Good HOOF guide for Primary Care and Out of Hours teams July 2017

This guide will support non specialist teams who need to order home oxygen for palliative and cluster headache patients (normally following a consultant recommendation and not already under the care of a Home Oxygen Assessment and Review [HOS-AR] team). All other oxygen requirement should be referred to a specialist HOS-AR team to ensure the patient fulfils the criteria for long term or ambulatory oxygen therapy – LTOT/AOT

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Produced on behalf of the National Home Oxygen Safety Group.

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On average, a GP will fill in a HOOF once every 5 years, so this guide is to help ensure it is completed correctly first time.

If your patient is palliative, please review the guidance from the BTS before requesting oxygen, or refer to local palliative care guidance where available.

BTS Guideline for Home Oxygen Use in Adults

www.brit-thoracic.org.uk/document-library/clinical-information/oxygen/home-oxygen-guideline-(adults)/bts-guidelines-for-home-oxygen-use-in-adults/

APPENDIX 3: ASSESSMENT PROTOCOL FOR PALLIATIVE OXYGEN

There is no consensus for the correct clinical assessment strategy for the use of oxygen in palliative care, although multiple tools exist for assessing dyspnoea. This assessment protocol is suggested best practice by the guideline group and applies to patients with cancer or end stage cardio-respiratory disease who are experiencing intractable breathlessness, who are hypoxaemic with resting SpO2<92% or who are normoxaemic but in whom all other approaches have been exhausted. The Numerical Rating Scale score is recommended as this approach was used in evidence sited. First ensure patient is on maximum treatment for underlying diseases where possible and reversible causes for breathlessness have been or are being treated optimally.

• As distress from breathlessness can be multi-dimensional, ensure psycho-social factors have been assessed and addressed.
• Trial of non-pharmacological measures including teaching of breathing relaxation and life modifying strategies by involving physio and occupational therapists.
• Trial of hand held fan before consideration of oxygen therapy.
• Assess response to opioids if they have been tried.
• Check SpO2 using pulse oximetry at rest and/ or after exertion.

The subjective severity and intensity of breathlessness should therefore be recorded regularly to evaluate the degree of suffering caused and the effect of treatment. A numerical rating scale (NRS) from 0 to 10 has been found useful for this purpose (0=no shortness of breath, 10=worst shortness of breath imaginable). Treatment should focus on patients with dyspnoea scores (NRS) of ≥4, and especially those with scores ≥7. Recurrent assessment with standardized scales is prudent, especially when using an N-of-=1 approach, as it is difficult to predict which patients will benefit (1).

1. Nonoyama ML, Brooks D, Guyatt GH, et al. Effect of oxygen on health quality of life in patients with chronic obstructive pulmonary disease with transient exertional hypoxemia. Am J Respir Crit Care Med 2007;176(4):343–9

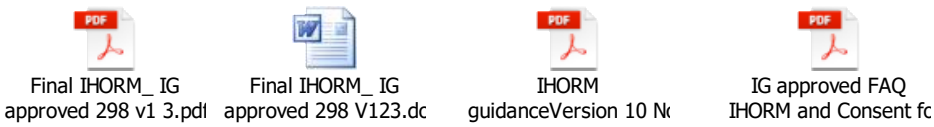
PRESCRIPTION
As distress from breathlessness is not correlated to degree of hypoxemia, the flow rates for symptom relief in the studies identified range from 2–5 litres/min. It is suggested therefore that oxygen flow rates be determined by symptom score on an individual basis rather than SpO2 reading, though caution is advised with this approach as cool air can relieve breathlessness (which is why hand-held and other fans are useful) and sometimes a lower flow rate plus a fan provide effective relief. Additional consideration needs to be given to potential risks of hypercapnia in those patients susceptible (commonly COPD and those with neuromuscular disease - see BTS guidance for detail) if oxygen is given at higher flow rates.

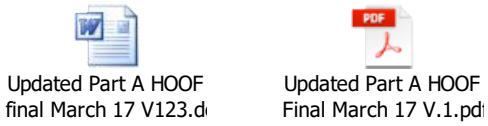
EQUIPMENT
Concentrator or cylinder as determined by patients' needs.
If the need is intermittent, then static cylinders may be considered. If it is considered, however, that the patients' needs are going to increase to >4 hrs a day, then a static concentrator should be first choice. NB Oxygen cannot be stored in the body, so using it pre-exertion to 'stoke up' is unhelpful; likewise, replacing lost oxygen post exertion is unnecessary as levels will normalise with rest anyway, so the perceived desire for a 'few whiffs' here and there, pre or post exertion, is not an indication. Hypoxaemia on exertion should be managed with AOT.

The NHS pays for every delivery of static cylinders and so, if a patient deteriorates, a new HOOF may be required, or the patient may have to keep ordering urgently, which is both an added stress at a difficult time for the patient and their family, and adds to the £120M (Correct 2012) National home oxygen bill.

