Family Nursing & Home Care

Standard Operating Procedures

Patient Pathway (EMIS)
District Nursing Services

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Document profile

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Policy Amendments

Version Number	Amendments
2 (2018)	Amended to reflect EMIS and multi-agency working New SOP for the delegation of insulin administration and blood glucose monitoring added. Delegation to non-registrants now differentiates between these staff working as part of a Family Nursing & Home Care community nursing team and working elsewhere as opposed to those employed by FNHC and not employed by FNHC. In essence, Registered Nurses should treat FNHC Care

	Assistants working in the Home Care Team in the same way as they would those working for any other approved provider.
3 (2020)	Amended to reflect EMIS developments , safety huddle , twilight working , service redesign, handover and multi-agency working, Regulation of Care (Jersey) Law 2014, removed delegation to be separate SOP changes to people not entitled to non-urgent care process
4 (2023)	Updated to reflect EMIS developments including electronic DN referral form for JGH , Maxims EPR , Triage, PROMS, holistic assessment, contact, discharge, dressings process, PURPOSE T, overnight nursing

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Introduction

These standard operating procedures (SOPs) have been developed to guide the practice of all team members and clinical nurse specialists (CNS) working in the District Nursing Service. The SOP provides a framework for the provision of safe and effective care. The SOP will inform enquiries into practice related issues.

Please note these SOPs are subject to change dependent on service development. Please ensure the most up to date version is used.

Principles

The following are overarching, guiding principles for safe and effective practice when using these standard operating procedures.

- The SOP do not replace professional judgement which should be used at all times
- Where Registrants work outside of this SOP informed by their professional judgement they should always record the rationale and evidence base for this decision
- A clear rationale should be presented/recorded in support of all decision making
- Practice should be based on the best available evidence
- Patients receiving nursing care will be fully involved in developing care plans which detail how their needs will met based upon best available evidence, their goals, aims and preferences.
- Appropriate escalation should occur when care needs require this.
- The 'default position' should be to accept all reasonable referrals, assess the patient first then make an informed decision about the most appropriate team/service to care for the patient.
- Discharge planning should commence at the point of admission
- Where care is delegated to a Non-Registrant, the Registered Nurse remains accountable for the appropriateness of the delegation and for ensuring that the care has been given. They are also responsible for the overall management of the service user that includes a regular review of the care as a minimum fortnightly. Where a concern has been highlighted by a Non Registrant then the next contact should be with a Registered Nurse.
- Staff should be aware of and compliant with the Jersey Care Commission Standards for Home Care
- Where potential safeguarding issues are identified, staff will act appropriately in line with organisational and multi-agency procedures, seeking safeguarding supervision as per organisational policy.
- Staff will be alert to the identification of patients who may be in the last year of life and will follow the Gold Standard Framework (GSF) where this is required.
- See procedural document library for standard operating procedures, policies and guidelines relevant to practice FNHC Policy and procedures

- Adherence to this SOP will support achievement of service Key performance indicator (KPI)

Please note other standard operating procedures are available including those that are part of policy and guideline documents.

SOP 1 Referral and Clinical Triage

Purpose

To promote appropriate referral and triage to the District Nursing service to ensure access to all patient information in order to make safe and effective decisions about the patient's nursing needs.

Scope

All patients referred to District Nursing Service come from a range of sources.

Core Requirements

- All Referrals to the District Nursing (DN) services are received through email Adult.Referrals@fnhc.org.je or telephone call direct to admin hub team (AHT) 443603 Mon-Fri 08.30-5pm or the clinical coordinator (CC) outside of admin hub hours.
- Referrals from Jersey General Hospital will be accepted providing they are submitted using the electronic referral form JGH DN referral form 2022
- When a referral is received by the service, a member of the AHT will ensure that the patient details are recorded on EMIS
- At the weekend and out of hours the CC is responsible for ensuring the patient is registered on EMIS if their care is required before the admin hub opens again. A member of the AHT will be responsible for adding the referral to EMIS during hub operating hours where care needs are not urgent.
- The referring professional should have completed all relevant information on the FNHC referral form to support clinical decision making and managing risks associated with delivering care.
- Where referral information is unclear or insufficient, the necessary clarification should be sought from appropriate sources:
    - If ***demographic information*** is missing the AHT should return form back to referrer to complete as information available on Maxims EPR is not always most up to date
    - Where a referral is for a patient with a catheter, a catheter bundle should accompany the referral. If a catheter bundle is not sent, the referral should be returned with a request for a catheter bundle.
    - Where a referral requires the administration of medication, an authorisation to medicate form, insulin administration sheet or hospital prescription chart signed by a prescriber /non-medical prescriber should be sent with the referral.
    - If this is not sent please contact the referrer directly to request authorisation to medicate form /prescription. Liaise with the clinical coordinator (CC) to ensure that critical medication /care is not delayed

- Complete an ASSURE for any referrals for medication that are not accompanied by a prescription or authorisation to medicate form
- Please refer to FNHC medicines policy 2020 for guidance FNHC medicines policy 2020
- Where there is ***missing/unclear clinical information*** required to safely determine/deliver care, the CC will contact the referrer/ward/service to request the information required to deliver care.
- If the CC declines the referral due to being unable to complete missing information to safely deliver care they should return the form to the referee advising them that the referral has been declined and advising them that they remain responsible for resubmitting the referral with complete information. the CC will complete an ASSURE

- The primary reason for referral if clearly indicated on the referral form should be recorded at the referral stage in the 'reason for referral 'section.

- Where a referral is for the provision of care to a person not entitled to non-urgent nursing care in Jersey Health costs for those on holiday or newly living in Jersey. The AHT should liaise with the CC and Finance team as visitors and those new to the island would not normally be entitled to access free district nursing services. Patients would be expected to pay for their nursing care time including for consumables and dressings.

- The AHT or CC (at weekends and out of hours) will contact the referrer and the patient, (where their contact details have been supplied) within 2 hours of the referral being received to confirm receipt of the referral and advise that the CC will triage the referral to determine priority. The AHT /CC (out of hours) should provide the patient with contact details for the service should they have any questions.

- The AHT or CC should check all patient demographic details are correct before confirming the patient or registering the patient

- If next of kin (NOK) details are known from the referral form the AHT/CC should record the patients NOK and contact details in the registration section under NOK

- The nurse should check NOK details are correct at the initial assessment and amend on EMIS as necessary

- When the patient is currently an active patient on the DN service caseload the new referral is added to the care record and communicated to the team CC to advise them that there is a new referral for an already active patient.

- The referral form should be attached to the patients EMIS record.

- Where the referral is for a specialist nurse this should be reviewed by the district nursing team grade 5/6 and consideration for escalation to the appropriate CNS if required

- Where there is a lack of clarity about the most appropriate service/team to deal with the patient, efforts should be made by the CC, in the first instance, to gain better clarification. Where this is not possible, the patient **must not** be passed between

service areas/teams, instead the patient should be assessed and a decision made then as to the most appropriate team/service to care for the patient.

