations Breaths/min
2												21-24	
												18-20	
												15-17	
												12-14	
1												9-11	
3												≤8	
												≥96	A+B SpO_2 Scale 1 Oxygen saturation (%)
1												94-95	
2												92-93	
3												≤91	
3												≥97 on O_2	SpO_2 Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92%, e.g. in hypercapnic respiratory failure *ONLY use Scale2 under the direction of a qualified clinician
2												95-96 on O_2	
1												93-94 on O_2	
												≥93 on air	
												88-92	
1												86-87	
2												84-85	
3												≤83%	
												A = Air	Air or Oxygen?
2												O_2 L/min	
3												≥220	C Blood pressure mmHg Score uses systolic BP only
												201-219	
												181-200	
												161-180	
												141-160	
												121-140	
												111-120	
1												101-110	
2												91-100	
3												81-90	
												71-80	
												61-70	
												51-60	
												≤50	
3												≥131	C Pulse Beats/min
2												121-130	
												111-120	
1												101-110	
												91-100	
												81-90	
												71-80	
												61-70	
												51-60	
1												41-50	
3												31-40	
												≤30	
												Alert	D Consciousness Score for NEW onset of confusion (no score if chronic)
3												Confusion	
												V	
												P	
												U	
2												≥39.1	E Temperature °C
1												38.1-39.0°	
												37.1-38.0°	
												36.1-37.0°	
1												35.1-36.0°	
3												≤35.0°	
												NEWS TOTAL	
												Next observation due (Mins/Hrs)	
												Escalation of care Y/N	
												Initials	

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SBARD Escalation Tool and Action Tracker

(get your message across)

Herts Valleys Clinical Commissioning Group

REMEMBER TO SAY: The residents TOTAL NEWS SCORE is...

Name:

NHS No.

		Notes	Date, Time, Who
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 TOTAL NEWS SCORE is...** **Their normal NEWS/condition is...** I am calling because I am concerned that... (e.g. BP is low, pulse is XX, temp is XX, patient is more confused or drowsy)		
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 care plan or DNACPR form / agreed care plan with a limit on treatment/hospital admission They have had... (GP review/investigation/medication e.g. antibiotics recently) Resident XX's condition has changed in the last XX hours The last set of observations was... Their normal condition is... The resident is on the following medications...		
A	**Assessment** (summarise the facts and give your best assessment on what is happening) I think the problem is XX 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		
R -- D	**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) **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.	**Actions I have been asked to take** (initial & time when actions completed)	Initials

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The SBARD technique provides an easy-to-remember standardised framework for critical conversations, including what key information will be communicated about a resident's condition and what immediate attention and action is required. Record all your actions and conversations.

Communicate using SBARD

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Clinical Commissioning Group

Name: NHS No.

Notes Date, Time, Who	Notes Date, Time, Who	
		S
		B
		A
Actions I have been asked to take (initial & time when actions completed) Initials	**Actions I have been asked to take** (initial & time when actions completed) Initials	R -- D

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Handover to Medical professionals