FOLLOW UP
Oxygen therapy, like any pharmacological intervention, should be best considered on a trial basis and be reviewed regularly, while balancing benefits and risks.
Most benefit is likely to occur in the first 24 hours, and nearly all symptomatic and functional improvements within the first 3 days of use (1). Follow-up and assessment of response should fit with these timescales.

If the patient still requires oxygen, both a consent form and the Initial home oxygen risk mitigation form (IHORM) need to be filled in and signed before oxygen is requested. (There is a guidance document and a FAQ for the new consent form). All the documents for a GP or OOA team are below. Some areas will have these forms already uploaded onto local systems e.g EMIS





Assuming the patient passes the risk mitigation form then a HOOF needs to be raised.

Filling in the Part A HOOF

This extract for completing HOOF Part A is taken from the Dolby Vivisol guide and BOC completing a HOOF guide

In **very exceptional** circumstances a verbal HOOF maybe requested. Please contact the local home oxygen supplier for guidance. N.B. If requested the outstanding HOOF must be sent to the supplier within 24hrs of the request being made.

Some Suppliers encourage you to use their portal see local contact details on 5/6

Section 1 and 2: Patient and Carer Details

Please fill in all the boxes, with particular attention to including NHS number and contact details.

1. Patient Details					
1.1 NHS Number*	4321234567		1.7 Permanent address*	1.9 Tel no.	01764 321476
1.2 Title	MR		12, THE AVENUE, SPRINGFIELD, HAMPSHIRE	1.10 Mobile no.	07797 413210
1.3 Surname*	BLOGGS			**2. Carer Details (if applicable)**	
1.4 First name*	JOSEPH			2.1 Name	MRS MARY BLOGGS
1.5 DoB*	1ST JUNE 1978			2.2 Tel no.	01764 321476
1.6 Gender	☑ Male	☐ Female	1.8 Postcode* HP3 7FD	2.3 Mobile no.	07797 413330

Section3: Clinical Details

Complete the clinical coding to assist in data management and on-going reviews to provide an integrated care plan for the patient where required. Clinical Code definitions can be found in section 14 of the HOOF Part A and are now mandatory from 1st August 2017

On the very rare occasion where the patient is using NIV/CPAP or is a paediatric patient, it is recommended that you refer to their Respiratory Clinician/Paediatrician.

3. Clinical Details		
3.1 Clinical Code(s)	18	
3.2 Patient on NIV/CPAP	☐ Yes	☑ No
3.3 Paediatric Order	☐ Yes	☑ No

Section 4: Patient's Registered GP Information

Enter the details of the GP with whom the patient is registered.

4. Patient's Registered GP Information	
4.1 Main Practice name* DR JONES AND PARTNERS	
4.2 Practice address THE GLEBE, SPRINGFIELD	
4.3 Postcode* HP3 4ZY	4.4 Tel no. 01764 100100

Section 5: Assessment Service (Hospital or Clinical Service)

Please complete the details of the Assessment Service that will be used for follow up purposes. This enables us to communicate effectively and ensure seamless care for the patient. Prompt communication with specialist assessment centres/specialist respiratory teams will ensure that they are informed of the situation and are able to assess the patient at the earliest opportunity.

5. Assessment Service (Hospital or Clinical Service)	
5.1 Hospital or Clinic Name	SPRINGFIELD HOSAR
5.2 Address	MAIN STREET SPRINGFIELD
5.3 Postcode HP3 2PS	5.4 Tel no. 01764 222777

Section 6: Ward Details (if applicable)

If the patient is in hospital and due for discharge, section 6 should be completed. This will enable us to liaise with the hospital to ensure a smooth and consistent process with minimal delays disruptions.

6. Ward Details (if applicable)	
6.1 Name	N/A
6.2 Tel no.	N/A
6.3 Discharge date	N/A

Sections 7, 8, 9: Ordering

Section 7 relates to the oxygen the patient should use. The amount of oxygen being ordered needs to be stated in litres per minute, together with the number of hours of therapy required per day. All parts are marked as mandatory; failure to complete in full will result in potential rejection and ensuing delay in the provision of supply.
The flow rate must be given as litres per minute. If a fractional component is required (e.g. 0.5, 1.5 LPM etc) please ensure the decimal point is clearly marked. There should also be a digit to the left of the decimal point (e.g. 0.5 rather than .5).
The period of use required to meet the patient's need must be stated in hours per day, although periods of less than one hour can be expressed in minutes (e.g. 15 minutes or 15 min.).

Section 8 – The choice of equipment will ideally be based on a) the flow rate b) period of use c) expected length of treatment.
Ultra-high flow rates (> 12 LPM) are generally provided via cylinder supply, particularly if period of use is short (e.g. 15 – 20 minutes per day) Cluster headache patients are the most common patients to required static cylinders at these ultra-high flow rates.
• Lower flow rates and short periods of use (e.g. 1.5 LPM for 1hour per day) will generally best be provided via cylinder supply.
• Longer periods of use (e.g. above 4 hours per day) will generally best be provided via concentrator supply.
• Where the supply is likely to be in situ for a short period of time (e.g. a few days), with a consistent modest flowrate and period of use, again cylinder supply may be best, but if there is a concern that usage is going to increase then a concentrator should be considered, to save the family and patient from extra stress at this difficult time.
The quantity to be ordered will depend on flow rate (concentrators) or flow rate & period of use (cylinders), please consult your home oxygen supplier.

