Hertfordshire and West Essex

Shared Care Record

Case Study – Physiotherapy

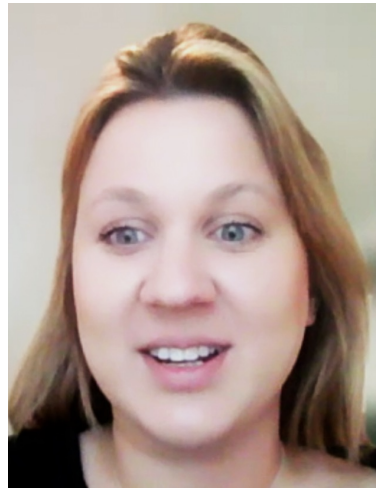
One of my service users is an autistic person, with a learning disability, in his early thirties. He has cerebral palsy in all limbs and was referred to our specialist team for physiotherapy.

Before our first appointment, I used the Shared Care Record to gather his medical history. I could see that he had seen a physiotherapist in the mainstream community service but had been discharged after four sessions. From the notes available, it was clear that the care had broken down because the individual was highly anxious and found it hard to tolerate any level of pain or discomfort in treatment.

Knowing this information, I was able to plan accordingly and asked a psychologist, already working with the individual, to attend the appointment with me. I was able to take a different approach and build trust with the individual from the start. This has made a huge difference to the success of the treatment.

When the same service user needed a referral for orthotics, I was able to look straight on the Shared Care Record to see when the appointment was booked. His care home is so busy that it is likely he would have gone to the appointment without me. I was able to give my professional opinion about what was needed and make sure he was given appliances that he would be happy to use.

"For someone with a learning disability, reasonable adjustments make the difference between being able to access a service successfully or not. We are able to provide that through the historical information available - I think that is amazing."



Alys Howells
Specialist Learning Disability Physiotherapist
Hertfordshire Partnership University NHS Foundation Trust

My Care Record

Hertfordshire and West Essex Integrated Care System

Hertfordshire and West Essex

Shared Care Record

Case Study – Adult Social Care

‘P.’, a gentleman in his late seventies, fell on the ice whilst away from home and was conveyed to the nearest hospital in London. Several weeks later, recovering from hip surgery, our team arranged a package of care to support him to return to his home in Hertfordshire.

On the day of his discharge, the visiting therapist quickly reported back to us that all was not well. P.s flat had no heating, was very damp and simply wasn’t safe for him to stay. The best possible solution was for him to spend a few nights in a care home. However, as this hadn’t been planned for, we hadn’t been provided with a covid test result as part of his discharge. It was approaching 5 pm and was too late to request a visit from a public health colleague. P. was at risk of being readmitted to hospital.

The Shared Care Record came to the rescue. We were able to see the record from his GP in Hertfordshire as well as information from the hospital in London. This allowed us to confirm to the care home that P. had had his vaccinations and boosters, and that a negative Covid result had been obtained by the hospital following his surgery.

By 9.30 pm he was warm and well, settled into the care home, having a cup of tea.

“We saved at least two hours of our team’s time. There was no time required from colleagues within the GP practice, 111, or local public health service. Most importantly the gentleman didn’t need to undergo another test or spend a number of hours of worrying how he would manage without having to go back to hospital."

Daryl Knight
Deputy Head of Service, Integrated Discharge Team
Hertfordshire County Council

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Shared Care Record

Case Study – Acute Pharmacy

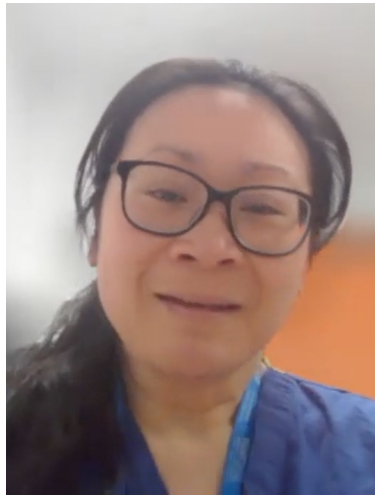
A seventy-year-old lady was brought into the Frailty Unit presenting with confusion. The patient was epileptic and had had a fit earlier that day.

Before we had access to the Shared Care Record, it was common for me to spend forty minutes on the phone, queueing to get through to the GP practice for an up-to-date list of medications. However, within minutes of looking at the Shared Care Record, I could see that the medication she had been given in hospital wasn't the same as her standard prescription. The record also showed that the patient needed an opiate patch which is a strong painkiller and I was quickly able to ask the doctors to re-prescribe.

Without the correct medications, the patient would have been much more likely to have another seizure and be admitted to hospital.

For frailty patients, the consequences of getting a prescription wrong can be severe; often if a medication or the correct dose is not continued, a person's condition can deteriorate really quickly.

"The information available is invaluable in terms of getting the correct treatment plan. We get a picture from multiple providers of the patient's journey leading up to when they come to hospital. It's all about patient safety and continuity of care."