- The AHT will provide labels if required
- Once registered on EMIS, the AHT or out of hours CC moves the patient to 'awaiting triage 'section of EMIS. The AHT or out of hours CC must record the time referral received, attempted referrer and patient contacted in the EMIS record
- The AHT will contact the CC if the referral could be urgent, including request for visits because the patient is in pain from blocked catheter, end of life patient with any distressing symptoms, autonomic dysreflexia or pressure ulcer requiring urgent preventative measure . The CC will then determine the clinical response to the referral
- The CC will complete the triage template on EMIS
- Patients should be categorised by the CC into the following response time categories:

Referral Category	Timeframe	Examples
Urgent	Contact will be made with the patient within 2 hours and a visit made (if clinically indicated) within 4 hours.	Blocked catheters with pain Patients with spinal injury at risk of autonomic dysreflexia Pressure ulcers(initial risk reduction measures on same day) Terminally ill patient in pain or with other distressing symptoms
Non-urgent	Contact will be made with the patient within 24 hours.	Renewal of routine dressings Postoperative assessment
Routine	Contact will be made with the patient within 48 to 72 hours, or on a stated date.	Regular planned catheter change Planned dressings TWOC Continence assessments

- Where a referral is for a patient with an urgent care need ,the CC will make contact within 2 hrs and should care be required will allocate to an appropriate team member for the patient to be visited within 4 hrs of the referral being received

- Referrals for patients with pressure ulcers should be discussed with referrer to determine level of risk and the extent of damage that has occurred. Following triage the patient should be allocated to an appropriate team member on the same day for initial assessment including photographs and initial treatment and advice to reduce risk of deterioration
- The CC will decide if the patient is to be seen at home or whether they can be given a clinic appointment. N.B. home visiting is only offered to patients who are housebound or patients in the early stages of a painful procedure or a procedure better suited to being undertaken in the home environment
- Housebound is determined to be 'patients who are only able to leave their home to attend essential health related appointments i.e. Hospital /GP /AHP appointments with the assistance of patient transport services or considerable help of another person.' Patients who choose to attend regular social activities outside of the home with assistance of friends or family members are not considered to be housebound.
- Patients attending clinic should be able to mobilise sufficiently to get themselves out of the building from upper floors in the event of an emergency requiring them to evacuate without using a lift.
- Any patient with mobility issues who attend clinic should have an individual risk assessment, detailing how they will be able to leave the building (Personal Emergency Evacuation Plan (PEEP)).
- If the patient is unable to get themselves out of the building then they should be offered home visits to continue their care.
- For patients who are regularly not in when the nurse visits, consideration should be given to transfer their care to clinic settings. It may be necessary to undertake a face to face assessment of patients' needs to determine the most appropriate venue for care. This should be discussed with Team leader.
- Where it has been assessed that the patient can attend clinic and will not experience any adverse consequence of attending a clinic venue the patient will be advised that we are unable to offer a home visit and should they decline to attend clinic they may be discharged and advised to contact their GP. This decision can only be taken by a grade 5/6 nurse. A risk assessment should be completed and logged on EMIS to demonstrate that risks to the patient have been assessed and steps taken to minimise their impact. A letter should be sent to the GP explaining the reason for discharge. A clear record of the rationale for this decision must be recorded on the patients EMIS record.
- When a verbal handover is given in place of a referral form from RRRT, both the referrer and the nurse receiving the referral should record the handover on EMIS to include problem, plan of care with any timeframes and evaluation of care received. The GP RRRT discharge letter should also be referred to for reference.
- The CC for each team will be responsible for triaging all referrals into both the home visiting caseload and their clinic.
- When a patient is to be seen in clinic the team CC is responsible for booking the patient into an appointment that is appropriate to meet their nursing needs. The CC will contact the patient to inform them of the date and time of their clinic appointment.

- In order to effectively manage the clinic scheduling and avoid double bookings it is essential that all staff working in clinic schedule their patient's appointments at least 2 weeks in advance in order to secure a clinic appointment for their ongoing care. (See DN clinic SOP)
- Details of future clinic appointments should be given to the patient in writing.
- Where demand for clinic appointments exceeds capacity, consideration by the CC should be given to opening and staffing another clinic room rather than visiting ambulant patients at home to ensure effective use of staffing resource
- When considering whether a referral can be accepted, consideration must be given by the CC of demand and capacity in the twilight team to manage care where demands may exceed staffing resource. Joint working after 20.00hrs with overnight nurses, when available should be factored into the decision making.
- All team members are responsible for ensuring that only patients who have care needs that can only be delivered after 16.30hrs are allocated to the twilight caseload.
- Patients whose care needs are usually met during the daytime should only be allocated to the twilight caseload after discussion with other coordinators to ensure there is capacity within the twilight service to respond to urgent request for visits particularly EOL (end of life) patients and those on the caseload experiencing pain or other distressing symptoms.
- Initial visits to new patients who are not known to the service would not usually be undertaken during twilight hours. Staff should complete a staff safety checklist and identify any risks to visiting as a minimum, prior to the patient being visited by twilight nurses.
- Where a first visit to a patient previously not known to the service is unavoidable during the twilight shift due to the patient's condition i.e. red/amber on GSF, administration of a 'critical medicine' or a blocked catheter, then 2 staff should undertake the first visit and complete the staff safety checklist, assessments, risk assessments and care plans appropriate to the care required. Where this is not possible there should be a discussion with the manager on call
- Lone worker 5 point plans should be adhered to when visiting patients at all times.

  The designated CC on twilight who is highlighted on the rota * is responsible for scheduling regular patient visits from the assignment list for the following night before going off duty.
- The designated CC for twilight should contact the overnight nurse at 20.00hrs to discuss workload and agree a management plan. Twilight nurse should handover any patients to the overnight nurse who they are aware of who may require support overnight
- Team members are responsible for ensuring that their EMIS schedule notes reflect care required including any time specific care so that an assessment can be made when triaging new referrals.
- If the referral is to be declined due to capacity across the DN service a discussion should take place with the Registered manager at the safety huddle
- When a referral is declined the referrer should be contacted directly by the CC to inform them as to the reasons for decline and consideration should be given as to whether another service can provide the care required. Consideration should be given to determine if the care can be delivered at a different time or way i.e.

delegated to a carer. Negotiation should take place as to when the referral for care can be commenced. Decision-making should be recorded on the patients EMIS record.

- The CC for each team is responsible for reviewing all referrals to the caseload on a timely basis. The CC will be the point of contact for the AHT, members of the MDT, team members and patient enquiries that cannot be managed by the AHT. The CC role for each team/day will be identified on the electronic rota by the letter C and highlighted in yellow.

SOP 2 Admission to the District Nursing Caseload

Purpose

To complete holistic assessment in partnership with the patient or family/others as appropriate to inform appropriate care planning, delivery and risk management.

Scope

All patients referred to the District Nursing Team from a range of sources.

Core Requirements

- It is expected that Grade 5/6 Nurses would undertake the initial assessment on all patients with anything other than simple/routine care needs. When this is not possible the Grade 5/6 should review the assessment and care plan developed by their team members within 7 days and record their review on EMIS.
- Admissions undertaken by a Grade 4 must be discussed with Grade 6 / 5 Nurse before the end of their shift. Where the Grade 4 has any concerns, it is their responsibility to raise these with the Grade 6 or 5 before going off duty.
- SHCA's will not undertake initial /review assessments
- The admitting Nurse should review any existing hard copy/Electronic records i.e. EMIS /MAXIMS EPR for information regarding previous admissions and to inform clinical decision making.
- Obtain past medical history and current medication from an appropriate source including MAXIMS EPR and shared GP/Hospice /Diabetes centre EMIS record with patient consent.
- Ensure all relevant equipment, consumables and dressings are available for the home visit.
- The admitting nurse should check NOK and other demographics are correct with the patient or their family/carers
- Baseline clinical observations should be undertaken for all patients on admission to the service and recorded on EMIS.
- The admitting nurse should ensure that they take a supplementary patient record containing the core documents which includes :
    - Professionals communication sheet
    - Significant event sheet
    - Staff signature sheet

  In addition:

    - Hard copies of the care plans should be available in the patient's supplementary record and replaced as they are updated.
    - NEWS chart
    - PVAD
    - Wound care plans and wound assessment charts

- Signed authorisation to medicate forms
- Any additional documents relevant to the patients care needs

The admitting nurse should also take a welcome pack containing agreed leaflets which will include:

- Working together to keep you safe
- How we use your information
- Here to help from birth to end of life
- District nursing leaflet
- Pressure ulcer prevention leaflet
- Unacceptable behaviour leaflet
- Dressings leaflet

- The content of the leaflets should be discussed with the patient to support their understanding.
- Record on EMIS which leaflets have been discussed and record the patient's response. Leaflets are available in English, Polish and Portuguese on central filing.
- Patients should be offered information in a welcome pack
- Professional judgement should be exercised when determining the assessment templates to be completed during the first visit ,however this should comprise as a minimum:
    - Initial or review District nurse holistic assessment, which includes completed staff safety checklist.
    - A-E assessment (if appropriate)
    - Wound assessment
    - Photograph and measurements of wound(s)
    - PURPOSE T risk assessment and care plan
    - Moving and Handling Risk Assessment – (if there is a patient handling need)
    - NEWS (National early warning score)
    - Medication risk assessment
    - Falls risk assessment
    - Any other necessary risk assessments
    - Any care plans appropriate to care needs
    - Within 7 days of care commencing, it is expected that a comprehensive District nurse holistic assessment, will be completed including any additional assessments deemed necessary.
- Ambulant, usually well patients who attend a clinic setting with a self-limiting condition who will require only 1 or 2 contacts with the service before discharge, i.e.