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S	**SITUATION** • Your name and Care home name • Name of patient , age, DOB • What is the concern, what has happened? Describe symptoms which are different than normal. Does the patient have capacity to tell you what is wrong?	**Examples of symptoms you might describe:** • Falls – are there injuries? • Confused, disorientated, dizzy, unsteady • Drowsy or hard to rouse • Hot / flushed /sweating. Cold / clammy / shivering / pale • Breathing harder or faster, slower or shallower • Complaining of pain, grimacing, posture indicating pain if unable to communicate - describe where pain is • Weakness in legs or arms / facial differences • Coughing / bringing up phlegm / wheezing • Vomiting / nausea - how long for • Change in urinary continence / Smelly urine, blocked or problem with catheter • Change in bowel habit /Diarrhoea • Not eating or drinking / loss of appetite • Bleeding from what area?
B	**BACKGROUND** • How long have symptoms been present? • Did they come on suddenly? • Does the person have any other long term illness? • Have they already been seen by the GP for this change? If so was any medications started? What instructions were given to the home? • Have you got a list of their current medication? • Has the patient recently been into hospital? If so what for? • Does the patient have a current DNAR in place? If yes be clear why you are ringing.	
A	**ASSESSMENT** • What actions have you already taken? Is the patient in a safe place? • Has the person lost consciousness? Be very clear is it a true loss of consciousness? If yes how long for in minutes. • Are there any obvious signs of injury or bleeding?	**Examples of assessment actions you might describe:** • First aid options used /Recovery position • Pressure on bleeding area • BP, Pulse, respiration rate, temperature, urine analysis - give results
R	**RECOMMENDATION** • Explain what you need - be specific about the request and timeframe • Make suggestions i.e. ECP or Dr or advice only • Clarify expectations **Note: an ambulance can take from 9 – 60 minutes depending on urgency**	**Examples of recommendations you might describe:** • Review by GP urgently • Ambulance • Call back from Clinical Advisor • Clarify what is happening as a result of call – when you can expect a visit or ambulance

Not every question will be relevant to every person. The checklist will help with describing symptoms, (not exhaustive) Remember to document the outcome in the records. Write some answers down before you ring so you don't forget and can give relevant information.

SBAR COMMUNICATION TOOL- AIDE MEMOIRE

FINAL

If an ambulance is sent these are suggestions of what do whilst waiting for the ambulance to arrive?

Reassure the resident and stay with them, continue to monitor for signs of deterioration which may mean a further call to the service. Ask another staff member to follow the check list. Do you need an escort? Do you need to ask senior management to attend the home?

In no particular order:-

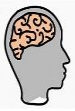
1. Inform relatives.

2. Prepare the RED BAG; Photocopy medication charts and bag all medication. Is there any in the fridge, room or cupboards?

3. Photocopy main care plan details or grab sheet making sure the details are up to date. Especially where you have allergies or special instructions around other medical conditions. Include copy of DNAR form. Is there any special information which may help staff to communicate or deliver care for the resident, (i.e. strategies to adopt when the patient is anxious especially with dementia residents)? Are there any triggers which are not recorded?

4. Prepare an overnight bag for the resident. Remember to take items that may offer reassurance. Maintaining the residents' dignity is paramount so having their own belongings may help.

Herts Valleys Service access information

Service	When to contact		How to contact
 **Emergency Care Practitioner (ECP)**	**If your resident is suffering from symptoms of** • Head injuries (without loss of consciousness) • Wounds • Burns & scalds • Joint & limb injuries • Soft tissue injuries	• Rib injuries • Back pain • Chest infections • Urinary tract infection • Dizziness/Vomiting Minor allergic reactions	**Call:** **0345 601 0552** **06:30-23:00 hrs seven days a week** **Ensure you are with your resident when you call.**
CALL 111 when it's less urgent than 999	**For out of hours health advice from** • GP • Palliative care nurse, • Mental health nurse, • Pharmacist • Dentist		**Call:** **111** **24 hours a day 7 days a week** **Ensure you are with your resident when you call.**
 **End of Life**	**The Palliative Care Referral Centre provides advice as a 1st point of contact for palliative and end of life patients.**		**Call:** **0333 234 0868** **Monday to Friday 9am - 5pm** **Saturday, Sunday and Bank Holidays 10am - 2pm** **Specialist Palliative Care advice is available 24 hours a day** **020 3826 2377.**
 **Mental Health**	**Contact for advice relating to:** A resident experiencing a mental health problem for the first time or is in need of urgent help. (If your resident is already using the service contact their case worker).		**Call:** **0300 777 0707** **24 hours a day 7 days a week**