For **section 9**, a choice of either nasal cannula or mask should be made. Most patients would use a nasal cannula unless there are issues with mouth breathing, the home oxygen supplier should be able to give advice. For Cluster headache patients a 100% non-rebreather mask is the default mask.

7. Order*		8. Equipment* For more than 2 hours/day it is advisable to select a static concentrator		9. Consumables* (select one for each equipment type)	
Litres / Min	Hours / Day	Type	Quantity	Nasal Canulae	Mask % and Type
		8.1 Static Concentrator Back up static cylinder(s) will be supplied as appropriate			
10	1	8.2 Static Cylinder(s) A single cylinder will last for approximately 8hrs at 4l/min	2		NON REBREATHER

Section 10: Delivery details

Please indicate the delivery timescale required. Be aware that there are cost implications if using other than standard delivery times

10. Delivery Details*		
10.1 Standard (3 Business Days) ☑	10.2 Next (Calendar) Day ☐	10.3 Urgent (4 Hours) ☐

Section 11: Additional Patient Information

If you would like the oxygen assessment centre to review the patient within a timescale, please indicate which month and year the review would be required. For example write "Review: April 2017". If no date is specified, we will notify the assessment centre to review the patient in 6 months time. Additionally, this section should be used to advise us of any special information relating to the patient's oxygen supply and on-going support requirements. This could include, for example, physical disabilities, language difficulties, non-English speaker.

11. Additional Patient Information
REVIEW: APRIL 2017 REGISTERED BLIND

Section 12: Clinical Contact (if applicable)

The details of the clinical contact for the patient need to be incorporated here. It is possible that this may be the same person signing the HOOF Part A and, in this case, those details must be repeated here.

12. Clinical Contact (if applicable)			
12.1 Name	DR. JAMES JONES		
12.2 Tel no.	01764 100100	12.3 Mobile no.	07793 420101

Section 13: Declaration

This declaration is mandatory and must be fully completed before the HOOF Part A is sent to the supplier. Both the Consent form and IHORM must be filled in and ticked. For all new patients, these forms must be signed off appropriately by the clinician and the patient/ patient's representative. If it is any existing patient please confirm with the patient that the forms were signed previously and it maybe in their notes.

Section 14: Clinical Code : This must be added to Section 3 as it is a mandatory requirement

DO NOT SEND the Consent form or IHORM to the oxygen supplier, send only the HOOF . We would strongly advise that 'Referred for Assessment' boxes are completed and, if possible, send both forms to your local home oxygen teams for follow up.

It is very important that not only is the declaration signed, but also a fax number/NHS email address is provided so that we are able to send confirmation/corrections back.

How to send the HOOF -All the suppliers and the areas they cover are below

By Fax in the usual way (until Faxing the planned discontinuation of faxing occurs by the NHS)
N.B if a patient is going on holiday please fax the HOOF to your local supplier and not to where the patient is going.
By Electronic means Some suppliers do have electronic portals which also may be a way to send the HOOF.

If being sent by NHS.net, contact the supplier if the email is not below, and ensure the clinician signature is replaced by "sent from my nhs.net account". This acts as the signature as it is sent from a named account. HOOFs cannot be sent from generic nhs.net accounts.

Oxygen removal

If the patient has passed away then this can be called through to the supplier by family or carers. Otherwise an email of fax should be sent to the supplier to request removal by a HCP.

If oxygen is removed as it is no longer clinically appropriate, the patient does not want to use it or following failure of a risk assessment, an email of fax should be sent to the supplier to request removal by a HCP after agreement with the prescriber or the local HOS team or GP.

Air Liquide covering London, North West, East Midlands and the South West regions

Email: alhomecare.hcpsupport@nhs.net

Tel: 0808 202 2099

Fax: 0870 863 2111

Portal: https://www.airliquidehomehealth.co.uk/hcp/portal_a/

Website: http://www.airliquidehomecare.co.uk

BOC covering North East and East of England regions

Tel 08456 094 345

Fax 0800 169 9989

BOC Website/ Portal
http://www.bochomeoxygen.co.uk/en/clinicians/howtocompleteahoof/how_to_complete_a_hoof.html

Baywater Healthcare covering West Midlands, Wales, Yorkshire and Humber regions

Tel 0800 373 580

Fax 0800 214709

By Electronic methods: healthuk@baywater.co.uk

Baywater Support website/ portal

https://www.baywater.co.uk/clinicians-commissioners/our-therapies/oxygen/online-portal

Dolby Vivisol covering south East Coast and South Central regions

Tel 08443814402

Fax 08007814610

Dolby Vivisol Website link/ portal

http://www.dolbyvivisol.com/our-services/healthcare-professionals/home-oxygen-services.aspx

By Electronic methods: hoof.dv@nhs.net

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