University Hospitals of Leicester NHS
NHS Trust

Patient Home Assessment Policy for Occupational Therapy

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Board Director Lead:	Chief Nurse
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CONTENTS

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

Reviewed December 2020 – changes made to DNACPR to refelect RESPECT form

KEY WORDS

Home Visit,Patients Homes, Occupational Therapy, Occupational Therapist, Access Visit, Discharge

1 INTRODUCTION AND OVERVIEW.

This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for Occupational Therapy (OT) home assessments with hospital inpatients to facilitate discharge from hospital.

This policy and the supporting procedures aim to ensure that home assessments are agreed, organised and carried out effectively; and that all necessary measures are taken to ensure the health and safety of both patients and staff.

2 POLICY SCOPE –WHO THE POLICY APPLIES TO AND ANY SPECIFIC EXCLUSIONS

2.1 This policy applies to all Occupational Therapists, including temporary or locum staff, and Occupational Therapy Technical Instructors (TI) (Band 4) who undertake home assessments.

2.2 Student Occupational Therapists may carry out a home assessment if accompanied by a member of the Occupational Therapy staff, with due considersation for their level of experience and ability.

2.3 Nursing staff or other medical staff who are needed for medical support for the patient whilst out on the visit. This would be for Home Assessments only

3 DEFINITIONS AND ABBREVIATIONS

3.1. A Home Assessment is conducted by Occupational Therapy staff to assess and evaluate the functional abilities of the patient in their home environment, enabling the Occupational Therapy staff to make recommendations to facilitate discharge or optimising independence in the home.

3.2. An Access Home Assessment is conducted if it is appropriate to carry out an assessment of the home environment without the patient present.

4 ROLES – WHO DOES WHAT

4.1 The **Chief Nurse** has executive responsibility for this policy

4.2 Consultant / Specialist Registrars

The Consultant/Specialist Registrars will be responsible for determining if their patient is medically fit enough to undertake the assessment; and confirming that their patient can undertake a home assessment if there is a Do Not Attempt Cardiopulmonary Resuscitation (DNA-CPR) order. The responsibility for discharge remains ultimately with the Consultant/Medical Team.

4.3 Named Nurse / Nurse in Charge

The Named Nurse or Nurse in Charge will be responsible for identifying any medication and/or oxygen needs that the patient may have during the

assessment, making arrangements for these to be administered, if required, and documenting this information in the medical notes.

4.4 Named Occupational Therapist or Technical Instructor (Band 4)

The Occupational Therapist or Technical Instructor is responsible for:

- The decision to carry out a home assessment in liaison with the multi-disciplinary team
- Arranging the home assessment or co-ordinating the arrangements if delegated o carrying out the home assessment
- Carrying out the home assessment
- providing feedback to the multi-disciplinary team

The Occupational Therapist or Technical Instructor will carry out the home assessment independently if meeting carers or other agency staff at the patient's home.

A second member of staff may attend to ensure the safe and effective management of the patient or equipment, i.e.

- Where the patient's clinical condition warrants additional assistance
- To accompany an Occupational Therapy staff when no-one else is present
- To assist with a patient where there are manual handling concerns or the patient has poor mobility
- To provide additional support where there are concerns regarding the home environment

The member of staff carrying out the home assessment will make arrangements with a colleague to act as a 'buddy' to ensure their safe return following the home assessment, in accordance with the UHL Lone Worker Policy (Trust Ref B27/2008).

4.5 Occupational Therapy Team Leaders

The Occupational Therapy Team Leaders are responsible for:

- Ensuring new staff are aware of policy via local induction procedures
- Ensuring any incidents are reported via DATIX incidents and reference to learning
- Providing advice / support / de-brief to staff during and following any incident.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS –WHAT TO DO AND HOW TO DO IT

5.1 Criteria for Home Asessment

a) The reasons for which a home assessment may be carried out include:

- To assess the patient's ability to manage at home

- To assess for equipment and minor adaptations essential for discharge to be requisitioned by OT staff
- To assess the home environment and it's suitability as a place of discharge bearing in mind the equipment needs and functional abilities of the patient.

b) Home assessments, where appropriate, are an integral part of occupational therapy intervention. The named Occupational Therapist or Technical Instructor (TI) (Band 4) will determine the need for a home assessment in liaison with the multi-disciplinary team and the patient. In exceptional circumstances a discharge home assessment may be undertaken with prior permission of the Therapy Lead and agreement with the Consultant/Medical team and nurse in charge of the ward to keep the bed open. All other requirements to enable a safe discharge must be in place e.g. discharge medicines, re-start of care packages.

c) Home assessments must ideally be carried out when the patient has reached their optimum level of performance in activities of daily living.

d) If the patient lives outside of Leicestershire and Rutland, staff must ascertain if it is appropriate and possible for the patient to be transferred to a local hospital, or for local agencies to carry out an assessment without the patient. Occupational Therapy staff at UHL must liaise with the patients local Occupational therapy team to discuss the clinical reasoning for the visit and to determine if there is capacity for this to be completed locally.

