Brochure

The Digital Care Home

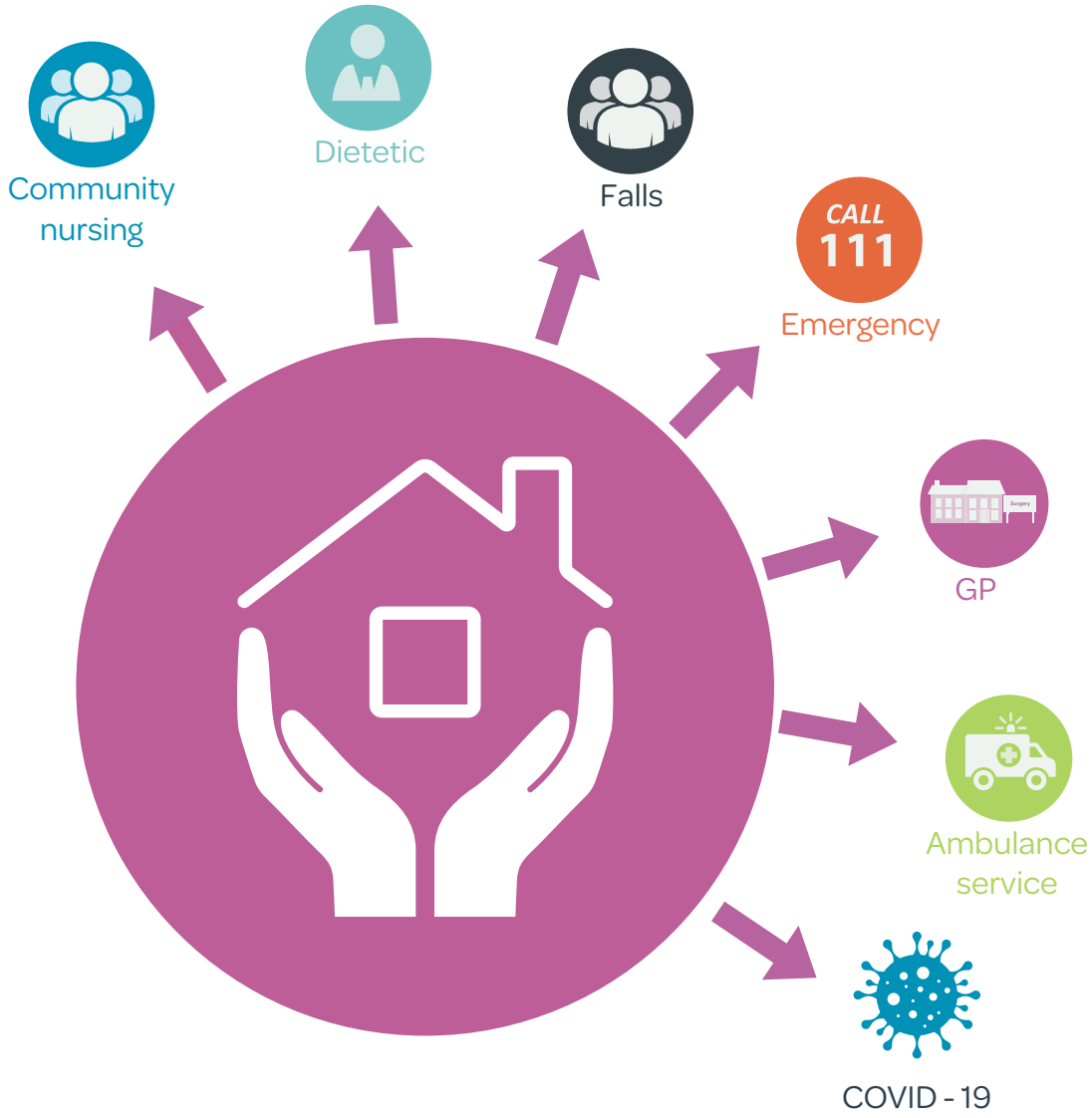
Improving health outcomes and bridging the gap between health and social care

inhealthcare

The digital care home service improves the monitoring of residents in care homes, improves communication between health and social care and reduces the need for healthcare staff to visit the home.

