

## **Updated Home Oxygen Order Forms & Consent/ Initial Home Oxygen Mitigation Form IHORM**

From March 2017, the home oxygen order forms and consent form are being updated. From the 31st July 2017 only the new HOOF forms will be accepted by the home oxygen suppliers, which include confirmation that consent and IHORM's have been signed ( at the time of raising the HOOF or previously)

### **The HOOFs will have the following changes**

- Tick boxes are now included in the declaration part of the form. To confirm that the consent form and the new IHORM have been completed or confirmed with the patient that they have been previously completed.
- The clinical code 21 has been removed as no patient should be requested oxygen without the clinician knowing why oxygen is being requested. Clinical code 20 has remained but the wording is now "other if no other code applies"
- Clinical code is now mandatory for all HOOF requests.

### **The consent form / IHORM will have the following changes**

- Consent form remains the same and is on the back of the form.
- The IHORM is on the front of the form and consists of a number of questions the clinician needs to discuss with the patient or their carer before oxygen is requested.

## **Frequently Asked Questions**

**Where can I find this form?** Information will shortly be available on the Primary Care Commissioning website (search PCC Home Oxygen) to find the page pointing clinicians as to where to obtain the form.

**Why are we being asked to fill in these forms?** The IHORM has been introduced to reduce the risk of a serious incident occurring if medicinal oxygen is installed in a home environment. So before a patient is initiated on oxygen some relevant questions need to be asked. The IHORM has been developed with the support of clinicians, suppliers, the fire and rescue services and BTS Home Oxygen Quality Standards Development Group. It has been peer reviewed and sent out for national comment to clinicians via at the regional home oxygen leads.

**Why has the hoof changed?** It was found that patients were not always being asked to sign consent forms when started on oxygen. There was no action on the HOOF to confirm a consent form had been signed, with just a declaration that one has been signed. The tick box to confirm this had been removed from the HOOF rolled out in 2012. This has now been reintroduced and must be confirmed by the Healthcare professional either by getting the patient or carer to sign the consent form/ IHORM or have verbally confirmed that a consent form/ IHORM has been signed in the past.

**What do I do if the patient is already on oxygen?** Verbally check with the patient or carer if a consent form has been signed in the past, if not fill one in and place in patient's notes.

Verbally check with the patient or carer if an IHORM has been completed in the past. If not fill one in and place in patients notes. This may raise issues and concerns around continuing oxygen for this patient. This should be raised with the local HOS team, respiratory specialist or lead consultant to discuss next steps.

**Our team already uses a risk/mitigation form that covers the questions in the IHORM?** If a risk/mitigation approved form is already used by the specialist teams/home oxygen services or is a regionally endorsed form AND the questions covered in the IHORM are assessed in the local form then this can be used as an equivalent. Once this form has been filled in and the consent form signed then the confirmation boxes on the hoof can be ticked off. E.g. for clinicians in the East Midlands region they would continue to use the EMHORT for assessing patients and tick the IHORM box on the HOOF.

**What about oil based emollients and creams?** These products should not be used with patients on home oxygen. This advice should be included in the information your patient receives from the supplier.

**What if I am not with the patient?** E.g. GP's requiring palliative care oxygen for end of life patients. End of life patients are a particularly challenging group. Although the oxygen may not be in the patient's home for very long, the risks may be increased due to their ill health and lack of mobility. Consent and IHORM's should be filled in after discussions with carers/family if the patient is too unwell to discuss these issues.

If the patient is not hypoxic, other medication and symptom relief for breathlessness can be instigated to help maintain the patient at home.

**The patient does not have capacity to sign the consent form?** The consent and IHORM should be filled in with the input and help of a carer or someone with parental responsibility or lasting power of attorney who will then sign the form. For further guidance in relation to consent please see the IHORM Supporting Notes. .

**What if the IHORM indicates that the patient is too high a risk to install oxygen?** Clinicians make risk benefits decisions every day, home oxygen and particularly long term oxygen therapy has been shown to extend life but in most cases is not lifesaving. Once oxygen has been installed to a high risk patient there is a huge amount of work required to remove it. In these cases discuss with specialist teams mentioned in the IHORM if the risks identified could be mitigated to allow oxygen to be installed or the risk is too high.

## **Clinical teams Caring for Children**

**What if my patient is a child?** A consent form and the IHORM questions should be discussed with the child's parent, carer or lasting power of attorney then signed in the usual way. For further guidance in relation to consent please see the IHORM Supporting Notes. It is unlikely that a child would be too high risk to install oxygen, but the IHORM will help raise awareness for parents and carers of children on oxygen.