5.2 Organisation of Home Assessment

a) All the arrangements for the home assessment must be recorded on the Home Assessment Arrangements Form – Appendix A.

b) The need for a home assessment must be discussed and agreed with the patient, their carers/relatives and relevant members of the multi-disciplinary team.

c) The decision and reason to carry out or not carry out a home assessment must be recorded in the patient case notes.

d) The patient's consent must be obtained and documented in the patient case notes before carrying out a home assessment.

e) Patient's family/carers, as identified by the patient, must be invited to attend the home assessment. Consideration must be given to the number of people invited.

f) The Occupational Therapy staff must arrange for relevant professionals to attend the home assessment e.g. Physiotherapist, District Nurse, Social Worker, and Social Services Occupational Therapist where their input is essential for decisions to be made on the assessment. The number of professional representatives must be kept to a minimum.

g) If the patient's relative/carer or advocate is not available to attend an access home assessment; in an unoccupied house another healthcare professional must accompany the Occupational Therapy staff. The patient must complete the consent form, Appendix B, prior to the assessment.

h) If there is an infection risk regarding the patient, the Infection Prevention Nurse must be contacted for advice and arrangements made in accordance.

i) Transport arrangements must be appropriate to the patient's needs. Taxis are the preferred mode of transport, the appropriate type i.e. saloon, estate or wheelchair friendly must be booked as per the Taxi Booking Procedure which can be found in the Occupational Therapy Dept on all three sites. If an ambulance is required this must be booked following local ambulance booking procedures.

j) If an out-of-county assessment needs to be carried out, the Team Leader must liaise with the relevant CMG Manager for authorisation to book transport via the ward. If this is not possible staff must arrange appropriate transport: a taxi booking must be approved by a Therapy Lead

k) Occupational Therapy staff may use their own cars for access home assessments ONLY providing they have appropriate insurance and authorisation If an access home assessment is at the end of the day, and staff wish to go straight home following the assessment, they must obtain permission from their Team Leader or Band 7 therapist and follow the procedures in the UHL Lone Worker Policy (Trust Ref B27/2008).

All home assessments must be completed by 4.00pm. If a home assessment is carried out at the end of the day, when it may be getting dark, another member of staff must be present.

5.3 Administration of oxygen and medication

a) Where the patient requires oxygen on a home assessment the procedure outlined in Appendix C must be followed and documented.

b) The nurse caring for the patient is responsible for identifying any medication needs or issues that the patient may have during a home assessment. Any concerns must be discussed with the patient's medical team. If the patient requires medication to be administered during a home assessment consider:

- Can the patient administer their own medication
- Can the dose times be negotiated without affecting the drug therapy
- Could appropriate carers administer the medication?

If the medication is considered essential, must be administered during the visit and the patient cannot administer this themselves a nurse must escort the patient on the visit. This must be discussed with the medical team and Nurse in Charge /Ward Sister.

c) Occupational Therapy staff must NOT administer medication.

5.4 24-48 hours prior to the Assessment

a) Prior to the assessment (24 - 48 hours), the Occupational Therapy staff must contact the Doctor to ascertain that the patient is medically fit enough to undertake the assessment this must be recorded in the patient case notes.

b) If the patient has a RESPECT form completed, check this is in date and confirm with the Consultant that the home assessment can go ahead. Section 4 on the RESPECT form indicates what the recommendations are for emergency care

and treatment. Take a photocopy of the RESPECT form with you on the home assessment.

c) Make arrangements with an OT colleague, to ensure safe return to the hospital. Please ensure that they are aware of where you are going, a contact telephone number and an estimated time that you are expected back to the hospital. This will referred to as a 'buddy system'

5.5 On the day of, and during the Assessment

a) The named nurse must inform the Occupational Therapist of any changes in the patient's condition

b) When collecting the patient from the ward the OT must make a final verification with the nurse in charge that the patient remains fit enough to undertake the assessment. This must be recorded in the patient case notes.