The digital care home service coordinates the monitoring of residents across a care home. Staff input readings directly into the easy to use Inhealthcare app. Alerts can be raised for clinical follow up and readings are sent directly to NHS teams, including the GP, community nursing and dietetics. The service can be used to intensively monitor those discharged from hospital and gives care home staff reassurance help is at hand. Critically this service helps to bridge the gap between health by enabling patient information to be seen by the right person, at the right time.

With the outbreak of COVID-19, it is essential the elderly population is kept safe and well at home. The care home service includes video conferencing allowing health care staff to physically see a resident, without having to travel to the home. This increases capacity for health care staff and reduces the risk of infection associated with the virus.



What is our digital care home service?

- The digital care home service coordinates the monitoring of key health indicators.
- Health indicators can include C02, SP02, NEWS, glucose levels, weight, heart rate, blood pressure, MIST and risk of falls.
- The service can be used to intensively monitor patients discharged from hospital and data can be reviewed by NHS teams including an NHS 111 operator or a GP.
- Staff input resident's readings directly into the app, without the need for a WiFi connection.
- The service can be accessed securely by health and social care staff via desktop or an app. The data integrates into clinical systems, including SystmOne and EMIS Web meaning it can be accessed by NHS teams remotely.
- Video conferencing can be used, enabling residents to be physically seen by healthcare staff. This removes the need for healthcare staff to travel to the home and reduces the risk of infection associated with COVID-19.

Management of COVID-19

The service supports residential care workers to identify residents at risk of COVID-19 and who may require timely clinical assessment by a registered nurse or doctor.

Care home staff complete digital assessments using a smartphone application. This information is shared with health care professionals and allows staff to effectively triage residents. The service reduces unnecessary call outs, improves monitoring to reduce admissions and keeps residents safe in the home.

The challenges facing health and social care

The health and social care divide:
The pressures facing t he NHS and social care are unprecedented and now, more than ever, services need to join forces and work together.

Non elective admissions:
Care home residents account for nearly one in 12 emergency admissions for people aged 65 and over.

A need for a consistent approach:
There is a need to understand the health of the population in care homes in a systematic and consistent way. Records are often not shared with care teams and trends are not monitored.

An aging population:
An estimated 325,000 older people live in care homes in England, 4% of the total population over 65. The NHS needs to radically change to adapt to our aging society.

Benefits of the digital care home

- **Highlights changes in health:** The service acts as an early warning system, highlighting changes in health in a timely manner.
- **Reduces non elective admissions:** Enables timely intervention, reducing non-elective secondary care admissions.
- **Improves compliance:** Regular monitoring improves compliance around care and meets individual needs.
- **Reducing delayed transfer of care:** Clinicians are given the confidence that patients' needs will be met within the care home, increasing capacity within hospitals, supporting earlier hospital discharge and reducing delayed transfer of care.
- **Bridges the health and social care divide:** Integration with clinical systems including SystmOne and EMIS Web improves coordination between the NHS and care homes, bridging the gap between health and social care.
- Reduction in hospital stays.

Digital care home available services

The digital care home can monitor residents for a range of health conditions

- Undernutrition
- SBAR
- Diatetes
- MIST
- COVID - 19
- NEWS
- Heart rate
- Falls
- High Blood pressure

Data can be made available to NHS teams

Critical resident information can be shared by NHS teams. We integrate with leading GP and hospital systems, meaning potentially lifesaving patient data can be accessed by authorised healthcare professionals.

Community nursing | Dietetic | Falls | Ambulance service | GP | Emergency | COVID - 19

Single Point of Access (SPA)

Case study:

NEWS and SBAR in care homes across Darlington and Durham

Challenge:

- Community nursing services are under increasing pressure to deliver care to patients in care homes
- Multiple visits to the same care home each day by different teams
- No way to track incoming requests
- Care homes default to calling 999 / 111 and ambulances are dispatched

Solution:

- Digital assessment form for carer to complete with patient observations
- Central triage of patients and their symptoms enables nurses to direct the right care to the right patient at the right time
- Appropriate information is given to NHS responders
- Patient electronic health record is updated with latest results from carers and triage team

Outcomes:

- **45%** reduction in specialist nurse visits
- **18%** reduction in overall unplanned admissions
- **13%** reduction in out-of-hours unplanned admissions
- **24%** reduction in in-hours unplanned admissions

How does the SBAR service work?