Shirley Ip
Lead Frailty Pharmacist
The Princess Alexandra Hospital NHS Trust & Herts and West Essex Integrated Care Board

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Shared Care Record

Case Study – Out of Hours

We received a call to the 111 service as an elderly lady, around ninety years old was walking outside, confused and disorientated, unable to find her way home. A concerned neighbour made the call to ask for help but didn't know the individual well.

In this kind of situation, we need to build a picture of what is happening, but the patient and caller are not able to provide background information. We were able to access the patient's medical history through the Shared Care Record and this showed that they suffer from vascular dementia.

If we hadn't had access to that critical information, it is likely that we would have sent that patient to A&E. Calling an ambulance would have been very distressing for the individual. Actually, they would benefit more from a home visit or just calling a family member.

Using the Shared Care Record meant we had a better outcome. You've prevented an admission; you've prevented an ambulance coming out that could then be going to see someone else with a heart attack or stroke.

"If you have one system, one care record, it's just so much easier. It can save a lot of time and we can get the patient to where they need to be."

Oliver Poole
Consultation Nurse
HUC

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Shared Care Record

Case Study – Community

A sixty-two-year-old woman had been referred to the community complex care team because of concerns about her capacity to administer insulin. The individual had multiple health issues alongside diabetes, including mental health problems, a learning disability, Parkinson's Disease, and a history of falls.

The District Nurse found the patient did not want support and was difficult to engage with. Using the Shared Care Record, I could see several recent incidents and frequent calls to the Out-of-Hours service, however, the patient couldn't remember or communicate the details of these incidents.

The Shared Care Record allowed me to build a picture of what was really going on. The main issue the patient presented with was falls and her blood sugar was under control.

I didn't need to spend additional time calling the Out of Hours service for more information and I could more confidently say she could be discharged from the District Nurse's care. For the patient it is much better that the right services are going in to deliver care.

"I use the Shared Care Record every day. It's just there at your fingertips and I am right up-to-date. It is what the patients deserve."

Grainne Costello
Complex Case Manager
Central London
Community Healthcare
NHS Trust

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Case Study – Acute A&E

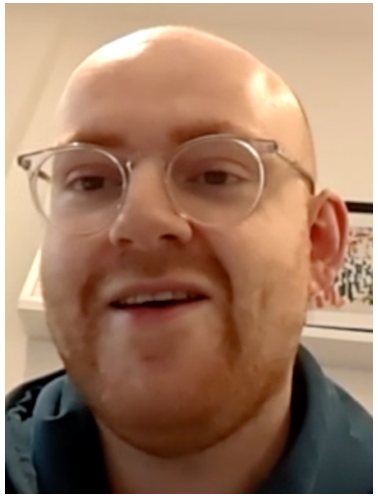
A young, male patient with complex neurological and mental health conditions attended A&E at Princess Alexandra having seizures. The individual hadn't been seen at the hospital before but records from previous care at a hospital in Croydon were available in the Shared Care Record.

The letters and discharge summaries available meant I could see not only his diagnosis, but also the medication he needed immediately in order to avoid further seizures. Without this information, I would not have felt it was safe to prescribe the medication at the level needed.

The Shared Care Record really affected how we managed the patient; it definitely avoided an admission to hospital as we were able to say it was safe for him to be discharged and referred directly to social services.

For the patient this is a much better outcome. He received the right medication to control his seizures without delays and avoided repeat investigations. For most patients, if you can avoid an admission it is the best thing for them.

"I use the Shared Care Record for every patient that I see in A&E. It saves a lot of time and makes decisions easier. It is crucial."



Oliver Holman
FY2 doctor
The Princess Alexandra Hospital NHS Trust

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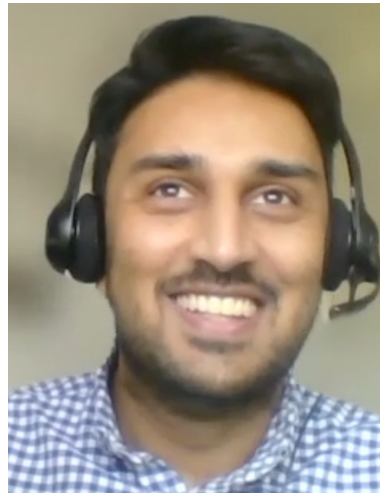
Case Study – General Practice

An elderly patient from London recently moved into a care home in East & North Herts. I conducted a telephone consultation as the carers at the home reported that she had confusion but they didn't know if this was an existing condition or a new issue.

Normally the next step would be a dementia screen; the patient would have to provide a urine sample and undergo a CT scan and blood test. However, looking at the Shared Care Record I could see letters and test results from London hospitals and information from her previous GP practice in London. This showed that she had already had the tests she needed and I could refer her directly to a memory clinic.

The Shared Care Record prevented the need to repeat the tests which would have been time-consuming and created a delay to the patient receiving care. It also prevented the need for a GP to visit the home on this occasion.

"The Shared Care Record is a valuable resource of additional information. It will help clinicians to make better decisions and has already helped to speed up referrals and prevent repeat investigations."



Dr. Rajni Vekaria
GP
East and North Hertfordshire

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