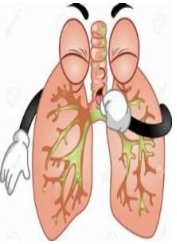
Approved Training Provider

NHS Herts Valleys Clinical Commissioning Group

Herts Valleys Service access information

 **Community Adult Health Services (CAHS)**	**Community nurses, community matrons, physiotherapists, occupational therapists and specialist palliative care nurses who support with:** • Wound care management • Chronic disease management • Palliative treatment and care • Injections/eye drops • Tissue viability • Leg ulcer management • Bladder and bowel management • PEG management • Therapy assessments and treatments	**Call:** **01727 732001** **8am to 10pm** **7 days a week**
 **Wheelchair service**	**Provide wheelchairs and equipment such as:** • Manual wheelchairs • Powered indoor and outdoor wheelchairs • Specialist buggies, wheelchairs and seating for children • Specialist bespoke seating systems for use with a wheelchair • Pressure relieving cushions and some accessories for wheelchairs	**Call:** **0333 234 0303** **8.00am to 5.00pm Mon-Fri** **For current wheelchair users.** ***New users should be referred into the service by a qualified healthcare professional such as a GP, district nurse, physiotherapist, occupational therapist.
 **Community Speech and Language Therapy (SLT)**	**Contact for advice and support relating to:** • Difficulties with communication, eating, drinking and swallowing • Newly identified or as a result of medical conditions, such as stroke, head & neck cancer, parkinson's disease and dementia	**Call:** **01438 285287** **9.00am to 5.00pm Mon-Fri**
 **Community Diabetic nursing team**	**Contact for advice relating to:** • Advice and education for adults with diabetes • Healthy living • Diabetes treatments • Initiation of insulin • Blood glucose monitoring and how to use a glucometer	**Call :** **01707 621152** **9am–5pm Mon - Fri**

Herts Valleys Service access information

 **Community Dieticians**	**Contact for advice and support relating to:** • Diabetes and weight Management • Nutrition support • Home enteral tube feeding • Long term conditions	**Call:** **01727 732011** **9am-5pm Mon – Fri**
 **Community Respiratory team**	**Contact for advice and support relating to:** • Pulmonary rehabilitation • Home oxygen • Hospital at home • Community respiratory clinic • Chronic obstructive pulmonary disease (COPD) • Asthma • Bronchiectasis • Interstitial lung disease (ILD) • Obstructive sleep apnoea (OSA) • Non-invasive ventilation (NIV); and tuberculosis nursing service	**Call:** **07944 960825** **Mon - Fri 9am to 5pm**
	**FOR LIFE OR LIMB THREATENING EMERGENCIES ONLY**	**Call:** **999** **24 hours a day 7 days a week**

EN Herts Service Access Information

Click for your area:

- Lower Lea Valley Care Homes- Service access information
- North Herts Care Homes Service access information
- Stevenage Care Homes- Service access information
- Stort Valley & Villages Care Homes- Service access information
- Upper Lea Valley Care Homes- Service access information
- Welwyn / Hatfield Care Homes- Service access information

Early Intervention Vehicle Information For EN Herts

The Care Home Early Intervention Vehicle service is available for East & North Hertfordshire care home residents. It can respond to residents that may have had a fall or require medical attention and aims to prevent unnecessary emergency department visits or admission. An Urgent Care Practitioner (qualified Paramedic or Nurse) will visit the care home to assess the resident and where possible treat them for a number of ailments.

Operating hours:

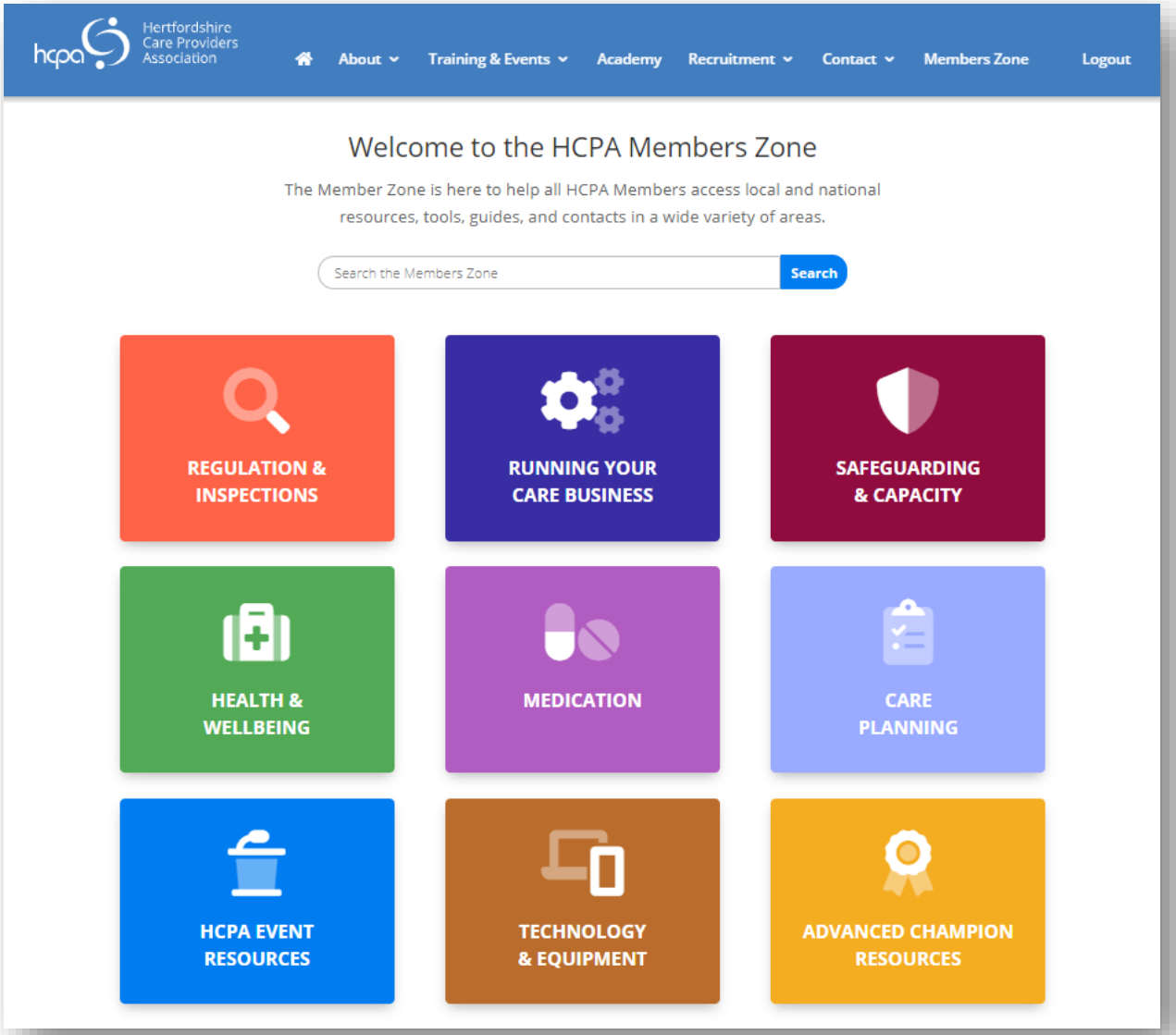
- **The service operates Friday, Saturday, Sunday and Monday from 13:00pm-21:00pm, with last referrals being at 20:00pm.**
- **To access the service cares homes should call NHS 111 and then select option 6**
- **Outside of these timeframes care homes can call the Health and Care practitioner (HCP) hotline through NHS 111 option 4, for further advice and support**

Introducing the brand new Member's Zone!