ROS, simple wound care (a break in the skin limited in depth at the sub cutaneous fatty tissue , that does not affect the underlying structures (bones, joints , major arteries, nerves, tendons) and without significant loss of tissue or one off injection may not require a full assessment. The rationale for not completing a full assessment must be documented in the patient's EMIS record.

- Patients who are housebound, by the very nature of not being able to leave their home will have more complex nursing needs, which require holistic assessment
- In order to inform understanding of the complexity of patients on the caseload it is essential to record all of the patient's current health problems including active and significant past health problems on their holistic assessment both initially and at any review. These should be updated as the patients' health changes
- The patient complexity low/medium/high should be recorded on the holistic assessment template at initial assessment and at each subsequent contacts.
- If the patient is admitted to the service requiring treatment for injuries caused by a fall then a falls risk assessment should be completed on admission
- Patients should be encouraged and supported to complete the Pre Smiles on admission as this is a key performance indicator for the service. If this is not completed then the reason for non-completion should be documented in the text box on the holistic assessment
- Where it has not been possible to complete part of the admission process within the set timeframes, this must be discussed at handover, documented on EMIS and a plan put in place for its completion.
- The nurse will develop care plans, which are available on EMIS as documents, for the identified nursing care needs and update these plans as nursing care needs change. Care planning should be undertaken in partnership with the patient and where appropriate, family/others.
- Patient consent to their planned care should sought and be indicated on care plans.
- It is important that all care plans are personalised to reflect the individual patient's needs. It is essential to 'hear 'the person's voice' to reflect their stated outcomes and goals.
- When completing the 'what to do if…..' section of the care plan it is imperative to be specific about what patients/carers should be observing for i.e. redness, smell ,increased pain and also who and how to call when they have concerns
- When saving care plans as documents on EMIS they should be clearly labelled with type of care plan and date. Care plans that are no longer relevant should be labelled with end date.
- In order to help colleagues locate the patients home please use 'What 3 words' and record as a patient alert to ensure it is visible to all staff who access the record
- Patient details including ethnicity (as the patient would describe), language spoken and whether an interpreter is required should be recorded in the patient details section of EMIS. There should be a clear plan in place to support communication at all contacts. It is not appropriate to use family members/friends so professional interpreting services should be organised.
- Professional contacts should be recorded and updated in the professional contacts section. This should include care provider, social worker etc.

- Commence discharge planning at the admission stage. An estimated date of discharge from the service should be recorded in the relevant section the health and social needs assessment template (mandatory) (excluding patients on red/amber GSF).
- The nurse undertaking the initial assessment, in discussion with the team CC is responsible for ensuring that the patient's nursing care needs are scheduled on EMIS. The schedule should be labelled i.e. leg ulcer care, catheter care etc. and proposed days of visits, time of visit, if care is time specific, predicted length of time care should take and dependency. Schedules should only be changed by a nurse and in discussion with the team CC.

SOP 3 Ongoing Care

Purpose

To support ongoing nursing care that meets the patient's identified nursing care need, to manage risk and support patients to achieve their desired care outcome.

Scope

All patients on the District Nursing caseload.

Core Requirements

- The CC is responsible for allocating appropriately skilled /competent staff to visit the patient.
- The CC will determine the most appropriate venue for ongoing care i.e. home or clinic. Home visiting is only offered to patients who are housebound, in the early stages of a painful procedure or having care better suited to being undertaken in the home environment. Discuss early transfer of care to clinic setting with patient if appropriate.
- Twice weekly review of the caseload to ensure patients have a scheduled next contact should be completed by the CC to reduce the risk of the patient being missed
- Send letters/referral forms which are available on EMIS to any other relevant professionals involved in the patient's care e.g. Social Worker, Respiratory Team, having first obtained verbal consent to do this which should be documented.
- The following documents/referral forms/outcome forms are available on EMIS which can be completed in the patient record using the EMIS outbound referral process and emailed to appropriate department

    - SPOR
    - CASS alarm
    - Dietetic
    - Safeguarding concern
    - Respiratory team referral
    - Subsidised product
    - TWOC outcome forms
    - CNS escalation form

- This list is not exhaustive and as the service develops new EMIS documents, they will be added to this list and staff informed. All staff are responsible for ensuring they have easy access to an updated template/document list.
- Maintaining consistency of staff team members visiting a patient is essential to ensure effective practice and be alert to any changes in the patient's condition. At times this is not always possible. It is essential to review the recent records prior to visiting the patient
- Team members should offer their ID badge to all patients to view at the visit.

- Team members should wear their name badge when visiting patients unless this would present a risk i.e. Patients with pacemakers (due to magnetic clasp), moving and handling issues or lone worker issues.
- At each contact with the patient, complete the DN contact template on EMIS. It is vital to record all inspections/risk/discussions/actions in respect of skin integrity and patient presenting as unwell. The ROPE tool should be used to guide recording.
- The patient complexity; low/medium/high should be reviewed and recorded at each contact to inform daily reporting of patient acuity which will inform decisions regarding staffing resources
- Where two team members visit a patient at the same time this should be reflected in the patients EMIS record. Each team member is responsible for making a record of their contact, actions, decision making, advice and discussions on the patients EMIS record.
- Team members must ensure that they record the duration of the travel time, face to face contact, associated administration, e mails, and telephone calls on the patient's record on EMIS. It is important that the venue of contact is accurately reported on EMIS
- Registered nurses should review visiting schedules reflect patient nursing needs at handover and changes made to the schedule at the time. Team members must take extra care when changing /ending a patient schedule to ensure that the correct patient's schedule is edited and they are not missed.
- Should a patient who is currently on caseload have a fall since the last contact whether witnessed or unwitnessed, then an ASSURE should be completed detailing the information that is known about the fall and any injuries. Complete a falls risk assessment and follow the appropriate falls policy and procedure.
- Where patients require 'critical medication' as detailed in the medicines policy, they should be highlighted in red on the EMIS schedule and the team member allocated to administer the medication should verbally communicate with the coordinator that the medication has been administered to the specific patient within an hour of the time the medication was due . CC should have a daily updated list of patients who require critical medication to reduce risk of missed medication.
- Where patients require intravenous (IV) therapy, clinical consumables for those who have been inpatients are funded by HCS. Clinical consumables can be ordered from FNHC stores for up to 7 days. Each team should hold an emergency stock, enough to deliver IV therapy out of hours until stock can be ordered from stores.
- Where patients are receiving injectable medicines, the care plan should clearly indicate the blood monitoring that is required for safe care. There should be a discussion with the GP/Prescriber and clear agreement of who will take bloods, the frequency and monitor and action results.
- The CC should ensure completion of the outpatient antimicrobial therapies (OPAT) spreadsheet (located in L drive District nurse/ A2 manager/ OPAT folder) to support discussion and decision making at the weekly OPAT meeting with Microbiologist and HCS pharmacist. Details of the MDT discussion should be recorded on the patients EMIS record using the MDT template
- Clinical observations including pulse, Respiration rate temperature and oxygen saturation at every contact (other than GSF red patients where agreed) and recorded

on NEWS chart. blood pressure should be undertaken should this be clinically indicated

- Patients receiving intravenous medication should have visual Infusion Phlebitis (VIP) score recorded using appropriate care bundle at least daily.
- If the patient presents or reports being 'unwell' during the contact, complete A-E assessment template, UTI assessment tool, hard copy NEWS and Sepsis screening tool template and action as per NEWS clinical protocol as detailed in the Early recognition of sepsis Management and recognition of the deteriorating patient NEWS 2 policy
- Where patients are coded on the Gold standard framework (GSF) this should be recorded on the palliative care template. The appropriate coding should be recorded and reviewed as appropriate. This will ensure that their information and status are aligned to the GP practice GSF list for discussion at the planned GSF meetings.
- The professional responsible for care coordination should be agreed at the hospice or CNS/DN joint meeting and recorded on EMIS record.
- A PURPOSE T risk assessment should be completed for all patients on admission to the caseload. The PURPOSE-T review schedule should be guided by clinical judgement, if a patient's condition deteriorates then best practice would be to review the risk assessment. The frequency of review should be determined at team level and clearly recorded on record and schedule set for reviews. If a patient is on the caseload for infrequent care such as catheterisation then monthly would be recommended.
- Guidance:

PurposeT **RAG pathway/outcome**	**Review schedule to complete Purpose T again and update relevant care plans**
Green	If active on caseload then complete as part of re-assessment of needs or if change in clinical condition
Yellow/Amber	monthly or earlier if clinically indicated
Red	Weekly or as clinically indicated and should a deterioration in condition indicate review and change in care plan

- All patients will be given an FNHC Pressure ulcer Prevention information leaflet and the information discussed with them and recorded in the patients EMIS record
- All pressure ulcers should be categorised correctly. Photographs, measurements and wound assessment document should be completed on EMIS.
- If the patient has a category 1 or above pressure ulcer, an ASSURE should be completed detailing the injury details and care given within 24hrs. Please indicate whether the pressure trauma occurred under the care of the DN team or elsewhere.
- If the patient has multiple category 2's, a category 3 or a category 4 pressure ulcer or Deep tissue injury (or suspected DTI) or unstageable, whether the pressure damage occurred in the care of the DN team or elsewhere, this may be a safeguarding issue. Please discuss with the Safeguarding Lead Nurse or Registered

Manager and a member of the Tissue Viability team as soon as possible and record outcome of discussions on EMIS.

- In order to support the principles of Making Safeguarding Personal (MSP) it is important to hear the person's voice in relation to their care and support and what they would wish as an outcome which may include referral to adult safeguarding for an enquiry
- Consideration should be given to the completion of the adult safeguarding decision tool for patients with multiple category 2 or above pressure ulcer developed in the care of FNHC or other formal care provision i.e. Hospital , homecare or residential care to understand if there is a safeguarding concern .Pressure ulcer SOP
- A root cause analysis (RCA) should be completed on ASSURE for all patients who develop a category 2 or above pressure ulcer in the care of FNHC to inform learning and to safeguard the patient.
- There is a requirement to report all category 2 /3/4 /Suspected DTI / unstageable pressure ulcers to the Jersey Care commission within 48hrs which will be completed by the Registered Manager or their nominee.
- A core Purpose-T care plan is on EMIS, it links to the Purpose-T decision pathways Red (secondary prevention and treatment) & Amber (primary prevention). The Green pathways is low risk and would not need a care plan unless it was felt to be clinically necessary. Appropriate care plans should be in place for all patients with a current pressure ulcer or at risk of developing a pressure ulcer, and will need to be personalised on the core template (clearly indicate relevant information or add in anything specific to the individual), consideration to concordance, onward referral, TVN, equipment requirements etc.
- Photographs of wounds should be clear, taken at the appropriate distance and in focus. Photographs should be filed on EMIS with the location of the wound and date and time that the photograph was taken. Ensure context of where the wound is, this may mean a 'distance shot' of area. You may need to arrange a time to take images if the person need carers to position or hoist them or someone to support positioning in order to get a clear and accurate photograph
- If the patient has a leg ulcer, the Lower Limb Wound Pathway should be followed. The District Nurse Lower limb assessment and a Doppler should be completed to enable a differential diagnosis of wound aetiology to be made. The wound assessment document, alongside a photograph with measurements, date and location of wound should be completed on EMIS.
- A Doppler study should be performed within two weeks of admission to the caseload using the DN Doppler mobile template. If indicated, compression should then be commenced, either bandaging, wraps or hosiery. There will be fixed review points to determine if the wound is making progress and when to seek further advice or make onward referrals to other appropriate professionals.
- Where the patient has a condition that could cause pain, the pain assessment template on EMIS should be completed at each contact and a pain management care plan developed where a patient is experiencing pain.
- Where there are concerns about risks/concordance or care then consideration should be given to coordinate an MDT, including all professionals, patients and their representative (if appropriate). Complete the MDT template on EMIS to reflect those

in attendance, main points discussed and actions agreed. Complete a risk assessment template or include the risk in care planning and acknowledge patient voice and input to this.

- Significant events should be recorded using the significant event template on EMIS. Significant events may range from patient admission to hospital, changes in their social circumstances, health and care needs, violent or aggressive behaviour or anything considered out of the ordinary.
- Re assessment of needs should be undertaken as a minimum 6 monthly or should there be a change in the patient's condition i.e. after a hospital admission, to ensure that they continue to meet the patients nursing care needs, are evidence based and reflect any change in circumstances or emerging risks. This should include care plans, risk assessments etc.
- Care plans should be updated when care changes including change to wound dressing , evolving health needs and new treatments
- Patients on the caseload on a 'long term' basis should be offered the opportunity to complete the online patient satisfaction survey on a mobile device every six months. Plans for this should be reflected in the patient record.

SOP 4 FNHC staff dressing stock

Purpose

FNHC charity will fund the first basic dressing so as to allow patients time to purchase dressings required from a pharmacy of their choice

Scope

All members of the nursing team who require access to a basic stock dressings to initiate safe care as an interim measure at the first contact

Core Requirements

- FNHC nursing team will maintain stock level of basic dressings
- At the first contact an appropriate dressing from this stock items will be applied to the wound and the patient advised on the need to purchase their own dressings. Initially this may not be would be used going forward but is an 'assessment' or holding dressing until an assessment and request for specific products has been made.
- Patient should be advised that FNHC charity is funding the first dressing but is not able to continue to fund dressings (see next patient dressing supply)
- Nursing team members are required to submit a weekly order to restock their dressing stock. This order sent to FNHC stores who will source the order from FNHC preferred provider
- The Stores manager will monitor orders that may be in excess of what could be reasonably be expected to be used during the previous week and escalate this to team leaders

SOP 5 Patient Dressings supply

Purpose

To support nurses to advise patients on the most appropriate wound care dressing choice based on the clinical presentation of the wound and best available evidence.

Scope

All patients on the DN caseload who require wound care

Core Requirements

- On admission to the caseload for wound care patients will be given a dressings leaflet informing them that they have to purchase their own dressings and ensure that there is a supply available to the visiting nursing team member.

- Patients, their families or carers (if appropriate) will be given a list of primary and secondary dressings on FNHC headed pads that they will need to source before the next contact from a pharmacy of their choice. Patients should be reminded that many pharmacies deliver. The team member should take a photograph of the order form given to patients and load the photograph onto EMIS as evidence of request made for patient to purchase dressings

- Should the patient claim that they are unable to source the dressings as they are housebound then a discussion regarding their support services to access food and other essential living items needs to be undertaken and recorded in their EMIS record. If they have carers then it should be established exactly what the care package consists of as this may need to be reviewed to support them to access required wound care products.

- Should a patient be thought to be highly vulnerable due to a learning disability or other risk factor then it may be appropriate to seek their permission to refer to SPOR for support and Customer and Local Services (CLS) to check they are in receipt of all benefits including funding for healthcare needs.

- all efforts must be made and documented to support patients to source their own dressings

- Should the patient refuse permission to be referred to SPOR or CLS it is essential that this decision and relevant discussion is recorded using the decision making template on EMIS. If it is thought that the person lacks capacity to make this decision then seek safeguarding supervision.

- Where the patient is at risk of deteriorating health and potential sepsis because they continue to fail to supply dressings there should be a discussion detailing the risks to the patient on the recorded on the visit contact template.

- When advising on dressings it is vital that patients are advised on the predicted number of items that will be required for a specified period so as to reduce cost to patient and avoid stock piling dressings that won't be used.

- The rationale for dressing's choice and any changes should be discussed with the patient and clearly recorded in the patients EMIS record and dressings order form.

- Should the patient not have the recommended dressing stock available then a temporary interim dressing from the nurses stock bag should be applied and the issue escalated to the grade 5/6.