c) The Occupational Therapy staff must ensure the patient is appropriately dressed for the home assessment. In inclement, cold or hot weather the Occupational Therapy staff will determine whether the home assessment must be postponed.

d) The Occupational Therapy staff must wear their identification badges.

e) Mobile phones are available, and must be taken on the home assessment in case of emergency and to increase safety.

f) The Occupational Therapy staff must take the completed Home Assessment Arrangements Form on the assessment. Other essential information, which may be required on the assessment, or noted on the assessment, must be detailed on the back of this form. This must be kept in the secure folder provided. Diaries must not be taken on the assessment. It is advised that any confidential information relating to the patient stay within the hospital unless absolutely necessary. If it is essential to take such a document on a home assessment, staff must use the document wallet provided and ensure that the documentation is kept safe and confidential at all times.

g) The Occupational Therapy staff must take the completed Home Assessment Arrangements Form Self Discharge Form, Minor Adaptations Forms and a kit bag containing supplies to deal with minor emergencies.

h) The provision of equipment or minor adaptations must be in accordance with the Joint Working Arrangements. Occupational Therapy staff carrying out home assessments may be under pressure to provide equipment or services, which are not judged to be essential, or which have cost implications beyond their authority. Care must be taken to avoid any promises or agreements in such cases.

5.6 Self Discharge

a) Should the patient refuse to return to the hospital the Occupational Therapy staff must encourage him/her to return and advise him/her of the implications of not doing so. If the patient still wishes to remain at home, the Occupational Therapy staff must ask the patient to sign a Self Discharge Form, explaining the nature and purpose of the form.

b) The Occupational Therapy staff must ring the Nurse in Charge and the GP as soon as possible, to inform them of the situation and for them to arrange relevant health/social care support.

c) On return to the hospital the Occupational Therapy staff must or inform the medical/nursing staff and OT Team Leader or record DATIX incidents or record

the details in the patient case notes or file the Self Discharge Form in the patient case notes. The Occupational Therapy staff should also update Nerve Centre.

5.7 Medical Emergency - Medical Assistance Not Required

a) First establish the need for medical assistance, if the therapist is in any doubt medical assistance must be summoned.

b) Reassure the patient and relatives/carers

c) Make the patient comfortable

d) Carry out basic first aid if competent to do so, eg for burns, cuts, grazes

e) Determine if patient is able to continue with the assessment

f) If patient is not able to continue with the assessment and if appropriate, make arrangements to return to the hospital earlier than the pre-arranged time

g) On return to the hospital immediately inform the medical staff, nursing staff and OT Team Leader. A DATIX incident must be completed

5.8 Medical Emergency - Medical Assistance Required

a) First establish the need for medical assistance, if the therapist is in any doubt medical assistance must be summoned.

- Reassure the patient and carers
- Delegate to staff or carer to ring 999 for an ambulance
- If you suspect the patient may have died; confirm cardiac arrest and if the patient has stopped breathing and shows no signs of life, start cardio-pulmonary resuscitation. Continue resuscitation until someone else assumes lead responsibility i.e. EMAS by phone or ambulance crew.
- Accompany the patient to ED and remain with them until they are admitted via ED or returned to their original ward
- At the earliest opportunity telephone the ward, speak to the nurse in charge. Inform them of incident and action taken. Ask the nurse to inform the Medical staff and Occupational Therapy Team Leader

b) On return to the hospital report DATIX incident must be completed. Occupational Therapy staff to document event in patient case notes.

5.9 Threatening or Violent Behaviour

a) In the event of any threatening behaviour or violence, by the patient or members of his/her household, towards the OT staff, he/she (including any other members of staff present) must leave the household calmly without engaging in any argument. In the event of a member of the OT staff being attacked, they are entitled to protect himself/herself with only such degree of force as is necessary and reasonable.

b) The Occupational Therapy staff must leave as soon as possible. If appropriate the police must be summoned. At the earliest opportunity they must inform their line manager and the ward. If appropriate/possible the patient must complete a Self Discharge Form.

c) In the event that the Occupational Therapy staff are unable to leave the situation and it is not appropriate to contact the police, they must attempt to contact the OT Department at UHL. The Occupational Therapy staff must ask the

department to ‘cancel the visit with Mrs Grace’. The Occupational therapy staff within the department must then contact the police as the staff on the home assessment are unable to exit a threatening situation.