Visit:

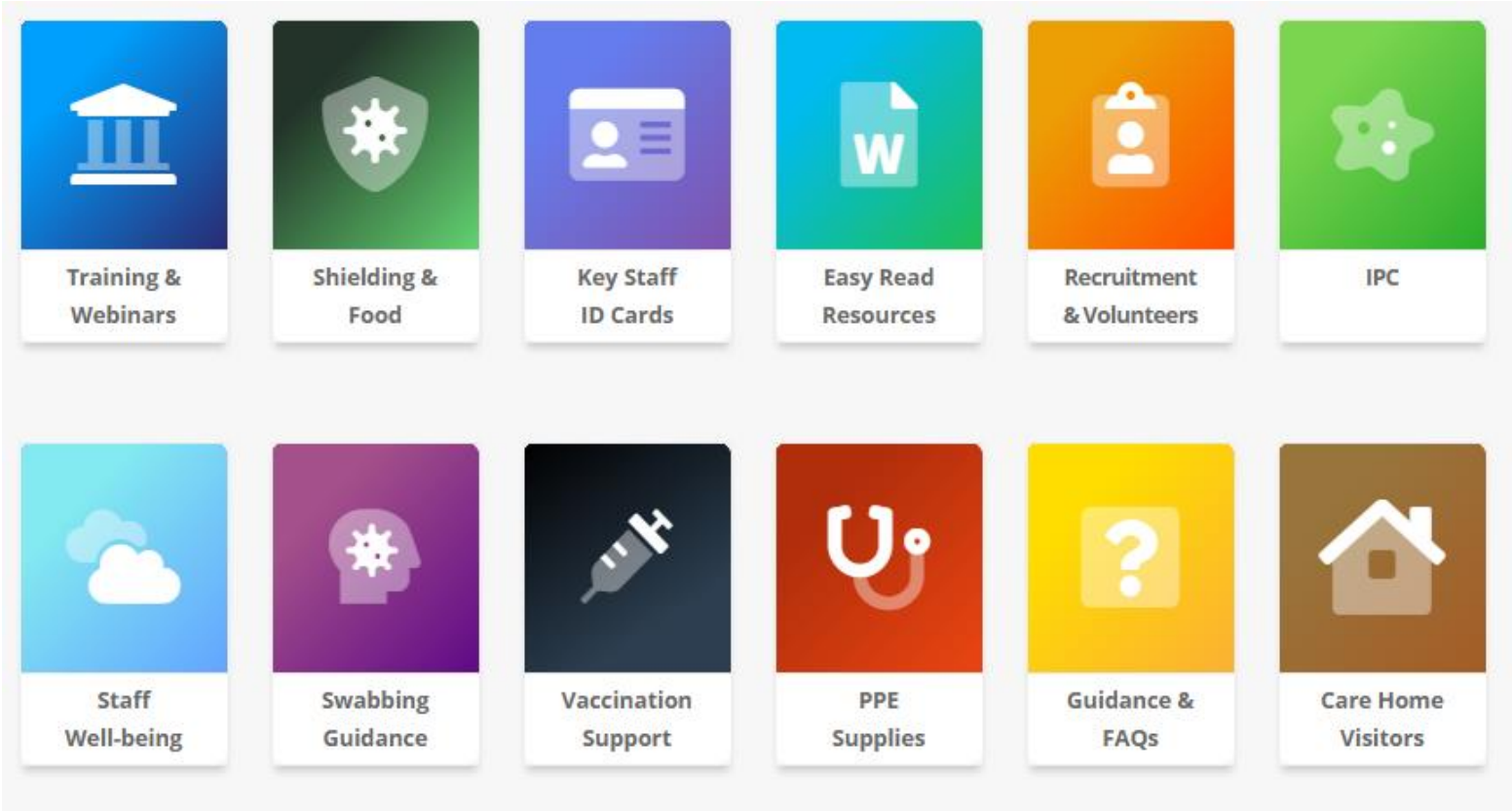
hcpa.info/members-zone

The site is **available for HCPA members** access this with your login and password you received when you signed up for membership.



Support COVID-19 pages managed on the HCPA website

www.hcpa.info/covid-19



Thank you

Any questions?

Provider Hub

Call 01707 708 108 (9am – 5pm | Mon – Fri)
Email assistance@hcpa.info
Visit- www.hcpa.info/covid-19
Sign up for the Daily HCPA newsletters