- Should there be continued failure to supply the requested dressings then the grade 5/6 should complete the Dressings risk management panel (DRiM) referral so that risks to patient can be discussed and a plan agreed. There a decision will be made to either continue funding basic dressings or discharge the patient

- It is important to note that the DRiM panel is not for patients who are unable to source or fund their dressings as FNHC are unable to assist in these circumstances.

- Clinical observations should be completed at every contact to detect signs of sepsis or deteriorating health

- The Patients GP should be informed that due to the patients failure to provide dressings that they are not concordant with evidence based care and that they are at risk of further deterioration in their health

SOP 6 Escalation to Clinical Nurse Specialist (CNS)

Purpose

To support care delivery and agree actions. CNS do not usually hold a caseload of patients. They are available to offer specialist support and advice

Scope

All patients on the DN caseload whose care needs require specialist nurse advice

Core Requirements

- CNS have a key role in education and development of competency frameworks, development of clinical policies and procedures and provide specialist advice to nurses in a range of settings who are managing complex patient nursing care issues.
- CNS do not hold their own caseload as all patients referred to the DN service are the ongoing responsibility of the Team leader.
- Referrals from nursing care providers and for specialist input should be placed in the appropriate DN team triage and further discussion should be undertaken with the referrer and CNS to determine if specialist support is required . If the patient is in a nursing care setting then it is not necessary to complete an initial assessment but is good practice to review the nursing assessments already completed by the nursing home team and make recommendations which should be documented in both the homes and EMIS patient record.
- CNS will be able to support nurses caring for patients in a nursing care setting with specialist nursing advice and support when the DN team feel it is beyond the level of support they can provide.
- Escalation to a CNS is via the grade 5/6 in the team
- The CNS will offer monthly supervision with team members to discuss any complex patient care needs.
- Team leaders will support their team members to identify their training and development needs and attend specialist training.
- CNS can support team members by accompanying them on visits to patients with complex care needs to inform care delivery and support staff development.

SOP 7 Daily Handover

Purpose

To support safe nursing care delivery, effective communication and agree plans and actions.

Scope

All patients on the DN caseload including those seen in clinic and twilight.

Core Requirements

- The CC will lead handover and ensure that staff are actively engaged in handover and attend at a pre agreed time.
- Handover should only be used to discuss patient care/safety issues and not for team operational issues i.e. rota management, annual leave requests, etc.
- Interruptions should be kept to a minimum and it is expected that handover should take on average 30 minutes.
- Teams should ensure they are not interrupted by indicating 'handover in progress do not disturb' on office door.
- Team handovers should be structured around SBAR (Situation, Background, and Assessment and Recommendation/Response) to ensure effective sharing of information.
- In order to support handover, patient contact template should reflect principles of ROPE (reason, observation, plan, evaluation)
- Priority for handover discussions should be
    - Unwell patients
    - Pressure ulcer new/non healing /deterioration
    - New patients
    - Palliative patients
    - Non healing wounds (changes to treatment to be agreed)
    - Patient discharges/deaths
    - Safeguarding
    - Problems/issues
- Clinical decisions and actions should be recorded on the patients EMIS record by the team member who raised the issue.
- Clinic staff should contact the CC at an agreed time during each day to complete a verbal handover, which is recorded on the patients EMIS record.
- Twilight staff should contact each CC at the start of their shift to receive a verbal handover for each team.
- Twilight staff should record all relevant handover information on the patients EMIS record before going off duty and email/voicemail the CC and AHT for the next day

to indicate which EMIS records they should review. Voicemail messages are not appropriate handover method.

SOP 8 Safety Huddle

Purpose

To support safe care delivery, effective communication across the service, manage risk and agree actions.

Scope

All issues that have the potential to impact safety of patients and staff.

Core Requirements

- All CC, CNS and the Reregistered Manager or their deputy will meet in person or via telephone/skype at 16.00hrs each weekday to discuss any patient or staff safety issues.
- Any potential staffing or safety issues anticipated over weekend should be discussed on Thursday.
- Attendance at the weekly OPAT meeting should be agreed on Thursday
- Any incidents/accidents/risks should be bought to the safety huddle to manage risk and agree actions.
- Each CC should review the patient schedule and workload prior to attending the safety huddle to inform decision making in respect of resource allocation. A daily report of the current caseload RAG rating and expected daily contacts should recorded on the daily huddle template
- When there are staffing pressures or high levels of complex care needs including support for palliative patients/IV therapy this should be raised at the safety huddle meeting to ensure resources are deployed across the service to meet periods of high demand.
- The safety huddle will include reviewing EMIS diaries to ensure that resources are deployed appropriately across the service at periods of high demand.
- Consideration to cancelling or sending a representative from FNHC to non - patient based meetings should be taken at the safety huddle to ensure resources are directed to safe patient care and staff safety when demand for the service is high and has the potential to exceed capacity within the service.
- Priority must be given to patient focused meetings including MDT's (multi-disciplinary teams), safeguarding or discharge planning meetings.
- The decision to request staff work extra paid hours or bank staff will be agreed at the safety huddle to ensure effective deployment/funding of resources.
- Should staffing resources and service demands be such that decisions are made to cancel essential /mandatory training attendance then this should be agreed at the safety huddle meeting and communicated to the education and development team.

- FNHC escalation policy FNHC escalation policy will inform decision making to manage demand and capacity to deliver safe nursing care.

- Agreed actions are recorded on the safety huddle template and an electronic scanned copy circulated to Registered manager all attendees and all grade 5/6.

SOP 9 No Access /Refused Service/ DNA Clinic

Purpose

It is inevitable whilst delivering a service that supports patients to be as independent as possible that missed clinic appointments and no access home visits will occur. This SOP is to guide staff in their assessment of risk associated with patients not accessing the care they need and to ensure their safety.

Scope

All housebound requiring home visits and ambulant patients who are able to access clinic settings.

Core Requirements

- If visiting a patient at home the anticipated date and approximate time (where appropriate) of the next visit should be written in the patients supplementary record and the patient or their representative informed of when the visit can be expected.

- If no arrangements for a follow up visit are made at the last contact then the patient should be contacted by telephone in advance of the visit.

- Clinic patients should leave the clinic with written details of their next appointment on a clinic appointment card and recorded on the clinic appointment diary in EMIS.

- For patients who arrive late for their clinic appointment due to unavoidable issues including weather, transport etc. their care should be accommodated within a reasonable time frame which is informed by risks associated with their health needs and the needs of other patients.

- Where patients consistently attend on the wrong day /time, this should be escalated to the Grade 5/6. A meeting should be organised with the patient to look at risks and concordance issues and a patient contract should be developed which includes risks and responsibilities of both the service and the patient.

- Did not attend (DNA) a clinic appointment is failure to attend at the appointed time or arriving later than 1 hour after the appointed time. This should be recorded on EMIS as DNA even if the patient visit is rescheduled for another time

- Clinic staff should attempt to contact patients who do not attend planned appointments. If they are unsuccessful in contacting a patient then they should liaise with Grade 5/6 or Registered Manager to agree a plan.

- No access is defined as when a staff member is unable to gain access to provide care/services as arranged and the staff member is unable to establish contact with the patient as a result of
    - No response
    - Access refused by the patient or third party.

This should be recorded on EMIS as DNA even if the patient visit is rescheduled for another time

- Staff members have a duty of care to patients, however patients also have a responsibility wherever possible to inform staff if they will be unavailable to receive care in their home or attend clinic as appointed.

- Patients should be given the contact details of the AHT to contact should they wish to cancel their home visit or clinic appointment. This information should be passed onto the visiting nurse or clinic immediately.

- If the team member is unable to gain access to the patient home or the patient fail to attend clinic the team member should contact the AHT who should check Maxims EPR to see if a patient has been admitted to hospital.

- It is good practice to have emergency contact numbers for next of kin that are accessible to staff on EMIS should the patient fail to attend or no access.

- Access codes for key safes should be recorded on EMIS.

- Where patients are thought to be at risk of a sudden deterioration in their health or have confusion issues this should be documented in the risk assessment.

- If a staff member is not be able to gain access to a patient's home for a planned visit then attempts should be made to contact the patient by telephone.

- It may be appropriate to speak to neighbours to ask if they have seen the person recently to inform decision making. However, consideration should be given to preserving the patient's confidentiality.