d) On return to the hospital the Occupational Therapy staff must report the incident to a Team Leader / Lead OT and complete an incident form (DATIX incidents). Any physical assaults must be reported via the reporting line on ext. 2728. In the event of an incident the staff involved must be offered a de-brief and support as appropriate, reference UHL Management of Violence, Aggression and Disruptive Behaviour policy (Trust Ref B11/2005)

5.10 Money / Valuables

a) If the patient wishes to bring valuables back to the hospital for safe keeping, the value/details must be placed in an envelope, with the valuables listed, sealed and signed over, and witnessed. The patient must be informed that of any money deposited at the hospital will be held in a central safe off the ward; only £250.00 will be returned in cash, the rest will be returned in the form of a cheque. Any valuables/property taken at the patient’s request must be handed to the Nurse in charge on return for taking into safekeeping as per the Management of Patient Property Policy and Procedure (Trust Ref B24/2007).

5.11 Medication

a) If a quantity of medicine is found in the patient’s home that is considered inappropriate or hazardous, the Occupational Therapist must advise the patient to take it to the ward and hand over to the nurse in charge. If medication is left at home, the Occupational Therapist must alert the Consultant/medical Team.

b) In the event of a patient attempting to take medication or other substances e.g. alcohol found at home, the Occupational Therapist must advise against it. Where the patient takes such medication, against the therapist’s advice, the therapist must inform the team doctor/nurse in charge at the earliest opportunity upon return to the hospital. An incident form (DATIX incident) must be completed and the line manager informed

5.12 Gas Heating Appliances in Sleeping Accommodation

a) If it is recommend that the patient’s sleeping arrangements change and that they are to sleep in a room with a gas heating appliance the Occupational Therapy staff must advise the patient, or their carer, to have the appliance checked, issue a letter (Appendix E) and inform the Social Worker, if appropriate. A copy of the letter must be retained in the patient’s case notes, including their hospital number.

b) If during the home assessment it is noticed that any gas appliance appears dangerous (covered in soot, fumes etc) then the Occupational Therapy staff must advise the patient, or their carer, to have the appliance checked by a Gas Safe registered engineer. A record of the advice given must be made in the patient case notes.

5.13 Post-Assessment

a) The Occupational Therapy staff must give a verbal and written summary to the multidisciplinary team at the earliest opportunity. This is particularly relevant where the discharge is imminent and the home is unfit to return to or the patient is unsafe.

b) A home assessment report must be completed after each home assessment, which must be filed in the patient case notes within two working days. The report must be typed and copies may be sent to other member of the multi-disciplinary team as appropriate, and in line with Data Protection procedures. The report format is detailed in Appendix F.

c) If minor adaptations are required these must be ordered in accordance with the Occupational Therapy Joint Working Arrangements with social services.

This policy is supported by the following procedures which must be used in conjunction with this policy:

Procedure	Appendix
Home Assessment Arrangements Form	A
Patient's Agreement for OT Staff to carry out a Home Assessment when they or their Relatives are not in Attendance	B
Procedures for Patients requiring Oxygen on a Home Assessment	C
Procedures to follow if the Patient has a current DNA-CPR	D
Gas Heating Appliances in Sleeping Accommodation	E
Home Assessment Report	F
Guidelines and procedures issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from any relevant Trust guidelines or procedures providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible healthcare professional' it is fully appropriate and justifiable - such decision to be fully recorded in the patient's notes	

6 EDUCATION AND TRAINING REQUIREMENTS

All Occupational Therapy staff complete the Occupational Therapy competencies upon commencing at UHL. Additional support maybe required depending on circumstances of visit or individual learning needs.All Ocupational Therapy staff to be indate with their Basic Life Support and Deteriorating Patient ELearning on HELM. Where appropriate staff should also complete the RESPECT ELearning on HELM.

7 PROCESS FOR MONITORING COMPLIANCE

8 EQUALITY IMPACT ASSESSMENT

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs. As part of its development, this policy

Element to monitored	Lead	Tool	Frequency	Reporting arrangement	Acting on recommneda tion and lead	Change in Practice and lessons to be shared
DATIX incidents reports	**Therapy Quality and safety**	**Report run**	**Quarterly**	**Through Quality and safety Lead**	**Escalating concerns**	**communication to all staff**
Complaints	Therapy Quality and	Report run	Quarterly	Through Quality and safety Lead	Escalating concerns	Email communication to all staff

and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

This document must be read in conjunction with:

- Occupational Therapy Joint Working Arrangements
- Lone Worker Policy Trust Ref B27/2008
- Taxi Booking Procedure
- Cardiopulmonary Resuscitation Policy Trust Ref E4/2015
- UHL Management of Violence, Aggression and Disruptive Behaviour Policy (including Restraint Guidelines) Trust Ref B11/2005
- UHL Management of Patient Property, Policy and Procedure Trust Ref B24/2007
- Recommended Summary Plan for Emergency Care and Treatment (RESPECT) Trust Ref E1/2020

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This document will be uploaded on to SharePoint and available for access by Staff through INsite. It will be stored and archived through this system.

