

Title	BADGER HOME VISITING GUIDELINES			Number	CL09
Effective From:	16.05.09	Duration:	Ongoing	Review:	01.05.25
Author:	Dr Fay Wilson			Version:	3.0
Other Ref:					
Contacts:					

Version Control

(Only last 3 versions, earlier versions can be found in the appropriate Archive directory for the document)

DATE	CHANGE	CHANGED BY
05.12.16	Reviewed. Patients not contactable by telephone and WM clinical hub added.	SMcD
22.05.19	Reviewed, no change	SMcD
21.04.22	Reviewed, minor changes in addition to 4.4, 4.5 5 being added. Also added CL16 Prioritisation of Home Visits - Guidance for Clinicians (CL16 archived)	SMcD/FW

1. Introduction

These guidelines are based on guidelines developed by Staffordshire Local Medical Committee in 1996, adopted by the National Association of GP Co-operatives and widely used throughout the UK.

NHS regulations require that in the case of a patient whose medical condition is such that in the reasonable opinion of the clinician the patient needs to be seen and it would be inappropriate for him to attend the Treatment Centre (TC), the clinician may decide to see the patient at home. The clinician may also take into account social circumstances which together with the patient's medical condition mean travel to a TC inappropriate. The clinician may also decide to refer the patient without first seeing him / her if sufficient assessment has been carried out without examination and a referral is appropriate.

2. Situations where a home visit is likely to be indicated:

Where a face to face consultation is needed for examination or treatment and the patient's medical condition means travel to the TC is not appropriate:

- The terminally ill
- Bed-bound patients
- Patients for whom travel would cause deterioration in their medical condition or unacceptable discomfort
- Housebound patients who are unable to travel without an attendant and where this cannot be arranged
- Where the patient is in prison, a secure unit or a unit with special arrangements
- Patients who cannot be contacted by telephone after reasonable attempts (i.e. a minimum of three failed attempts) to do so (visiting cards can be left at the patient's

- address with further instruction to contact BADGER on receipt of the card, sometimes known as a “safe and well check”)
- Patients deemed appropriate for home visit following assessment by WM clinical hub

3. Situations where on occasions visiting may be useful:

Where, after initial assessment over the telephone, a seriously ill patient may be assisted by a GP’s attendance to prepare them for travel to hospital. This applies where other commitments do not prevent the GP from arriving prior to an ambulance. If a GP has other patients requiring attention and is informed that a patient at home has symptoms suggesting immediate hospital transfer is required, it is more appropriate to request emergency ambulance than to arrange a home visit.

Examples of such situations are:

- Severe chest pain
- Severe shortness of breath
- Severe haemorrhage

4. Situations where visiting is not usually required:

4.1 Children

Fevers, cold, cough, earache, headache, diarrhoea/vomiting and most cases of abdominal pain; these patients are almost always well enough to travel by car. The “old wives’ tale” that it is unwise to take a child out with a fever is untrue. It may be that children are not fit to walk or travel by bus, but car transport is appropriate and may be arranged via friends, relatives or taxi firms. The NHS does not provide or pay for patient transport to a PCC.

4.2 Adults

Adults with problems of cough, sore throat, “flu”, back pain, abdominal pain are usually fit for transport by car to PCCs. Distance from a PCC is not itself a reason for a home visit. Where car owners are unable to drive because they have taken alcohol, the assistance of friends, family or taxi firms should be encouraged. The NHS does not provide or pay for patient transport to a PCC.

4.3 Older People

Age, care/nursing home residence or staff shortages at homes are not in themselves reasons for a home visit. Problems such as poor mobility, joint pain, general malaise are usually appropriately managed by consultation at GP premises. The exception is the patient whose acute medical problem adds to an underlying condition and therefore fulfils the guidance for a home visit.

4.4 Prescriptions & Documents

When a phone or remote assessment has been carried out by the clinician or another clinician (e.g. district nurse) there is no need for a visit to be carried out to see the patient or to deliver a prescription or medicines administration document.

4.5 Recognition of Death

See CL48 for guidance on remote ROD process

5. Prioritisation of Home Visits - Guidance for Clinicians

The purpose of prioritisation is to ensure that the most urgent visits are dealt with most quickly. The NHS has National Quality Requirements for home visits as follows:

Emergency **Priority 1** Clinician should arrive at patient's home within 1 hour of the decision being made to visit.

Urgent **Priority 2** Clinician should arrive within 2 hours of the decision.

Routine **Priority 3** Clinician should arrive within 6 hours of the decision.

5.1 Prioritisation of Visits

Clinicians forwarding BADGER calls for home visits select a clinical priority in line with these requirements. In summary:

Emergency P1 Life threatening emergency - patient will be at serious risk if visit is delayed more than 1 hour. [Note: if this is the case you should consider whether a 999 call would be more appropriate]

***Illustration:** If you were in your practice with a patient you would bring the current consultation to a close and immediately leave the surgery to do the visit.*

Urgent P2 Non life-threatening emergency where patient would be at risk of harm or undue suffering if visit delayed.

***Illustration:** In your practice you would finish the consultation, ask the receptionist to reschedule the appointments of patients not yet arrived, finish seeing patients already waiting and then immediately leave to do the visit.*

Routine P3

All other visits

Illustration: *In your practice you would finish the session, deal with any immediate administrative matters and queries and then set off to do the visit.*

St Giles Hospice

*Telephone advice calls should be made within 20 minutes of receiving the call.
Hospice visits must be started within 1 hour of the decision that a visit is required.*

If anyone is unclear or requires assistance please contact the Medical Director, Dr Fay Wilson on 07788 418513 or via the Team Leader. Comments and suggestions on this guidance are welcome.