Care worker refers resident onto service →

Care worker uses Inhealthcare professional app or online portal to complete questions about the resident's well-being →

In built algorithms determine which community team the residents information goes to ↓

Resident results are triaged, using the responses and NEWS2 algorithm ←

The care home is contacted either through the Inhealthcare system or via phone on how to proceed with care

Find out more at **www.inhealthcare.co.uk**

Southern Health and Social Care Trust

Case study:

Undernutrition monitoring at Southern Health and Care Trust

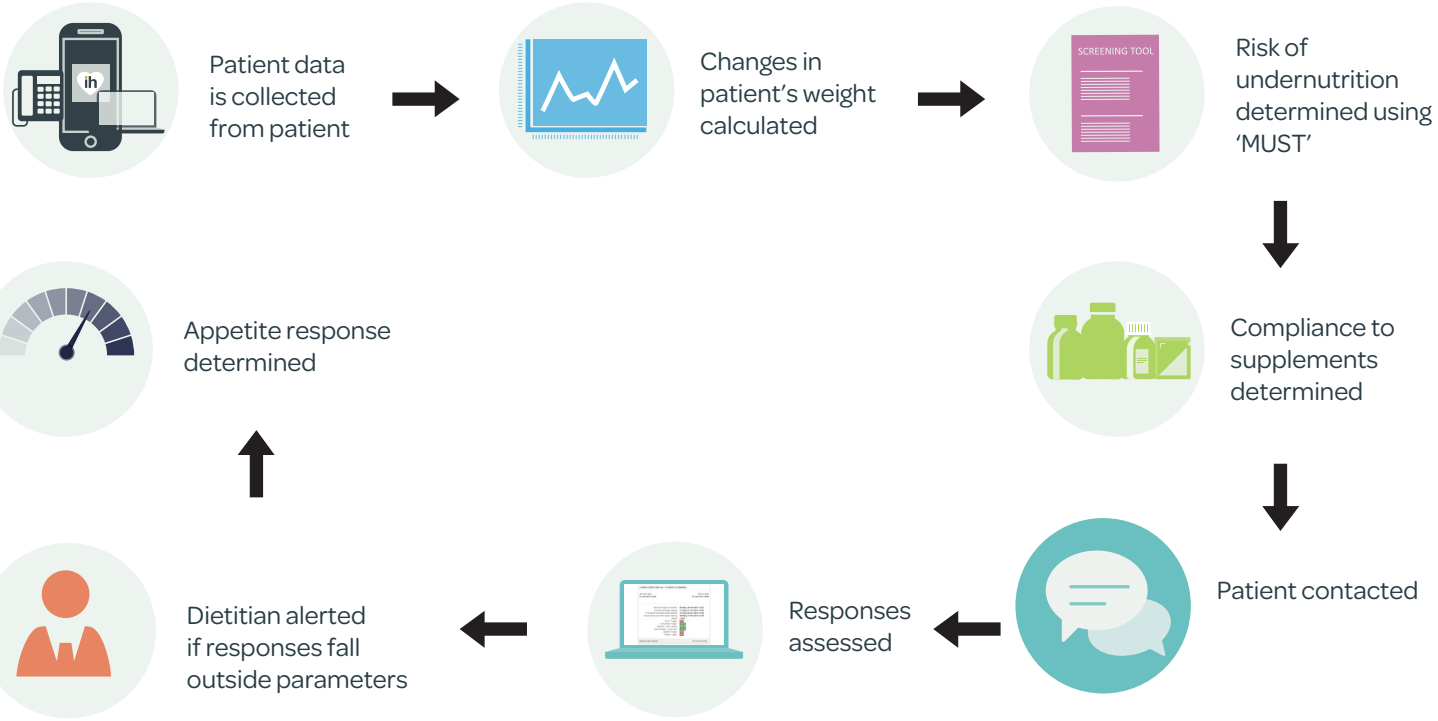
Problem:

- In 2014/15, oral nutrition support in the community/ domiciliary setting accounted for one-third of the adult Nutrition & Dietetic Service caseload.
- There was an increasing demand on the Nutrition & Dietetic Service as patients referred to the community service are more complex, often with multiple comorbidities.
- A significant resource was required for staff consultation time, travel time and travel costs.
- Dietetic intervention entails the use of oral nutrition supplements, which can be costly.

Solution:

- Inhealthcare delivered an on-line system that regularly monitors adult patients who are identified as at risk of malnutrition and prescribed an oral nutritional supplement.
- Care pathways were developed with the aim being to provide a more responsive Nutrition & Dietetic Service, with a significant proportion of care provided remotely.
- Patients triggering alerts would receive Nutrition & Dietetic support, whilst those patients who remain stable would continue to be monitored by the care home staff.
- Patient information is made available to authorised health professionals through the patient record.

How does the undernutrition service work?



Results

90%
Reduction in domiciliary visits

1-2 WEEKS
More timely reviews: 1-2 weeks, compared with up to 6 weeks

£3000
Saved on inappropriate use of Oral Nutritional Supplements for one Trust

4 MONTHS
Patients average time under the care of a Dietitian reduced from 6-9+ months to 4 months

" The automated system offers great support to the dietitians and empowers the care home staff to take a more proactive approach to monitoring their increasing number of vulnerable residents. The residents and their families feel more supported too because the frequency of monitoring has been increased along with more timely reviews. We couldn't go back to what we did before ".

Mandy Gilmore, Head of Dietetics at Southern Health and Social Care Trust

Case Study:

Management of COVID-19 in care homes in Northern Ireland

The care home sector has been badly hit by COVID-19. As well as housing a population that's inherently more vulnerable to the virus, Coronavirus has exposed existing vulnerabilities in our care homes, including staff shortages and inefficient coordination between homes and the NHS.

The simple service supports residential care workers to identify residents at risk and who may require timely clinical assessment by a registered nurse or doctor.

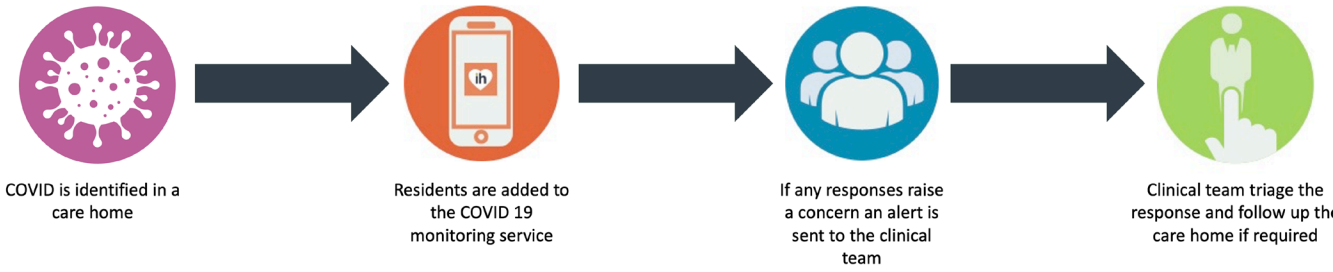
Care workers complete a daily questionnaire with residents outlining the signs and symptoms associated with COVID-19 and feed the answers into an app which sends the data safely and securely to community-based health care teams, such as district nursing and Enhanced Care at Home.

If any responses fall out of the range set for the resident, clinicians are alerted so they can intervene in the care of the individual and respond with appropriate support.

"I have learned the importance of observation, noting changes and communicating more closely with my colleagues and I am enjoying the opportunity to have more responsibility. This knowledge and experience has given me more confidence and made me more aware of any changes that arise as observations are done."

Care worker - a Health and Social Care Trust, Northern Ireland

How does the service work?



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