- Attempts should be made to contact the patient's emergency contact who will be expected to take responsibility for making a decision about accessing the premises.

- If the staff member is unable to speak to the emergency contact person then they should seek the support of their Line Manager/ on call manager unless there are obvious signs that the patient is at immediate risk.

- If police are to be called, the patient's nominated emergency contact must take responsibility for any damage made to access the property.

- Attempts should be made to gain access to the property or view inside the property for any obvious signs that the patient is unable to open the door. **Care should be taken to ensure that the staff member is not exposed to risk of injury.**

- If there are obvious signs i.e. patient can be seen and is unresponsive, that a patient may require urgent assistance then the staff member must alert the appropriate emergency service.

- Should a staff member gain access to the patients home and there are **signs that the patient has died and been deceased for some time, only a Registered nurse is able to make the decision not to commence CPR based on their clinical assessment and information available regarding DNA CPR decisions**. In the absence of a current DNA CPR form non-registrants are expected to dial 999 emergency services and follow instructions.

- If it is known that a patient will often not be at home for planned visits then a risk assessment should be completed, detailing the actions staff should take should they arrive to deliver care and the patient not be in.

- Should there be a history that a patient is regularly not in when a visit has been agreed then consideration should be given to offering a timed clinic appointment rather than home visits.
- Following a dynamic risk assessment and actions outlined above a Community Nurse calling card should be left for the patient. The team member's name, date and time of visit should be completed and details of next planned visit. No access contacts should be discussed at team handover and a response agreed when considering the risks.

- Should a patient not attend three consecutive clinic appointments then it should be considered they have declined the service. Each patient will be assessed on their individual care needs and vulnerability factors to determine the risks associated with not accessing the service and should be discussed with the Grade 5/6, Safeguarding Lead Nurse or Registered manager prior to any decisions being made regarding discharge.

- Patients have a right to decline the services offered by the DN team, however if the staff member believes that this is not in the patients best interests or there is cause for concern they should seek the support of their Grade 5/6 and the Safeguarding Lead Nurse or Registered manager prior to discharging them.

- It is important to inform the patients GP and the referrer (if appropriate) that the patient has declined the service and record any discussions, plans and actions in the patients EMIS record.

SOP 10 Non-Concordance with Recommended Treatment

Purpose

Working in partnership with patients is essential to ensure that their desired outcomes of care are met. There may be instances where patients are non-concordant for a number of reasons. The nursing team are committed to ensuring that patients have the information they require to make informed choices about their care and are supported to manage risks.

Scope

All patients on the District Nurse caseload

Core Requirements

- Consideration should be given to the patient's capacity and self-determination policy to make the decision.

- Where capacity to make a specific decision is questioned, a Grade 5/6 should complete a decision making assessment recording the outcome on the decision making template on EMIS taking into account any temporary impairments or consider if the decision can be delayed until temporary impairments are resolved
- After completing the decision making template if you are concerned that the person lacks the capacity to make an informed decision then liaise with GP/ hospital consultant /appropriate health or care professional /key family members to organise a best interest decision meeting.

- All cases where a patient who is thought to lack capacity and who is being cared for by a relative or carer who is non-concordant with recommended care / treatment should be discussed with the Safeguarding Lead Nurse or Registered manager.

- If informal carers/family members / friends caring for the patient prevent the nurse /SHCA from delivering nursing care, including skin inspection, wound care, symptom control or change of position this should be escalated to the Team Leader / Safeguarding Lead Nurse / Registered manager. Whilst respecting patients' rights to choose who delivers their personal care or meets their nutritional needs, it is vital that nursing care needs are managed by the nursing team.

- Where a family member states they have a lasting power of attorney in respect of health and /or finances they should be asked to produce the documentation to support this claim. If they are unable /unwilling to produce documentation then liaise with the registered manager or safeguarding lead to agree next steps.

- Where it is thought that the patient has the capacity to make an informed decision regarding their care and they remain non-concordant with recommended care the risks and agreed actions should be discussed at each contact recorded on EMIS on the DN contact template

- Recommendations for care/treatment should be evidence based and consistent across the service. Where treatments/dressings/recommendations are being changed frequently the Grade 5/6 should undertake a review of the patients care to support consistency of advice and support.

- The care plan should detail the nursing care required and also the escalation process should the patient not be concordant with the care.

- If a patient where you have no reason to doubt their capacity is non-concordant with recommended treatment / care e.g. pressure relieving equipment, it is essential that the reasons for, the benefits and risks of not adhering to the recommended treatment / care are discussed with the patient and the discussion documented in the patient's EMIS record. This discussion should continue to take place at appropriate intervals to allow patient to make informed decisions.

- When discussing with patients it is important to check their level of understanding of the risks. Patients should be able to retain the information given and be encouraged to articulate their understanding and views on the care they receive and these should be documented in the patient's EMIS record. Where a patient has communication difficulties then steps should be taken to support communication including the use of interpreters and information delivered in range of formats.

- It is important to engage a skilled translator for complex discussions in the patient's own language. The Big Word can be booked to translate discussions (see appendix 1)

- It may be helpful to show patients photographs of their wounds that they are unable to see easily to support their understanding of their care needs and gain their commitment to care.

SOP 11 Caseload Management

Purpose

There will be consistency across the service of the management of workload planning to ensure that staff can move easily between areas and understand the process. Scheduling of caseload needs to be undertaken to ensure proactive management of the caseload, support staff in managing their workload and inform decisions about capacity and demand and effective deployment of resources.

Scope

This SOP pertains to patients who are in receipt of District Nursing services. It encompasses how to manage the DN caseload and how to schedule patient contacts.

Core Requirements

- Each caseload should be managed on EMIS by way of advanced scheduling which is a consistent process across all teams.
- In order to reduce the risk of missed visits the nurse /SHCA visiting the patient should check that the patient has a schedule on EMIS for the next visit
- Patient appointments are generally booked as follows using the EMIS coding :
  - L = Low risk
  - M=Medium risk
  - H =High risk

Nursing need	Time	Health /Social/Environmental					
	including documentation	Independent with ADL's	shared care in place	no package of care if required	concordance issues	self-neglect	complex medical /social
Simple wound care i.e. skin tears	30 (home)20 (clinic)	L	L	L	M	M	M
Long term stable diabetic	30 (home)20 (clinic)	L	L	L	M	M	M
Injection (clexane/B12 etc.)	30 (home)20 (clinic)	L	L	L	M	M	M
JIC meds management	30	L	L	L	M	M	M
PEG/RIG care	30	L	L	L	M	M	M
ROS/Clips	45	L	L	L	M	M	M
lower leg assessment (no Doppler)	30	L	L	L	H	H	H
Leg ulcer dressing	per leg 30	L	L	L	H	H	H
Doppler assessment	45	L	L	L	H	H	H
lower leg assessment (Doppler)	90	L	L	L	H	H	H
Hosiery measurement	45	L	L	L	H	H	H

IV bolus	45	L	L	L	H	H	H
IV infusion	60	L	L	L	H	H	H
Catheter change	45	L	L	L	H	H	H
Stoma assessment	45	L	L	L	H	H	H
Large wounds - surgical/traumatic/NPWT	45	L	L	L	H	H	H
stable GSF yellow palliative	45	L	L	M	H	H	H
Unstable /New diabetic	45	L	L	M	H	H	H
TWOC	pre TWOC 60 min 1st visit 30 2nd 15 phone call 3rd visit 45	L	L	M	H	H	H
Bowel care	60	L	L	M	H	H	H
Continence assessment	60	L	L	M	H	H	H
Pressure mapping	60	L	L	M	H	H	H
Initial assessment	90	L	L	M	H	H	H
Review assessment	60	M	M	M	H	H	H
Complex palliative symptom control	60	M	M	H	H	H	H
unstable GSF yellow palliative	90	M	M	H	H	H	H
New pressure ulcer including ASSURE/ RCA	90	M	M	H	H	H	H
Red GSF EOL Palliative	60	N/A	M	H	H	H	H

- The CC should access their team RAG rating and expected contacts reports on EMIS each day to inform decisions regarding resource allocation and escalation
- Staff should manage their diary to ensure that they have protected time for starting their day, appropriate breaks and handover at end of day. Staff should inform the clinical coordinator at the earliest opportunity if they are not able to factor this into their day so that the coordinator can support them. The coordinator will raise any issues at the daily safety huddle to ensure staff are supported
- Changes to patients visiting schedule should be undertaken at the daily team handover and changes made to the EMIS schedule at that time.
- It should be recorded on the care plan where a SHCA can carry out the delegated care. The care plan should be developed by a Nurse who is responsible for ensuring that the SHCA is able to follow the care plan, deliver the care and is aware of the parameters in which they are able to deliver care. There should be a clear review period and the escalation process should there be a concern contained within the care plan.
- Where consideration for a nursing task to be delegated to a carer in either a residential care setting or a homecare provider you should follow the delegation SOP and FNHC personal care and clinical tasks guidance
- It is anticipated that Grade 5/6 nurses will focus on initial assessments, review of complex patients and timely discharge of patients who can self-manage.