This policy will be reviewed in November 2023 or sooner should significant changes be required.

Home Assessment Arrangements Form

Appendix A
Occupational Therapy Home Assessment Policy

Name: Organiser:

Address: Date:

Time:

Access:

Post Code: G.P.:

Tel No: G.P. Tel No:

Alert / Special requirements:

Reason for assessment:

Other agencies/staff attending (inc. contact no):

Other relevant information:

Transport Arrangements:

- Taxi
- Estate taxi
- Wheelchair friendly taxi
- Own car

Outward time:
Return time:
Pick-up point:
Date booked:

Action:

- Inform patient / ward / carers
- Details in ward diary / departmental diary
- Before you leave check that the patient is medically well enough to attend, has had relevant medication and is appropriately dressed.
- If the patient has a current DNA-CPR form this must be taken on the home assessment in case of a medical emergency. The form MUST be returned to the medical notes on return to the hospital.
- Remember to take with your supplies to deal with an emergency
- On your return, give a verbal report to the nursing/medical staff and make the patient comfortable

Patient's Agreement for OT Staff to carry out Home Assessment when they or their relatives are not Present

(to be printed on Trust headed paper)

Hospital No:_____ Ward: _____

I (name) _____

Of (address) _____

_____

agree to (name) _____, Occupational Therapy staff accompanied by (name) _____visiting my home, in my absence, for the purpose of assessing my home environment on (date)_____.

I confirm I have given (name) _____keys to my property in order to gain access. I understand nothing will be altered or changed in my property without my prior knowledge and consent.

Signed: _____ Date: _____

Witnessed by:-

Name: _____ Post: _____

Signature: _____ Date: _____

Original - kept with Occupational Therapy records. Copy - given to the patient.

I, (name)_____, acknowledge that the keys to my property have been returned to me by (name)_____on (date)_____ following the home assessment carried out on (date)_____.

Signed: _____ Date: _____

Witnessed by:-

Name: _____ Post: _____

Signature: _____ Date: _____

When arranging a home assessment for a patient requiring oxygen, the following procedures must be followed and details documented on the check list.

1. If required, a suitably trained member of the nursing staff may accompany the patient on the visit and be responsible for the administration of the oxygen.

2. The Occupational Therapist/nurse must arrange for the provision of oxygen supply. In determining an adequate supply of oxygen the following must be given consideration:

   a) Is the oxygen required continuously or intermittently?
   b) The concentration level required.
   c) Does the patient have an oxygen supply at home, if so, what type?
   d) The duration of the journey (outward and return) and time required to carry out the assessment
   e) Ensure the size of the cylinder is appropriate to the above. Do NOT take cd/pd size cylinders as extra oxygen must always be available to cover delays or emergencies

   Consideration must also be given to the oxygen tubing to allow the patient to move around the house whilst connected to the oxygen supply if this is appropriate.

3. Prior to the visit, ensure :
   - OT checks the amount of oxygen left in the cylinder and how long it will last, if insufficient, contact the porters for a replacement cylinder
   - the valve is opened and checked at least 30 minutes before departure

4. The Occupational Therapist must arrange the transport. The type of transport will be determined by the individual patient's needs and their oxygen requirements.

   If patients require continuous oxygen or a large supply of oxygen, ambulance transport with an oxygen supply on board must be used, in order to maximise the use of the cylinder.

   When booking an ambulance two clear working days notice must be given. The ambulance requirements must be discussed with the Ambulance Liaison Officer.

5. If carrying oxygen in a taxi a compressed gas sign must be displayed. This is the responsibility of the Occupational Therapist. When oxygen cylinders are transported, they must be properly secured.

