CBC health

URGENT PRIMARY CARE SERVICE

Clinical Bulletin

February 2020

Home Visiting

It's better to go than say no!

(Raise your concerns later if you feel a visit request has been inappropriate)

Patients who are considered to need a home visit by a health professional should have a home visit in line with the timescales set out in urgent primary care specification *contractual requirements. There may be occasions when the preferred option, for example the Community Services Rapid Response Team (formerly Urgent Care Team), is unable to accommodate a GP's request to undertake a domiciliary assessment. In these circumstances it is preferable for the GP to visit. GPs may find it helpful to be guided by South Staffordshire LMC visiting guidelines.

Routine visit - within 6 hours from the time determined that a visit is necessary
Urgent visit - within 2 hours from the time determined that a visit is necessary

Should the patient be found in circumstances which renders assessment difficult or near impossible, GPs are encouraged to seek the support of the GatDoc driver who may be able to assist in making the patient more comfortable and accessible. GMC good medical practice advises that prompt action should be taken if you think that patient's safety, dignity or comfort are being compromised.

Caring for Carers

Requests for home visits can reflect that a carer has reached the point where they feel no longer capable of providing the support needed. This may manifest itself in a variety of ways which may impact on the welfare of the patient and need to be taken into consideration by the visiting clinician (safeguarding).
It may not always be the patient that <u>needs</u> the visit.

Record Keeping

GMC *Good Medical Practice Domain 1: Knowledge, skills and performance* says that doctors must record their work clearly, accurately and legibly.

A doctor's contemporaneous clinical record should include relevant clinical findings and the patient's circumstances, for example the home environment and who is present at the consultation. The record should also include decisions made and actions agreed, the information given to the patient or their carer(s), any drugs prescribed or other treatments recommended or administered, and who is making the record and when.

A recent case study that was externally reviewed by the PHSO found that a GP's record of a patient contact failed to meet the standards expected. This is rare in GatDoc with most doctors making clear reords. Home visiting records will continue to be subject to peer review on a quarterly basis to ensure consistently high standards and GPs will be provided with constructive feedback..

 Learning point arising from an actual incident

Pulmonary Thromboembolism – A diagnosis to consider

(https://cks.nice.org.uk/pulmonary-embolism)

How should I manage a person with suspected pulmonary thromboembolism?

Arrange immediate admission for people with suspected pulmonary embolism (PE) if:
They have signs of haemodynamic instability (including pallor, tachycardia, hypotension, shock, and collapse).
They are pregnant or have given birth within the past 6 weeks.

For all other people, use the two-level PE Wells score to estimate the clinical probability of PE:
Clinical features of deep vein thrombosis (DVT [minimum of leg swelling and pain with palpation of the deep veins]) — plus *3 points.*
Heart rate greater than 100 beats per minute — plus *1.5 points*.
Immobilization for more than 3 days or surgery in the previous 4 weeks — plus *1.5 points*.
Previous DVT or PE — plus *1.5 points*.
Haemoptysis — plus *1 point*.
Cancer (receiving treatment, treated in the last 6 months, or palliative) — plus *1 point*.
An alternative diagnosis is less likely than PE — plus *3 points.* Alternative conditions to consider include:

- Respiratory conditions, such as pneumothorax, pneumonia, and acute exacerbation of chronic lung disease.
- Cardiac causes, such as acute coronary syndrome, acute congestive heart failure, dissecting or rupturing aortic aneurysm, and pericarditis.
- Musculoskeletal chest pain. Note that chest pain with chest wall palpation occurs in up to 20% of people with confirmed PE.
- Gastro-oesophageal reflux disease.
- Any cause for collapse, such as vasovagal syncope, orthostatic (postural) hypotension, cardiac arrhythmias, seizures, and cerebrovascular disorders.

For people with a Wells score of more than 4 points (PE likely), arrange hospital admission for an immediate computed tomography pulmonary angiogram (CTPA) and, where necessary, other investigations.

- **If there will be a delay in the person receiving a CTPA,** give immediate interim low molecular weight heparin (LMWH [dalteparin, enoxaparin, or tinzaparin]) or fondaparinux, and arrange hospital admission.

For people with a Wells score of 4 points or less (PE unlikely), arrange a D-dimer test:

If the test is positive, arrange admission to hospital for an immediate CTPA and, where necessary, other investigations. If a CTPA cannot be carried out immediately, give immediate interim LMWH (dalteparin, enoxaparin, or tinzaparin) or fondaparinux, and arrange hospital admission.
If the test is negative, consider an alternative diagnosis.

Feedback

Have you anything you wish to contribute to our next newsletter?
We would welcome any comments about the style and content of this bulletin, and suggestions for future articles. Please give us your feedback by contacting the UPC Team at NGCCG.GATDOC@nhs.net