- Each patient must have an up to date personalised care plan visible on EMIS in documents that should be revised when care needs change i.e. wound care changes from debridement to moisturising etc.
- Each care plan should be labelled to indicate type of care plan i.e. left leg ulcer and reflect the date of development. Where a care plan is discontinued the document should be edited to reflect discontinuation date.
- Where it is noted that there is no care plan for each nursing need visible on EMIS this should be completed during the visit by the nurse or if identified by a visiting SHCA then it should be raised to the Grade 5/6 and plans put in place to complete the care plan before the next patient contact.
- Team members should only give timed visits when the care needs require a specific timed intervention. It is good practice to advise patients that the visit will take place in the morning or afternoon, however they should also be advised that this may be subject to change due to the unpredictable nature of the work.
- When resources are under pressure, consideration should be given to prioritising initial assessments, critical medication and wounds with potential for infection reducing non-essential visits, reviewing care plans and visiting patterns that would not have a detrimental effect on patient care. This should be discussed at the handover and safety huddle.
- It is vital that staff maintain competency in their clinical practice and staff must proactively manage their own training requirements in conjunction with their Team Leader. Staff members should be scheduled to attend/undertake essential /mandatory training in advance as part of the monthly rota development. Mandatory training and clinical competencies should be reviewed at quarterly supervision and a plan made to undertake any training deficits.
- When working with patients who are receiving care from Level 1, 2 and 3 Rapid Response and Reablement Team (RRRT) (Therapy led) the nurses from RRRT will be responsible for managing the patients nursing needs unless the care is complex /specialist. If the nursing need is complex or specialist there should be a joint visit with RRRT and DN /CNS to agree who/how nursing needs will be met. The exception to this will be when the patient is solely under the care of the RRRT social worker and their nursing needs will be met by the DN team

SOP 12 Visiting Patients (who don't ordinarily receive nursing care) in Registered Care Homes or who are in Receipt of Care from a Registered Home Care Service

Purpose

To promote safe and appropriate care for patients (who don't ordinarily receive nursing care) in a registered care home or from a registered home care service.

Scope

All patients on the District Nursing caseload who are accommodated in a registered care home or who receive care from a registered home care provider.

There are three types of care that registered care services may provide:

- Nursing care
- Personal care
- Personal support

FNHC nursing care will be provided to patients living in care homes or receiving care from a home care provider where nursing care **is not** provided for them.

Please note that some care homes/home care services will provide nursing care to a limited number of patients, so it is important to establish whether patients are receiving nursing care as part of their care package.

Where nursing care is being provided to the patient, there may be occasions where nursing staff from the care home/home care service contact FNHC for support/advice, please see SOP: Provision of Support to 'Nursing Care Patients' in Registered Care Homes / Home Care Services below

Core Requirements

- All patients in a care home must be treated as if they are in their own home i.e. FNHC nursing staff should not assume that the care home is meeting all the care needs of the resident.
- The same holistic approach to care should be taken as would happen if they lived in their own home.
- FNHC are committed to working in partnership with other registered providers of homecare. **The DN Team leader maintains continuing responsibility for the nursing needs** of patients on their caseload **who do not receive nursing care** from their care home and in their own homes from registered home care providers.
- FNHC nursing staff are responsible for liaising with GP's, hospital and members of the multi-disciplinary team about the patient's health. This cannot be delegated to a non-registrant i.e. if a swab is taken the nurse remains responsible to follow up the results and liaise with GP.
- Communication with care staff is essential and FNHC staff should work collaboratively with the registered care providers to provide optimal standards of care.

- FNHC team members and registered care providers are responsible for ensuring they share information about any risks or changes to the patient's condition to inform care planning.
- It is recommended that if the patient has complex care needs that there be an initial meeting between the FNHC Grade 5/6 and registered care provider to share risks and ensure that care plans are developed that reflect care needs.
- The resident's list of medication can be obtained from the pharmacy generated 'MAR' chart or from GP shared record.
- When documenting the communication of specific information/actions with care staff, FNHC nursing staff must record the name of the professional and their job title. For example, "Discussed with Senior Healthcare Assistant Julie Smith and asked her to …"
- FNHC team members should write in the care provider's records wherever appropriate e.g. whenever there are clinical concerns, changes to risks, information to share, recommended actions equipment required.
- FNHC Nursing staff are responsible for the outcome of any intervention they request to be carried out by the care provider e.g. if care home staff are requested to use / provide / organise equipment, the nurse must check that this request has been carried out and take appropriate action if it has not happened. Registered care homes are responsible for ensuring that the patient has access to relevant equipment and consumables.
- Prior to delegating nursing tasks, FNHC nursing staff must seek agreement to do this from the Registered Manager of the care home/home care service
- FNHC nursing staff are responsible for ensuring any ongoing care needs, including equipment and preventive measures e.g. turning schedules, are documented in the care providers records and relevant information such as a copy of the preventing pressure trauma leaflet is provided.
- Where FNHC team believe that the persons care needs are increasing and the residential home and FNHC visiting nursing service are unable to meet those needs the grade 5/6 should coordinate an MDT meeting to ensure that increasing risks are managed. Should there be a delay in transferring the patient into a nursing bed then a risk management plan should be agreed by the MDT until the patients can be accommodated into a nursing bed.
- In care homes, FNHC nursing staff should advise the appropriate person of their arrival and departure and if required should sign themselves 'in' and 'out'.
- Before leaving, FNHC nursing staff should wherever possible, communicate in person with the appropriate senior care home staff. Should there be critical information to share it is recommended that this is communicated to the Registered manager or their deputy and jointly recorded in the patient's home based record
- FNHC nursing staff should be aware of the requirements of the FNHC Medicines Policy for medication administration in care homes.

SOP 13 Provision of Support to 'Nursing Care Patients' in Registered Care Homes / Home Care Services

Purpose

From time to time District Nursing (DN) Teams and Clinical Nurse Specialists (CNSs) are approached by Registered Care Homes/Home Care Services who provide nursing care, for advice, support or guidance with a variety of patient care issues. This SOP enables staff to manage such requests.

Scope

Requests for advice and support to manage patient care from registered care homes/home care services who provide patient specific nursing care.

There are three types of care that registered care services may provide:

- Nursing care
- Personal care
- Personal support

FNHC nursing care will be provided to patients living in care homes or receiving care from a home care provider where nursing care **is not** provided for them.

Please note that some care homes/home care services will provide nursing care to a limited number of patients, so it is important to establish whether patients are receiving nursing care as part of their care package.

If the patient **does not** receive nursing care from their registered care home/home care service then refer to SOP: Visiting Patients (who don't ordinarily receive nursing care) in Registered Care Homes or who are in Receipt of Care from a Registered Home Care Service.

Core Requirements

- All requests from nursing homes for support from the team should be led by the Grade 5/6
- If the request is deemed appropriate the DN service can provide ***generalist*** advice and support to nursing staff in registered care homes/home care services if the patient's needs fall outside of what would reasonably be expected from Registrants in a registered care home/home/care service. This may include initial support in IV therapy, syringe driver or wound care but ongoing training and nursing care is the responsibility of the Registered Provider.
- Clinical Nurses specialist (CNS) may be called upon to offer ***specialist*** advice and support where the requirements fall outside of the remit of the generalist team. This may include complex wound care or stoma/continence issues
- DN team members/CNS must make it clear to registered care home/home care service staff and the patient that they are not assuming any clinical responsibility for the patient's care which remains the ongoing responsibility of the nursing provider. Direct patient care should only be undertaken if part of teaching a skill to others.

- DN team members/CNS cannot sign off nurses from another organisation as competent in a skill.
- DN team members/CNS should document their actions/advice/guidance in the Nursing Home's patient care record and in the patient EMIS record.
- **N.B.** It is the registered care home/home care services' responsibility to ensure that the learning needs of their staff are addressed in order to meet the care requirements of patients within their care.

  Where FNHC staff have concerns regarding this, the issue can be escalated to the Jersey Care Commission and if necessary through the Safeguarding policy and procedures.

SOP 14 EMIS Record Keeping /Activity Recording

Purpose

The patients EMIS record will comply with FNHC polices and Nursing and Midwifery Council (NMC) Code to reflect the care that was given, any changes in the patient's condition and actions taken to proactively support the patient's health and wellbeing.

Records should be written in a way that is appropriate to share with the patient at the time of recording should they request to see them.

Patient based activity will be recorded to reflect the type of contact with the patient, their relatives or other professionals.

Scope

This SOP pertains to the recording of care delivered to patients who are in receipt of District Nursing home visiting service and attending clinics. In addition, it includes how to record activity in a standardised way that will enable data to be extracted to demonstrate the performance of the service, the quality of service that has been provided and patient focused outcomes.

Core Requirements

- See FNHC record keeping policy and NMC Professional standards of practice and behaviour for Nurses and Midwives. Code NMC code
- Records should be made in the patient's EMIS records in the patient's home or before the patient leaves clinic. This will help to support access to the contact record should the patient request this.
- All staff are reminded that they should only record on EMIS in a style and language that they would be happy for the patient to review. Records should reflect the facts of the contact, which could include what is observed and verbalised and professional judgment based on best available evidence. The use of the ROPE tool will support this.
- The visiting team member should also make notes in the patient's hard copy supplementary records which could include communication with other professionals, significant events, medication administered, advice given and changes to care should be recorded in the record as minimum.
- Should a patient wish to view the content of their EMIS record made of the contact they should be supported to do so by the team member visiting at that time .Patients will always be able to make a subject access request to have a copy of their records. Should a patient request this then please seek advice from the Registered Manager or Director of Governance and Care. Where a team member is concerned that sharing the details of the EMIS contact notes would cause anxiety or distress to the patient then they should advise the patient that they will seek advice from the registered manager or Director of governance and care /Caldecott Guardian. A plan to share information with the patient will be agreed

- Contacts made directly with patients in both their home or a clinic setting should be recorded as **face to face** contacts with time from start to finish of the contact being recorded.

- Records must reflect the actual time of the contact and the time of recording. If this is different the time of recording should be indicated in the body of the consultation and the actual time of the visit as part of EMIS consultation.

- Patient related administration should be recorded against the patient record as **administration** with duration from start to finish**.**

- Any telephone contact with the patient or their representative should be recorded as **telephone contact** with duration from start to finish.

- Telephone liaison with another professional should be recorded as **discussion with other professional** with duration from start to finish.

- Attendance at an MDT should be recorded on the MDT template and as **attendance at MDT patient present** / **not present** whichever is relevant with duration from start to finish.

- It is essential to record venue for the contact i.e. home, residential home, and clinic. Only use Le Bas for telephone contact

SOP 15 Discharge from the District Nursing Service

Purpose

To promote safe and appropriate discharge of patients from the District Nursing caseload

Scope

This SOP pertains to patients on the District Nursing caseload considered ready for discharge and encompasses checking that all goals have been met, the management of ongoing needs, communication with senior staff, GP liaison, correct completion of the care records, pre-archiving requirements and archiving.

Core Requirements

- A Senior Healthcare assistant (SHCA) should not be making the decision to discharge patients from the DN caseload. This decision should only be made by a registered nurse
- Where there is a task that has been delegated to a trained, competent carer as part of the patients care, the patient should remain on the DN caseload to ensure that changing health needs that could affect delegation decisions are managed appropriately.
- On discharge the discharge template on EMIS must be completed
- Prior to discharge the nurse should check all assessment review dates and plan how to manage any that have been set for a future date e.g. if at risk of pressure trauma – does patient have to be reviewed again? Can this be managed through patient education and direct re-referral?
- If the patient has died and they have expressed a preferred place of death (PPD) than this should be recorded on the discharge template to support reporting of Key performance indicators (KPI)
- The Nurse should review all care plans to check if goals have been met, ensure all care plans are appropriately evaluated and the 'problem/issue' does not require ongoing care. If ongoing care is required, the nurse should ensure that there is a documented plan in place to address this need. For example, patient at risk of developing pressure damage – plan might include patient information leaflet given and explained, information about referral back to the service if concerns arise.
- Every care plan must have a clear evaluation indicating its outcome.
- Team members should discuss all planned discharges with the CC prior to the patient being discharged from the caseload and record the discussion and outcome with the Grade 6/5 in the patient's nursing records.
- Patients should be encouraged and supported to complete the Post SMILES on the discharge template on EMIS as this is a key performance indicator for the service. If this is not completed then the reason for non-completion should be documented in the patients EMIS record and escalated to the CC
- Offer the patient or their representative the opportunity to complete the online patient survey.

- Inform other professionals via letter of patients discharge and copy in any relevant services involved in the patient's care (with patient agreement).
- Patients in registered care homes/receiving care from registered home care services: – FNHC nursing staff are responsible for ensuring any ongoing care needs, including equipment and preventive measures e.g. turning schedules and trigger points for referring back to the DN service are documented in the care providers records and relevant information such as a copy of the preventing pressure trauma leaflet is provided.
- Ensure all hard copy supplementary records are sent for scanning into the EMIS record. Only new hard copy records should be scanned onto EMIS.

Appendix 1 - The Big Word Interpreting Service

thebigword

Telephone Interpreting Service

Dial: 03333449473

Enter your access code 97950006 followed by #

Enter the language code from the list below, followed by the # key:

702	Albanian	**4**	German	**735**	Lithuanian	**1**	Spanish
91	Amharic	**993**	Greek	**97**	Mandarin	**998**	Swahili
92	Arabic	**738**	Gujarati	**533**	Mirpuri	**762**	Tagalog
727	Bahasa Indonesian	**994**	Hindi	**741**	Nepali	**729**	Tamil
706	Bengali	**724**	Hungarian	**796**	Oromo	**992**	Thai
17	Bosnian	**995**	Italian	**98**	Pashto	**773**	Tigrinya
707	Bulgarian	**96**	Japanese	**5**	Polish	**764**	Turkish
93	Cantonese	**3**	Korean	**996**	Portuguese	**709**	Twi
710	Czech	**520**	Kurdish (Kurmanji)	**749**	Punjabi	**765**	Ukrainian
713	Dutch	**730**	Kurdish (Sorani)	**750**	Romanian	**999**	Urdu
712	Farsi (Afghan)	**731**	Kurdish (Bahdini)	**997**	Russian	**2**	Vietnamese
94	Farsi (Persian)	**733**	Latvian	**755**	Slovak	**0**	**More Languages**
95	French	**734**	Lingala	**757**	Somali	**700**	**Cannot Identify**

Once connected, stay on the line and take note of the Interpreter's identity number.
Remember to direct your conversation to the client and not the Interpreter.

If you have any questions please contact Interpreting Customer Service

0800 757 3025 Or email info@thebigword.com

Top tips

- **Direct your questions to your client/caller**
  Make the conversation as natural as possible.

- **Speak clearly and distinctly**
  Help the Interpreter to understand you easily.

- **Language differences**
  A short sentence from you may appear longer when communicated in another language.

- **Be patient**
  It can take a little time for the Interpreter to build rapport with the caller. You can interrupt if you feel the conversation has digressed.

- **To ask a question**
  Refer to the Interpreter as 'Interpreter' to avoid confusion

If you have any questions please contact Interpreting Customer Service 0800 757 3025 or email info@thebigword.com