6. Do not allow the patient who is on oxygen to go near (minimum 10ft) any naked flames *i.e. gas fire, cooker etc.*

7. If the patient is on high flow oxygen, do not carry out the home assessment until this is discontinued.

PROCEDURES FOR PATIENTS REQUIRING OXYGEN ON HOME ASSESSMENTS

CHECK LIST

Name: _____ *Hospital No:* _____

Address: _____

_____

Staff Accompanying Patient:

Occupational Therapist: _____

Nursing Staff: _____

Home Assessment Duration: _____

Travel time: _____

Total: _____

Extra oxygen must always be available to cover delays or emergencies

Oxygen Requirements:

Continuous/Intermittent: _____

Concentration Level: _____

Oxygen at home: Yes / No Type: _____

Porters Informed: Yes / No

Size and Number of cylinders booked: _____

Compressed gas sign: Yes / No

Signed: _____ *Date:* _____

Transport: To be arranged by the Occupational Therapist following discussion with nursing staff.
Type Ambulance ϒ Estate Taxi ϒ Wheelchair Friendly taxi ϒ

Refer to :Recommended Summary Plan for Emergency Care and Treatment (RESPECT) Trust Ref E1/2020

1. ORGANISATION

   If a patient has a RESPECT form check this is in date, signed by a consultant or SPR and is filled in correctly. Take a copy of the RESPECT form on the vist. Please note the recommendation for the emergency care and treatment within section 4 on the RESPECT form.

   The named OT needs to check on the RESPECT form if the patient's family has been informed of the decision. If the family will be present on the home assessment, and are not aware of the resuscitation decision; then the patient will need to be advised that in the event of an emergency situation the family may need to be informed.

2. PRIOR TO THE ASSESSMENT (**24** hours)

   The named OT must confirm with the Consultant /SPR that the home assessment can go ahead and record this in the patient case notes

3. ON THE DAY

   When collecting the patient from the ward; the OT must make a final check with the nurse in charge of the patient that the patient remains fit enough to undertake the assessment. This must be recorded in the patient case notes.

   A copy of the RESPECT form must be taken on the home assessment in case of a medical emergency. This form MUST be kept confidential in a folder marked 'PRIVATE & CONFIDENTIAL' AND 'Property of the Occupational Therapy Service, University Hospitals of Leicester NHS Trust, including site and contact telephone number'. The form MUST be returned to the patient case notes on return to the hospital.

4. IN THE EVENT OF A MEDICAL EMERGENCY where medical assistance is required:
   - Reassure the patient and others present on the assessment
   - Delegate to staff or carer to ring 999 for an ambulance
   - Carry out basic first aid if appropriate and if competent to do so
   - Administer oxygen (maximum -15 litres) if available
   - If you suspect the patient has died; complete ABC assessment. If the patient has

stopped breathing and shows no signs of life; cardio-pulmonary resuscitation must NOT be started

- Inform the family, if present, that the patient may have died and that they are not for resuscitation.
- Dignity of the patient must be maintained throughout and comfort given to the family.
- When the ambulance crew arrives inform them that the patient is for active treatment but not for CPR, show them the RESPECT form
- The ambulance crew will record life extinct if the patient has died; and the patient will be taken to the mortuary at LRI
- At the earliest opportunity contact the ward to notify the nurse in charge. Ask the nurse to inform the medical team, the OT department and Bereavement Services
- On return to the hospital the Team Leader must be informed, and an incident form (DATIX incidents) completed

In the event of an incident the staff involved must be offered a de-brief and support as appropriate.

(to be printed on Trust headed paper)

(date)

Dear

RE: GAS HEATING APPLIANCES IN SLEEPING ACCOMMODATION

It has been noted that there is a gas heating appliance in the room you are planning to use as sleeping accommodation.

This appliance may be dangerous if it is not of the 'room sealed' type. The law states, under the Gas Safe (Installation and Use) Regulations 1994, that a room to be used for sleeping must have a heating appliance of the 'room sealed' type and not an open flue.

You are advised to have your appliance and its flue outlet checked immediately by either a British Gas or Gas Safe Registered (previously known as CORGI) engineer, to assess its suitability for use in a room used for sleeping.

If you are in privately rented or council property, please notify your landlord of the new sleeping arrangements.

It is also advised that a carbon monoxide detector is fitted prior to discharge if you are to sleep in a room with a gas fire.

In the event of any queries advice must be sought from a British Gas or Gas Safe Register engineer.

Yours sincerely

(Name & designation)

(Copy to be placed in the patient's case notes, including hospital number)

Home Assessment Report

Hospital No: ***Name:***

Address:

Area: ***Date of Assessment:***

Those Present:

Reason for assessment:

Social situation:

Views of patient & family/carers:

Recommendations: **Action by:**

1.
2.
3.
4.

Conclusion:

Signed: Name:

Designation: Date: