For further information please contact
Fold TeleCare on 0800 731 3081

case study

Chronic Disease Management

the challenge

Nicole is 31 and lives with her husband and two young children who are 9 and 10. Her life has been affected over the past 16 years by her type 1 diabetes. However, in recent years, Nicole has experienced more regular hypos which are often severe and violent in nature.

the solution

A TeleHealthCare package was provided in order to allow Nicole to effectively monitor her condition in her own home. Nicole measures her blood glucose at set times which fit in with her daily routine and should the results fall outside of Nicole's individually set parameters, the appropriate action can be taken.

the outcome

Nicole now feels more confident that her condition is constantly being monitored and should any changes in her condition occur, they are detected early and preventative action can be taken before a hypo takes place. Nicole feels that for the first time in 16 years she is in control of her condition and she is able to fit her condition management around her busy lifestyle rather than having to make regular doctor's appointments.

Fold TeleCare are working in partnership with Tunstall to deliver TeleHealthCare to the homes of Ireland. Fold is the leading provider of social alarms, TeleCare and TeleHealth services.

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Tunstall is a founder member of the Continua Health Alliance

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case study

Sector: Connected for Health **Client:** Fold and Tunstall	**Application:** Telehealth

the challenge

The European Centre for Connected Health announced in January 2008 the allocation of £46 million to bring Telehealth solutions to 5000 people by 2011 in Northern Ireland. They have also set an ambitious target of reducing the number of hospital admissions by 10% in the first year and by 50% by 2011.

The development focuses on the following three disease areas

Chronic Obstructive Pulmoary Disease (COPD)

Chronic Heart Failure

Diabetes

The challenge for Health and Social Care Trusts is to change the way care is delivered, moving away from the traditional care model towards a more person centred care in the community model. TeleHealthCare provides vital signs monitoring which allows people living with a long term chronic disease to live at home and prevent unplanned hospital admissions.

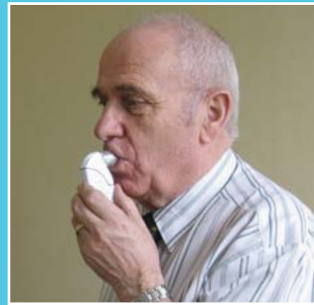
the project

Fold TeleCare, part of Fold Housing Association, is the leading 24 hour TeleHealthCare service provider in Ireland, working in partnership with the Tunstall Group.

Fold is a not-for-profit organisation currently supporting over 20,000 customers and works closely with housing providers, health and social care trusts and community groups throughout Ireland.

The efficient and unobtrusive service that TeleHealthCare offers, helps people enjoy safe and secure lives.
It provides an essential link via the telephone from the home to the 24 hours, 7 days a week response centre in Holywood, County Down.

All the reassurance you need



how does it work?

Fold TeleHealthCare service covers all operational aspects leaving the clinical team to concentrate on the quality of care:

- Initial non clinical triage
- Co-ordination and/or escalation to the appropriate field based clinician, e.g. district nursing team
- Installations, decommissions, decontamination, servicing, programming
- Patient and clinical training

Using product solutions from leading provider Tunstall, Fold's TeleHealthCare service is installed in the patient's home, where vital sign readings are taken daily, these include: blood pressure and oxygen levels, weight, temperature and heart rate. These readings are then sent securely tohealth professionals who monitor the readings on a regular basis. The system also automatically triages the patients and will raise an alert if any of the readings fall outside preset parameters, enabling early intervention.

Fold TeleHealthCare was launched in three Care Trusts in February 2008 and is already a mainstream service with over 75 clients today (May 2008).

We currently work in partnership with:

The Northern Health & Social Care Trust now supports a number of different TeleHealthCare programmes throughout the Trust area, focusing on Diabetes, Chronic Heart Failure and COPD.

Northern Health and Social Care Trust currently have three TeleHealthCare projects

- **Barn Halt Cottagers -** this scheme for Frail Elderly people who require additional support including TeleHealthCare
- **Your Health, Your Care at Home -** Acute Care at Home Teams enable early hospital discharge and Specialised Nursing Teams to manage people living with chronic conditions in their own home, preventing unplanned readmission to hospital
- **Floating Support -** this programme utilises telecare services, which are complemented with community support workers who assist the patient in their daily living

The Southern Health and Social Care Trust's programme provides TeleHealthCare to people living in Housing with Care, Nursing Homes and in the community.

One of the projects main aims is to provide this service to people who are suffering from Dementia. This provides the unique challenge of training both family members and professional carers to assist them in measuring their vital signs.

The Western Health and Social Care Trust is using their network of GP surgeries and District Nurse Teams to refer people in the community who are living with a long-term condition to their TeleHealthCare service.

District nurses are trained to remotely monitor their patients on a daily basis, ensuring early detection of changes in vital signs. This enables an early intervention, which should help to prevent a possible admission to hospital or unnecessary GP visits.

case studies

Chronic Heart Failure

the challenge

Margaret is 70 years old, she lives on her own and suffers from chronic heart failure and diabetes.

the solution

On her last admission to hospital her consultant referred her to the Acute Care at Home Team, to facilitate her early discharge. The Acute Care at Home Team referred her to Fold for a TeleHealthCare package to enable them to monitor her condition daily.

Each morning Margaret measures her blood pressure, pulse oximetry, heart rate, weight and blood sugar readings, which are remotely monitored by her nurse. For the first two weeks the Acute Care at Home Team visited Margaret on a regular basis, after this period her care was transferred to the Continuing Care Nurse.

Fold's TeleHealthCare service enables the nurses to monitor Margaret's condition to ensure that she becomes more stable and remains so. Visits to Margaret by her nurses will become less frequent as her daily monitoring enables the nurse to detect any early changes in her condition, which may require a telephone call rather than a visit.

the outcome

Margaret feels well cared for as she knows that her condition is being managed by her nurse on a daily basis and she will receive a telephone call or visit if required, reassuring her that her care plan is meeting her changing health needs.

Margaret receives regular visits from her family, who are impressed with their mother using technology in her own home, which they feel helps her have more choice and understanding of her condition, with the added reassurance that if anything does go wrong it will be picked up quickly and help keep her out of hospital.

Long-Term COPD Management

the challenge

John is 76 years old, lives in a rural area with his daughter, and suffers from Chronic COPD. A specialist nurse manages his condition with regular visits to his home. Admission to hosp, freq of visits.

the solution

John had the TeleHealthCare service installed into his home six months ago, to enable his nurse to better monitor and manage his condition. He takes his blood pressure, pulse oximetry, heart rate and temperature readings every day with the help of his daughter. These are then checked by his nurse who will call him if his readings are outside preset parameters to advise on any remedial action.

the outcome

John now feels reassured that his condition is being monitored on a daily basis and if there is any cause for concern his nurse will contact him. He is very pleased that he is able to remain at home and feels that his TeleHealthCare plan has prevented him from unnecessary hospitalisation.

John has now become more aware of his condition as he can see his readings and take additional readings throughout the day. When his pulse oximetry is low in the morning he would regularly take an additional reading later that day, which usually improved, making him feel better and more in control of his condition.