East London NHS
NHS Foundation Trust

Community Health Newham Directorate

Extended Primary Care Team & Virtual Ward Operational Policy

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Name of originator/author:	Dr Kate Corlett, Associate Director of Primary Care Petra Nittel, Governance Manager, CHN Directorate Timi Ogunlowo, Locality General Manager, West Locality Christine Callender, Locality General Manager, East Locality
Developed in consultation with	CHN Community Matrons Eirlys Evans, Deputy Director of Nursing Rafaela Peerutin, Associate Director of Therapies
Name of responsible committee/individual:	Directorate Management Team Community Health Newham Directorate
Circulated to:	CHN Extended Primary Care Team Social Care, London Borough of Newham Discharge Co-ordinator, BartsHealth, Newham University Hospital Specialist Nursing Team Specialist Therapies Team Director, CHN & MHCOP Services Lead Nurse, Urgent Care Centre ED Consultant, BartsHealth, Newham University Hospital Telehealth Team Newham GPs
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1. Introduction

1.1 The key function of the Extended Primary Care Service is to treat people in their homes through the establishment of integrated multi-disciplinary teams, working across two localities with strong inter-disciplinary relationships and broader partnership arrangements with other service providers. Intervention and treatment will be pro-active and based on the utilisation of a range of diagnostic tools and referral criteria to ensure fast track and efficient use of the community based resources.

1.2 The following policies and procedures reflect the changed relationships, new patterns of working and increased collaborative approaches envisaged in Transforming Community Services (Department of Health DH 2009) and Equality and Excellence – Liberating the NHS (DH 2010).

1.3 This policy covers the general principles pertaining to the operation of the Extended Primary Care Service and the multi-disciplinary teams.

2. Philosophy of Care

2.1 Newham Model for Integrated Care – Operational Model

The model of delivery is based on the principle of "Right care, right time and right place". It reflects the philosophy that providing the right kind of support to help people manage their existing long term condition and provide support to help them through any exacerbation of that condition is the surest way to avoid them being admitted into hospital.

Through an increased emphasis on health education and promotion people can be supported to stay well and develop independence and broader skills toward self-care. The service design for Extended Primary Care Services enables the provision of care and support to vulnerable people with the most complex medical and social needs in a range of community settings. The Virtual Ward uses the systems and staffing of a hospital ward, but without the physical building, providing preventative care for people in their own homes.

Various forms of Tele-health are used as tools integral to step-up and step-down and to enable increased self-care and monitoring.

A diagrammatic representation of the Newham model for integrated care is shown on page 8 of this Policy.

2.2 Self care

Patients who can care for themselves, and can be cared for at home or other community based environment. These patients are registered in a primary care setting and have strong primary care support.

2.3 Supported Self Care

These clients will be able to care for themselves in the community but will need support through enablement services to facilitate greater independence. The service interaction is envisaged to be infrequent but appropriate to the support needs identified by the individual and Tele-Health will be a strong component of this care offer. Strong linkages with primary care and the GP attached to the multi-disciplinary team in addition to District Nurse and Community Matron and other clinical rehabilitation specialists will support any long term need.

2.4 Long term multi-disciplinary support needs

Clients within this cohort will have long term needs and will require integrated support from multidisciplinary teams and identified specialist intervention. They will continue to be supported in the community and will be actively managed by

the appropriate professionals. There is recognition that these patients will have highly complex needs including rehabilitation, long term condition management and end of life care needs.

2.5 Patients with highly acute needs

We recognise that needs fluctuate, necessitating prompt interventions to put in place effective clinical management plans. We envisage an integrated community team developed utilising existing skilled practitioners and achieved by reorganising pre-existing commissioned services to enable early release from an acute setting or to ensure community intervention as an alternative. Pre-existing strengths of collaborative working with differing health and non-health professional specialities, with the addition of strict admission and discharge criteria and will ensure a flexible approach defined by patient need. The skills set within the virtual ward model is expected to encompass physical assessment and prescribing skills, Nursing , Medical, Therapy, social care and Mental Health.

2.6 Hospital Care

The structure and operational design of the service will not exclude patients requiring input from secondary care, and time limited support will continue to be offered in line with agreed safe clinical guidelines with any future discharge in to the care of appropriate community teams governed by the needs of the patient.

2.7 End of life

The EPCT will look after patients at end-of-life to enable them to die at home if that is their wish and their carers will be supported. This will be achieved by close working with the hospice service and maintenance of an end-of-life register.

2.8 Supported Discharge through Telehealth In-reach

The Telehealth Hospital In-Reach Team provides support in the community and acute setting and facilitates an early discharge service to patients discharge to the Acute Hospital.

The team works alongside the hospitals clinical team in identifying patients that are suitable for an early supported discharge home and arrange that patients will be visited at home by the Extended Primary Care Services/Virtual Ward teams.

Apart from early supported discharge the team aims to prevent patient admission to hospital where possible and safe. Education would be provided to patients and their carers.

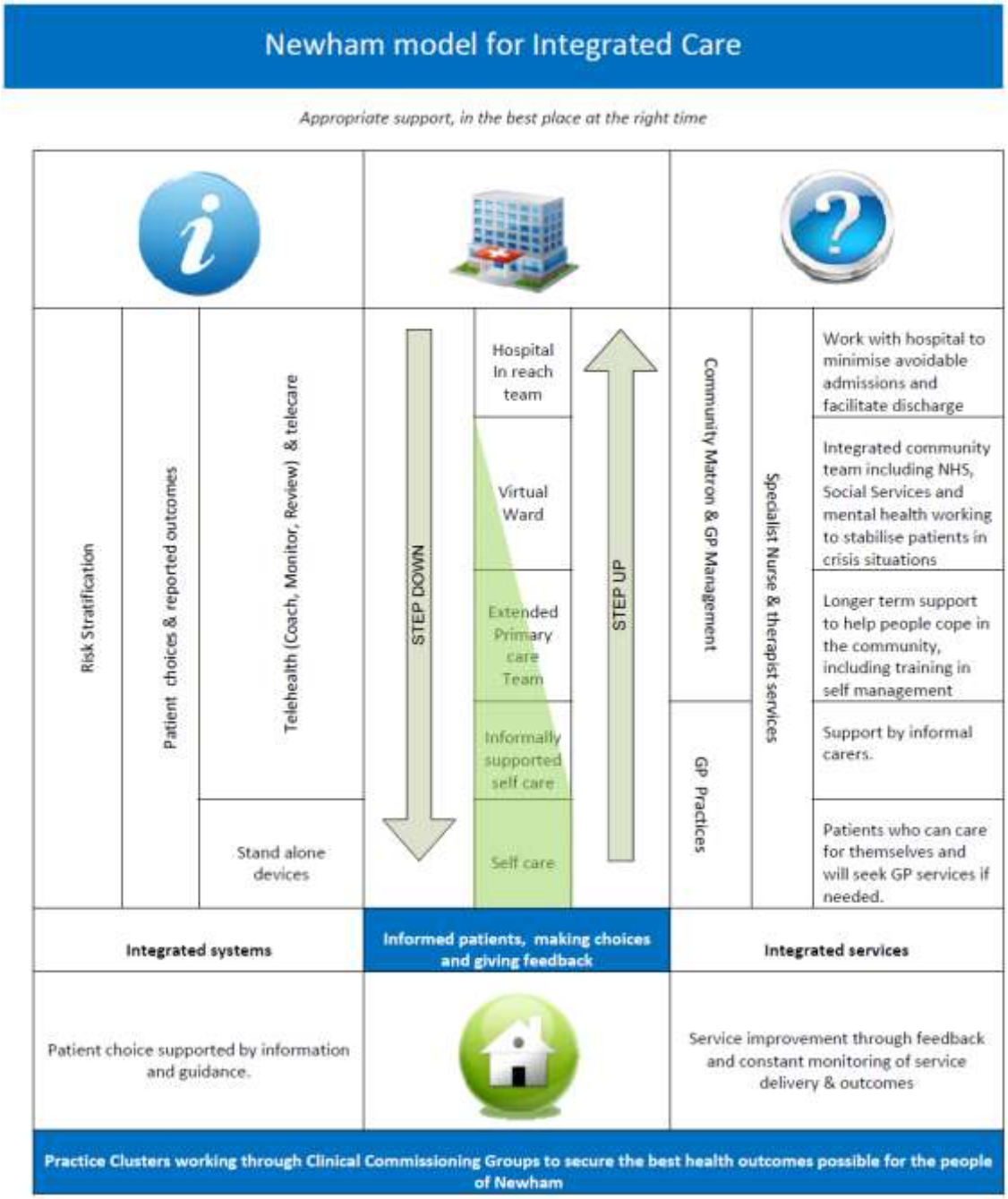
2.9 Telehealth

Newham Telehealth services can be provided via the service users TV, a mobile phone using SMS messaging or simply through using structured questions over the phone. The TV version is known as Motiva and the phone version is known as Florence or Flo.

Typically a service user will measure the vital signs relevant to their long term condition(s) on a regular basis and transmit these to a Telehealth Assistant Practitioner. The readings are monitored to look for trends that could indicate deterioration in health and exacerbations of the condition and will advise the service user in accordance with agreed protocols.

In addition to monitoring vital signs a TV based Telehealth service can provide instructional videos and questionnaires that seek to educate the

patient about their condition/s. Telehealth is offered via three key areas of provision, i.e. core Telehealth, simple Telehealth and the Diabetic Specialist Nurses.



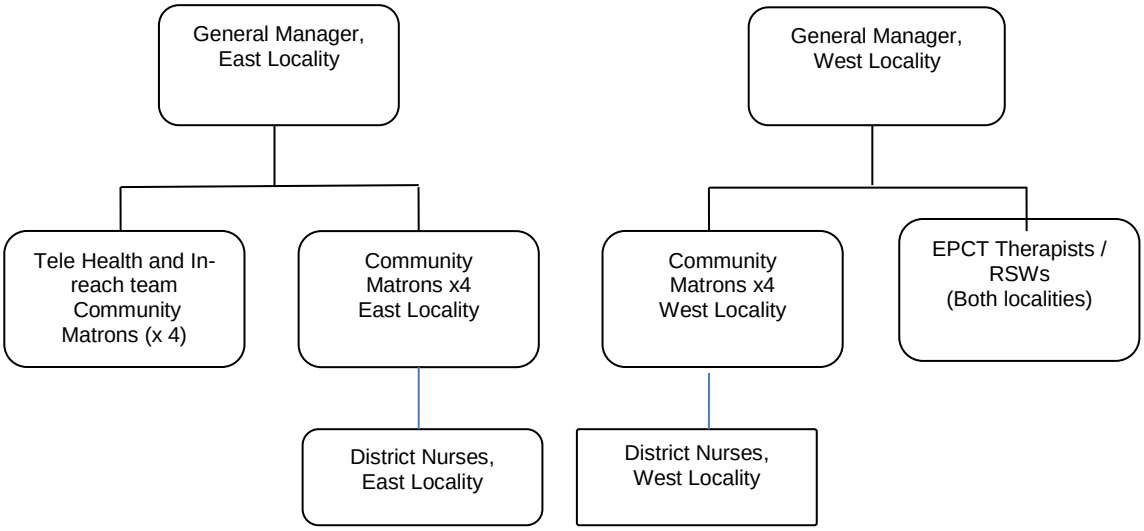
3. Staffing

3.1 Key Principle

The Extended Primary Care Service will comprise of personnel from differing clinical and operational disciplines. Whilst each member may carry distinct roles and responsibilities, case loads and input into the team, the general principle will be one shaped by patient need, collaborative practice and collaborative decision making.

3.2 Structure and operational management

The Extended Primary Care Service is divided geographically across four quadrants the Borough of Newham. The organisational chart below sets out the operational structure.



3.3 Membership of the Extended Primary Care Service

Full membership of the Extended Primary Care Service will comprise of personnel from all professional groups within Community Health Newham, London Borough of Newham.

3.3.1 Administration

Extended Primary Care Team Administrator

3.3.2 Allied Health Professionals

Occupational Therapists (OT)

Speech and Language Therapists (SLT)

Physiotherapists (PT)

Psychologists

Dieticians

Social Workers

3.3.3 Nurses

District Nurses (DN)

Community Matrons (CM)

Telehealth Community Matrons

Specialist Nurses (e.g. Diabetic Nurse Specialists, Neuro Specialist)

Community Psychiatric Nurse

St Joseph's Outreach Team (working closely with the EPCT, but not part of ELFT).

3.3.4 Additional Support and Rehabilitation Roles

Rehab Support Workers

Occupational Therapy Technician

Telehealth Assistant Practitioners

Clinical Assistant Practitioners

Healthcare Assistants

Physiotherapy Assistants/technician

3.3.5 Management Responsibilities

Responsibility for the strategic management of the team lies with the relevant locality manager(s) who in turn reports to the EPCT board. Day to day management is responsibility of the Telehealth Service Team Leader. Day to day monitoring of patients remains the responsibility of the Telehealth assistant practitioners. The Telehealth community matrons are also responsible for patient assessment for the step up and step down process.

It is the responsibility of the whole team to ensure targets are met and relevant policies, procedures and protocols, including the new EU Telehealth Code of practice are adhered to.

3.3.6 Doctors

General Practitioner (GP) input across four quadrants – 0.5 WTE in each Virtual Ward.

3.4 Staffing interactions and responsibilities

This policy recognises that each role within the multi-disciplinary team will work within the parameters set out of its related professional codes of conduct and guidelines though this policy acknowledges that elements correspondence and cross over will exist in terms of skills, knowledge, clinical application, patient interaction and problem solving. This policy recognises this as a strength bringing additional capacity and increased knowledge base to the team.

Each member of the multidisciplinary team is expected to work in close co-ordination with other professional groups within the scope of practice as directed by their clinical/operational team lead. In doing so, they will provide representation at multi-disciplinary team meetings, joint assessments and developing optimised multidisciplinary treatment programmes to facilitate affective discharge management.

3.5 Individual Professional Responsibilities

For detail see job descriptions and professional codes of conduct as per specific professions by grades. General descriptions are laid out below.

4. Roles and Responsibilities

4.1 Key principle

This policy recognises that each role within the Extended Primary Care Team will work within the parameters set out of its related professional codes of conduct, though this policy acknowledges that elements of correspondence and cross over will exist in terms of skills, knowledge, clinical application, patient interaction and problem solving. This policy recognises this as a strength bringing additional capacity and increased knowledge base to the team.

4.2 Roles and responsibilities

Each member of the Extended Primary Care Team will maintain effective communications between other members of the team, patient, the relatives and other professionals both internally and externally to the ward. Membership of the team requires a commitment to maintain and work towards continuous development of service skills and competencies in meeting the challenges demanded from the potential challenges of these new ways of working. Toward the continuous promotion of sustainable self-directed care, enablement, flexible working and supportive philosophy of home based multi-disciplinary intervention.

Responsibilities of the team include assessment and case-management of patients who are eligible for Continuing Care NHS funding as required.

4.3 Professional and Operational Management

The Newham Community Health and MHCOP Directorate provides clinical and managerial leadership and governance to services and are responsible for the business of the Directorate including quality, performance improvement and for ensuring that resources are used effectively. The Extended Primary Care Teams form a business unit of the Directorate. The Service Director, the Associate Medical Director for Primary Care, the Deputy Director of Nursing and the Associate Director of Therapies provide strategic leadership.

Whilst general management, operational and strategic decision making and other duties associated with day to day functions and resource allocation of the service will be the responsibility of the General Manager for each locality. There will remain elements of professional management i.e. specific to the clinician's professional group, which will continue to require supervision and clinical direction.

4.3.1 Locality General Manager

To manage and lead on supporting the strategic development of the Extended Primary Care Team ensuring services are always patient centred and responsive. They will provide managerial responsibility, line management and operational leadership across all disciplines and roles within the service. The General Manager will ensure continuity and consistency of operational and individual performance, service planning, and risk assessment.

4.3.2 EPCT Administration

The EPCT Administrators are responsible for the co-ordination and facilitation of high quality cost effective administration to the ward. The EPCT Administrator will work closely with clinicians, managers and other staff ensuring prompt prioritising of registration and discharge of patients, the liaison between staff within the Extended Primary Care Team and prompt action in systems management to ensure its smooth running. This includes entering and monitoring all referrals to the EPCT on the Referral Tracker and maintaining strong communication links with the front line practitioners, service users and other members of the team and ensure smooth running of the service every day.

4.3.3 Occupational Therapist

To provide occupational therapy interventions to the Extended Primary Care Service and participate in multi- disciplinary patient reviews. To write-up risk assessment and rehabilitation care plans in the patients hand held notes, prioritise programmes which encourage maximum independence, and other relevant reports, as required. Undertake home assessment for functionality, safety and request and obtain the adaptation equipment as relevant, monitoring its effective use and safety.

4.3.4 Physiotherapist

To assess, set achievable goals with the patient and form a physiotherapy care plan to help patients regain function and mobility by working towards set goals. This includes undertaking risk assessments and providing specialist input, i.e. tracheostomy and respiratory illness, training and advice to formal and informal carers as required and contribute to the overall aims of the service. They are also responsible for providing relevant reports and assessments of patients' functional abilities to assist other members of the EPCT.

4.3.5 Speech and Language Therapist

Provides support and intervention to patients with complex communication difficulties as well as offering advice and support to others within the EPCT. The Speech and Language Therapist will carry out comprehensive communication and/or eating and drinking assessments in the patients' homes using a range of observational and formal tools.

4.3.6 Community Matron

The Community Matron is responsible for managing virtual ward patients and co-ordinating client specific care within the Extended Primary Care Service. They would ensure close working with multidisciplinary team members and health and social services providers as well as other agencies from the statutory and voluntary sectors. All referrals to the Virtual Ward will be visited at home for assessment within the specified timescales. They will additionally ensure close collaborative links with General Practice and at all times at all times ensure that the clients' care is of the highest quality and standard. Community Matrons will lead and line manage the locality District Nurses ensuring supervision in line with ELFT policy and the safe and timely allocation of work with full utilisation of the electronic Team Planner ensuring that no referrals are missed and that no required care is delayed.

Continuing Care assessment and case management would be provided as required.

The Community Matrons, in conjunction with Team Leaders will review the care plans of all newly admitted patients and ensure that the care plan fulfils the patient's needs. They will monitor for an initial period that care interventions have been put in place as identified.

Community Matrons will play a key role in leading quality and assurance activities such as audits, review of complaints and incidents reports and patient feedback and identify remedial actions and monitor that these are implemented.

4.3.7 District Nurse

The District Nurse will ensure the effective assessment, planning, implementation, evaluation of care and that the discharge of patients from the case load meets the professional and clinical standards/guidelines at all times under the direction of the Extended Primary Care Service Community Matrons. The District Nurse will ensure that a high quality service is provided in patients' homes, clinics or residential care settings within available resources. They will carry out risk assessments as appropriate for individual patients. Where required District Nurses will carry out assessments for Continuing Care, continence needs, medical equipment, including pressure ulcer relieving equipment and ensure that referrals and orders are processed in a timely manner and monitor that equipment or other supplies are in place and evaluate their suitability and effectiveness.

District Nurses will work closely with the Tissue Viability Team with the aim to prevent pressure ulcers, or, where they have occurred that these are managed in an optimal way.

District Nurse Team Leaders will be responsible for the allocation of work with full utilisation of the electronic Team Planner ensuring that no referrals are missed and that no required care is delayed.

4.3.8 Community Psychiatric Nurse (CPN)

The CPN is registered nurse with special training in mental health whose job is to assess and support people with mental health needs to live as independently as possible. The CPNs in the in the Extended Primary Care Service have particular expertise in dementia and the mental health of older people, will work with colleagues to address the needs of people with mental health problems. If the team determine that a patient needs a higher level of mental health support than can be provided through the service locality teams then the CPN will facilitate further involvement of mental health services.

4.3.9 Rehabilitation Support Worker

Rehab Support Workers will liaise with other members of the Extended Primary Care Service to ensure sustainable intervention and support to special and clinical input. They will carry out exercise and support programmes as set out in individual care plans, agreed with and/or by other members of the service and the patient in whose home they are working.

4.3.10 Assistant Clinical Practitioner and Telehealth Assistant Practitioner

Assistant Clinical Practitioners will carry out assigned tasks and duties to assist with the physical, emotional and social care of clients. They will carry out care and support programmes as set out in individual care plans, agreed with and/or by other members of the Extended Primary Care Team and the patient in whose home they are working. Telehealth assistant Practitioners also monitor patients readings while at home via the use of Telehealth technology.

4.3.11 Social Worker

Social Workers are employed by the London Borough of Newham and work the EPCT. They ensure that those that meet the FACS (Fair Access to Care) criteria and their informal carers have the social care support they require to meet agreed outcomes based on assessed eligible needs.

Social workers ensure that service users have an individual resource allocation assessed and agreed to meet their social care needs. They offer individuals choice and control via direct support planning or facilitating links with independent support planners and brokers. Support plans identify agreed outcomes and how they will be met. Care reviews, led by social workers, ensure that outcomes are being met and support is managed effectively.

Social Workers also undertake safeguarding adult enquiries, assessing and analysing risk and contributing to the development of multi-agency safeguarding protection plans. This includes leading, coordinating, monitoring and reviewing multi-agency adult protection plans.

4.3.12 Clinical Psychologist

The Clinical Psychologist is not a direct member of the EPCT but works with the EPCT and provides assessment, intervention, counselling and support to individuals and their carers. Services include: Psychological assessment and intervention, neuro-psychological testing and assessment including memory, cognition, problem solving and emotional well being

Monitoring of behaviour, mental state and mood in addition to counselling, emotional support and working with other members of the multi-disciplinary team in delivery of an individual care plan.

5. Conduct and professional responsibility

5.1 Key governing principles

Each professional group represented in the multi-disciplinary team will follow and adhere to their respective professional code of conduct, e.g. Nursing & Midwifery Council (NMC), Health and Care Professionals council (HCPC).

All members of the Extended Primary Care Service will adhere to Trust policies guaranteeing inclusion and non-discriminatory practice both in terms of those working in the team, those accessing its services and those partners with which it operates.

All member of the multi-disciplinary team will work in partnership with patients and their carers and other provider agencies and professionals to ensure that care packages minimise duplication and omissions.

All staff within the Extended Primary Care Team will have equal responsibility to ensure the services commitment in upholding the trusts guidelines on misconduct. Any breach will be reported through the agreed Trust reporting structures.

All members of the Extended Primary Care Team will work flexibly across localities where fluctuations in demand, service capacity or changes in service priorities over a pre-determined time frame are identified.

5.2 Conduct for staff working in Peoples' homes

Staff will wear badges indicating their name and role at all times when carrying out duties for Community Health Newham.

Staff not wearing uniform will dress appropriately for the work they undertake and respect the cultural differences in the population they serve. A professional presentation will be maintained all times in line with existing policy on dress code in community settings.

Staff will ensure home based visits are planned in advance in agreement with the patients and their carers. Where visits are cancelled for any reason staff will, unless good grounds for exception exist, provide clear notice to patients and other professionals.

5.3 Conduct between professionals

Relationships at all times within the multi-disciplinary team will be directed toward meeting the key objectives of the service and needs of patients referred to it.

Formal multi-disciplinary team meetings and ward rounds or earlier if appropriate in line with Trust procedures. These will provide a formal arena for clinical problem solving, sharing best practice, assessment and discharge.

6. Communication

6.1 Key principle

Communication between staff employed in the Extended Primary Care Team, and other professionals working in collaboration with each of the multi-disciplinary teams will be central to its success.

This will equally apply where inclusion of other statutory, voluntary and private sector providers becomes a pre-requisite in ensuring long term care and support goals are met beyond the period of acute phase of interventions previously delivered through in the virtual ward or secondary care.

6.2 Communication within the multi-disciplinary team

Key decision making in regards to assessment and referral of new and existing patients will be made through discussion at meetings with representation where possible from all disciplines and staff attached to each locality. The views of each professional discipline will be sought in identifying the appropriate package of care and any potential “step up” to the Virtual Ward or other specialist service.

Handover is a significant element of care delivery and members of the EPCT will be handing over information about patients in a timely and comprehensive fashion and highlight urgent or unresolved issues.

6.3 Communication with professions outside of the Extended Primary Care Service

Community Health Newham recognises that the success and the broader sustainability of the extended primary care team and virtual ward will be co-dependent on the input and support or other organisations and agencies working in the London Borough of Newham.

Key agencies central to the successful delivery of the service will include though not exclusively:

- London Borough of Newham Adult Services
- Newham GPs
- Clinical Commissioning Group Clusters
- Barts Health Trust
- East London Foundation Trust Community Mental Health Services
- ICES
- Newham Voluntary Sector
- Other Community Health Newham specialist service providers

All members of the Extended Primary Care Team will work collaboratively with other professionals and agencies to ensure appropriate support is offered and delivered to clients, their families and carers. Responsibility will rest with Team leaders and other team members to identify key individuals responsible for maintaining these links, working relationships and problem resolution for each of its key partners from within their operation field of responsibility.

6.4 Key Relationships

6.4.1 London Borough of Newham Social Work Team

Each Extended Primary Care Team Locality Team will contain a named Social Worker. The Social Worker will ensure the efficient management of links to services and resources to ensure sustainable transition from the virtual ward to other longer term community based support and care.

The social worker will be an integral part of the locality team decision making process in terms of admission to, and discharge from the Extended Primary Care Service. The locality team social worker will be a key link between the Extended Primary Care Service and other London Borough of Newham Adult Services.

6.4.2 London Borough of Newham Enablement Team

The Extended Primary Care Service will work closely with London Borough of Newham Enablement Team in identifying collaborative approaches for

sustainable intervention and support to individuals under their respective models of care.

Mechanisms for joint working, transition to and from each of their respective services will be agreed and general service interactions managed through on-going discussion between their respective team leaders and service heads.

The Extended Primary Care Service recognises that any individuals identified as a potential referral to London Borough of Newham Enablement Team will be FACS (Fair Access to Care Services) Compliant. Where dispute arises on the appropriateness of a referral, and agreement cannot be reached, arbitration will be sought from a third party for resolution.

6.4.3 ICES

Equipment will continue to be provided through the Integrated Community Equipment Service (ICES) where demand is identified through appropriate assessment and request from clinicians within each of the locality teams for the Extended Primary Care Team.

All staff will follow Newham Adult Social Care equipment & adaptation guidelines, collaboration document, protocols and eligibility criteria when considering equipment. Any changes in funding, systems and provision will be negotiated and consulted on to ensure transition does not detrimentally impact on patient service.

6.4.4 Links to Barts Health NHS Trust

Links to Barts Health NHS Trust will be defined through their role in supporting the early discharge of patients in their care into the Virtual Ward. It is the responsibility of the EPCT Administrator to ensure all information relevant to a referral from Barts Health NHS Trust is collated and available to the multi-disciplinary Team assessment ward round. Additional support may be sought from the designated community matron, if necessary, in pursuance of a sustainable relationship with any Barts Health NHS Trust clinician to facilitate discharge.

In-reach team ELFT provide community matron and Therapists in-reach to the Newham site of Barts Heath NHS Trust. This team attends various ward rounds and MDTs on the acute site to facilitate timely discharge including step-down into the Virtual ward, other EPCT services and Tele-Health. The team work closely with LBN particularly their hospital based discharge team. Good relationships which build clinical trust and understanding are vital to this process and are a core function of the team.

6.4.5 Virtual Ward Beds at East Ham Care Centre

Virtual Ward patients may be admitted to the Cazaubon Unit at East Ham Care Centre by the Community Matron as part of step-up. Admission is governed by the Protocol for Admission to Virtual Ward Beds on Cazaubon Unit, using the EHCC admission checklist (shown on the Intranet). This is shown in detail in section 16.

Virtual Ward Patients may be referred to the Telehealth Team for continued monitoring as part of the step down process. This supports the Trusts self-care policy

6.4.6 GPs

The EPCT will work in partnership with the patient's General Practitioner where required in facilitating discussion with Barts Health NHS Trust discharge to the Virtual Ward takes place. Particularly where assurance is sought on the content and level of support offered in a non-acute setting.

7. Times of Operation

7.1 Key Principle

The Extended Primary Care Service will not exclude patients requiring input from secondary care, and comprehensive support will continue to be offered in line with agreed safe clinical guidelines with any future discharge in to the care of other appropriate community teams governed by the needs of the patient.

7.2 Hours of Business

The hours of business during which the Extended Primary Care Team and Virtual Ward will be in operation are as follow:

District Nursing:

Monday to Sunday

08.00 – 22.30

Therapy Services:

Monday to Friday – Physiotherapy and Occupational Therapy

08.30 – 16.30

Saturday/Sunday/Bank Holiday – Physiotherapy only

08.30 – 12.30

Telehealth & Hospital in-reach team:

7 days a week (Monday – Sunday)

08.00 – 16.00

A Community Matron is on call 24 hours a day.

8. Referral and Admission

8.1 Key Principle

The key principle for admission to the Extended Primary Care Team is one that reduces the use of emergency beds by anticipating conditions that would normally result in admission to hospital care.

8.2 Single point of Access

Simplification of referral into the Extended Primary Care Service will ensure decisions regarding assessment and admission are taken quickly, reduce confusion for those using the service and ensure fast clinical response from multi-disciplinary professionals attached to the service.

During day time operational hours there will be one public facing number (Direct Response) 0203 368 3843 directed to service dedicated ward administrators. Each locality will have in addition its own specific contact number direct to the Administrator, available to other relevant health, social care and community based professionals.

9 Eligibility Criteria

9.1 Eligibility Criteria for EPCT District Nursing Service

The District Nursing Service operates an open referral service; i.e. it will consider referrals from patients, carer and members of the multi-disciplinary team or out of borough agencies of residents of London Borough of Newham.

An urgent referral will receive a response within 4 hours; non urgent referrals will be contacted within 24/48 hours.

Hospital discharge referrals; i.e. for those patients who will require a nursing follow up after a period of acute hospital treatment, the referrals should be faxed to the District Nurse FAX number 0208 475 2146 no later than 48 hours prior to the discharge of the patient. In the hours of 9-5 Mon-Fri.

District Nurses can be contacted in a number of ways. Each main clinic base within the Area will have telephones staffed from 09.30 – 18.00 for taking referrals. These will then be passed on the appropriate district nursing team. Wherever possible, telephone referrals should be followed up by a faxed information sheet or transfer of care form. The phone numbers and fax numbers for each locality are in Appendix II.

All District Nursing teams have mobile phones that will be carried by a member of the team.

(District Nursing is usually reserved for individuals who are over 16 years, are Newham residents and housebound – that is they can only leave the house by ambulance, or there should be some other reason why a home visit is deemed necessary. District Nurses cannot carry out 'check' visits; all referred patients must have a recognised nursing need.

Appointment times are not usually given, but a time band can be offered to patients on the district nurses caseload. District Nursing is **not an emergency service**. District nurses service would not be used to collect prescriptions; this should be done by family carers or delivered by pharmacists.

9.2 Eligibility Criteria for the Virtual Ward

The Virtual Ward uses the systems and staffing of a hospital ward, but without the physical building, providing preventative care for people in their own homes.

In order to be eligible for admission to the Virtual Ward, patients need to:

1. Be 16 years of age and over
2. Live in the Borough of Newham
3. Have two or more chronic conditions: heart failure, COPD, Diabetes and other long term conditions
4. Have had more than two or more A&E admissions in the last 12 months
5. Have had two or more unplanned hospital admissions in the last 12 months
6. Be prescribed four or more medications
7. have frequent contact with community teams or the top 3% frequent visitors to the General Practitioners
8. Have had recent exacerbation of chronic illness or two falls or more in the last 12 months
9. be cognitively impaired, socially isolated and medically unstable
10. receive a high intensive social services care package over 25 hours a week

During day time operational hours the Ward Clerk will ensure contact and information is filtered to the appropriate member of the team, though where necessary direct contact to community based staff will be available where agreement between parties has been reached post referral to the service.

Out of hours, patients can reach the on-call Community Matron by contacting 0203 368 3843 (Direct Response).

Urgent referrals – via a phone call followed by a referral form faxed to single point of access 02084752146. The general practitioner will be expected to have undertaken the initial visit and referred for virtual ward to follow and provide the required intervention from multiple disciplinary team. Patients that have been referred to as urgent are seen within 2 - 4 hours of the referral having been received.

Non urgent referrals will be received via a fax to the single point of access and patients will be visited within 48 hours of receiving the referral.

9.3 Referral of Patients to other Extended Primary Care Services and Virtual Ward

Patient referrals (excluding those from hospital) to the Extended Primary Care Service will be from a variety of sources.

Referrals into any locality within the Extended Primary Care Service will correlate with that of the patients GP; i.e. the GP and the locality team must be based in the same operational area (cluster basis). No multi-disciplinary team under the locality arrangements for the service should accept a patient who's GP does not fulfil this requirement.

10. Discharge

10.1 Key Principle

A patient's discharge will not be time determined, and they shall remain under the support of the Extended Primary Care Service for the length of the treatment and period of additional clinical intervention. Any discharge from the Extended Primary Care Team will be governed by each of the locality teams agreement on that the right care packages and other community services being in place to ensure sustainable support in a non-acute setting. The Extended Primary Care Team is committed to planning discharge in partnership with the client and their family/ carers. Discharge arrangements will be according to the CHN Discharge and Transfer Policy, whereby a discharge letter is emailed within 48 hours to the GP and the patient issued with a copy.

Each member of the service team recognises the centrality of a more flexible approach in terms of self-directed care, rehabilitation and independence in regard to discharge (where appropriate) for patients treated under its provision. This policy additionally recognises the central role of the Extended Primary Care Team in supporting long term care beyond that of the Virtual Ward and the role of Tele-Health in facilitating step-down and self-care.

10.2 Mechanism for Discharge from the Extended Primary Care Service

From the commencement of treatment on the Extended Primary Care Team and throughout the course of the team's intervention, the MDT will assess and discuss the likely point at which discharge will take place.

Discharge from the Extended Primary Care Team will be directed by agreement between the patient and all members of the multi-disciplinary team. Patients will only be discharged after the appropriate care package is identified and implemented through Community Health Newham Extended Primary Care service, London Borough of Newham Adult Services or the local Voluntary Sector providers.

Clinicians will explain the rationale for any step up in treatment to the Virtual Ward from the Extended Primary Team to the patient and family/ carers, taking care to avoid clinical jargon. Any move in the opposite direction from the Virtual Ward to the Extended Primary Care Service will equally be dealt with the same sensitivity, and negotiated with the patient/family carers to ensure a smooth transition to the new arrangements.

Discharge planning takes into consideration the need for referral to other statutory and voluntary services. Staff must be proficient in identifying specific individual client needs and committed to ensuring high quality arrangements with other local services.

Discharge letters are sent to the patient's general practitioners within 48 working day hours after discharge.

10.3 Mechanism for Discharge from the Virtual Ward

From the commencement of treatment on the Virtual Ward and throughout the course of the team's intervention, staff will discuss and assess the likely/ expected point at which discharge will take place. Patients are admitted to the virtual ward for the maximum length of 10-14 days but this can be extended if necessary.

Discharge from the Virtual Ward will be directed by agreement between all members of the Multi - disciplinary Team. Patients are either discharge back to the care of the general practitioner or step down to the care of the extended primary care services for further interventions or the Tele-health Service for monitoring vital signs. Patients will only be discharged after the appropriate care package is identified and implemented through Newham Community Services Extended Primary Care service, London Borough of Newham Social Care or the local Voluntary Sector providers.

Clinicians will explain the rationale for the step down in treatment from virtual Ward to the extended primary care team to client and family/ carers, taking care to avoid clinical jargon.

Discharge planning takes into consideration the need for referral to other statutory and voluntary services. Staff must be proficient in identifying specific individual client needs and committed to ensuring high quality arrangements with other local services.

Discharge letters are sent to the patient's general practitioners within 48 working day hours after discharge.

10.4 Discharge Reports

A written discharge summary must be sent to the patient's GP and any other relevant professionals at discharge from the Virtual Ward and other Extended Primary Care services by email either before or at the point of discharge and attached to the patient's home record.

The following minimum information must be included in all discharge reports:

- Client's name and address
- Date of birth

- NHS Number (if known)
- Relevant medical history/diagnosis
- Summary of therapy assessment and intervention
- Notification of any referrals made
- Any recommendations or advice concerning on-going management or predicted therapy needs
- Names, titles and contact numbers for all staff involved in the client's care.

11. Admission to East Ham Care Centre

11.1 Key Principle

Operationally and medically circumstances will arise where recourse to treatment in a clinical setting will be necessary. This policy recognises the need for flexible and responsive arrangements in treatment and community based support and that East Ham Care Centre will provide the appropriate cover where need arises.

11.2 Eligibility Criteria

East Ham Care Centre will operate as a 'step up' unit for those clients supported through the Extended Primary Care Service and Virtual ward for whom treatment at home has temporarily been deemed high risk by the Case Manager or other member of the locality team. EHCC will in addition provide a 'step down' unit for clients from acute hospital wards prior to admission to the Extended Primary Care Service.

Eligible patients will be

- Above the age of 60 years
- Community Matron's current case load.
- GPs' referrals.
- The need for less than 2 weeks inpatient stay
- At risk of readmission to an inappropriate bed at the acute Trust

The perceived benefits are

- Effective communication between GPs, secondary care and community service.
- Reduction of acute hospital admissions.
- Improved patient health and satisfaction with the health services.
- Avoidance of duplication of work and optimizing use of resources.
- Increased support for health care professionals in the community

11.3 Governing arrangements for cover at East Ham Care Centre

Emergency/short notice placements will be considered providing that the intermediate care unit nurse in-charge and Extended Primary Care Service referee are satisfied that the criteria for admission to the Unit is met i.e. client does not require an acute hospital admission and there is bed availability.

The patient will have additionally agreed to admission to East Ham Care Centre and be aware of reason for this. Completed referral documentation will have also been received by the Nurse in Charge (the patient held record where there is one, medical summary including test results if any, reasons for referral,

medications, client consent to the admission and undertaking to provide clinical cover while client is in East Ham Care Centre).

The named case manager or other named clinician from the Extended Primary Care Service locality team will carry out a review within 24 hours of placement. S/he will liaise accordingly with the East Ham Care Centre staff, and jointly make a decision as to appropriateness of continuing the placement, or readmission to the Extended Primary Care Service, alternative placement or escalation to acute hospital care.

11.4 Referral

The Patient, carers as well as case manager and/or other named clinician from the Extended Primary Care Team must agree for the referral and possible admission to East Ham Care Centre. This is governed by the Protocol for Admission to Virtual Ward Beds on Cazaubon Unit, using the EHCC admission checklist (shown on the Intranet).

11.5 Admission

Admission to an in- patient bed can be considered when a patient's condition is such that s/he would require 24 hour care and monitoring but not acute medical intervention as provided in an acute hospital.

In so doing, the principle remains that the patient is cared for in the community, by clinicians who will continue to provide their care during the admission and when they return home.

When admitting a patient into the virtual ward in the Cazaubon Unit, it is imperative that these criteria are adhered to and maintained to ensure the appropriateness of the admission and patient safety and promote effective communication, in order that Virtual Ward objectives are achieved

The named Community Matron will

1. Maintain care coordination of patient journey within the VW.
2. Ensure that on admission, a full and comprehensive physical assessment has been carried out and documented including Past medical History.
3. Expected Date of Discharge (EDD) to be provided.
4. Evidence of relatives understanding of this admission and expected date of discharge.
5. Provide clear directions and specify expectations of patient admission with the Cazaubon Nurse in Charge in the patient care records on RiO including all key information to ensure discharge planning.
6. Update and complete the medication administration chart to support the care plan, ensuring that medication is not in dossette or blister packs.
7. Ensure that patient held virtual ward notes include a comprehensive care plan detailing care needs/ risks/ goals and rationale as well as an expected date to achieve the goals. Ensure better interdisciplinary communication. The patient held virtual ward notes MUST be completed including all the assessment tools and remain with the patient during the admission.
8. A daily review is undertaken by CM in the morning and before they conclude their late shift (Mon – Fri) between 2130 and 2200 hours including at the weekends, these reviews must be documented on RIO, written in the virtual ward patient held record and via verbal handover to the nurse in charge of the Cazaubon Unit.

9. Initiate and attend care planning meetings and other onward referrals, including discharge co-ordination.
10. Complete discharge documentation including discharge letter prior to discharge.

12. Provision of diagnostics and equipment

12.1 Key principle

The provision of supplementary services for the provision of medication, diagnostics, pharmaceutical supplies and equipment is critical to developing a sustainable model of delivery for clinical interventions enabled through the Extended Primary Care Team. Each plays an essential role in supporting these interventions from within the multi-disciplinary teams and the broader goal of reducing the need for a hospital bed.

12.2 Equipment

The central provider of equipment to the Virtual Ward will be the Integrated Community Equipment Team (ICES). The Extended Primary Care Team will build on existing relationships between Community Health Newham and ICES to ensure delivery of support and clinical interventions to patient on the ward.

Equipment will be ordered where clear clinical need has been identified by the following clinical specialists in the Extended Primary Care Team. Orders will be placed on the electronic system within 24 hours of the need being identified.

- Physiotherapist
- Occupational Therapist
- Speech and Language Therapist
- District Nurse
- Community Matron

The Telehealth Team has its own procedure for the allocation and recycling of

Telehealth equipment.

Once the order has been placed, the practitioner who placed the order will liaise with the ICES and about availability and suitable dates for delivery and ensure that equipment is in place in a timely manner. Where specialised equipment required is not available, the practitioner will identify what alternative equipment can be used in the interim and ensure that additional care interventions are documented on the care plan. Also, that this is escalated to the Team Leader and other related teams and services such as the Tissue Viability Team.

The practitioner orders the equipment and will liaise with relevant members of the EPCT to arrange for receiving and installing the equipment.

Once installed, relevant members of the Extended Primary Care Team have a duty to ensure that the equipment is fully functional and evaluated that the patient's needs are met as set out in the care plan. Where this is not the case, a new assessment will be made and alternative solutions identified.

The Extended Primary Care Team is responsible for the optimal functioning of all equipment installed and regular checks will be included on the patient's care plan.

Equipment lent to the patient will be ordered from Integrated Community Equipment Service via the electronic ordering system ELMS or purchased by the patient if a patient does not meet the necessary criteria for a loan. Where there is no longer a clinical need for equipment it will be collected by the Integrated Community Equipment Service, either through patients and carers contacting the service directly or through members of the multi-disciplinary team entering a request on ELMS. This should be done in a timely fashion inn order for it to be available for re-use.

Daily access to equipment over and above the service provided by

ICES will be available between the hours of 0800 - 1000 week days

12.3 Diagnostics

The main diagnostic tools available to EPCT Practitioners is blood testing and

X-ray.

12.4 Phlebotomy

Blood tests can be requested by the patient's GP, the Community Matron or the Virtual Ward GP. District Nurses take blood of those patients unable to attend phlebotomy centres.

During daily operating hours of the Phlebotomy service it will be the responsibility of any member of the Extended Primary Care Tem and/or Virtual Ward Multi-Disciplinary Team taking the blood to ensure samples are delivered safely to the appropriate collection centre. Though where hand held equipment is available such as for testing blood gases etc. tests should be conducted in situ.

Where tests are required outside of operating hours or in an emergency, samples will be sent by taxi to the central laboratory via the collection point at East Ham Care Centre.

12.5 X ray

Access to diagnostic x ray will be made on the basis of current provision at available sites across the borough, mostly during normal working hours. This is currently available at:

- Shrewsbury Centre
- Barts Health NHS Trust

For Virtual Ward patients, x-rays can be requested by the Virtual Ward GP and the Community Matron.

The patient's GP will be asked to refer for x-ray if EPCT practitioners perceive an indication.

13. Management Control System

13.1 Key Principle

The Management Control System has been developed to assist the EPCT Services to maximise the potential of the service delivery.

The objective of the system and management techniques is to control and improve the activity levels in the EPCT and compliance to the current patient referral and allocation processes, which in turn leads to increased productivity and a more structured working environment.

This system has been developed through a process of identifying key control points and designing documentation or meetings which the management and senior management can use to help achieve their goals.

13.2 Management Control Manual

The requirements of the Management Control System are described in the Management Control Manual. The section of the manual titled “Management Control System” contains all of the fine details of the control system in use, along with documented procedures and notes on how to use each control. These controls are not a computer system, these are the management actions which are required to be carried out to ensure that the utilisation and the work carried out by the EPCT are planned and monitored. The full East London NHS Foundation Trust Newham Community Services Improvement Programme Management Control System Manual is located on the Intranet adjacent to this policy.

The ‘System Concept’ provides the base structure upon which the various management controls can affect these improvements. The System Concept has four main elements:

FORECAST – PLAN – ASSIGN – FOLLOW-UP

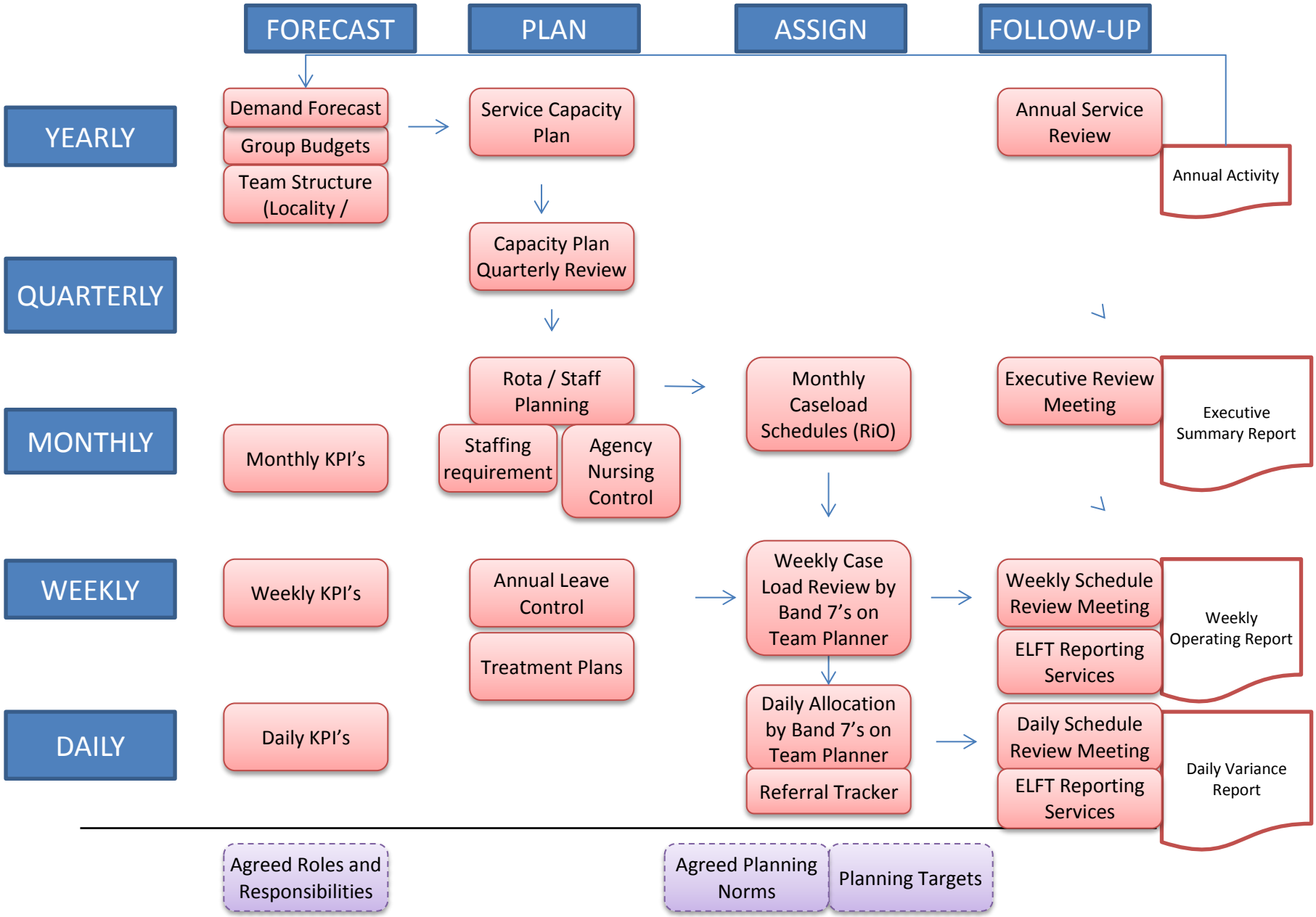
All care activities have to be scheduled via team planner.

The Management Control System is summarised in the diagram below:

East London NHS Foundation Trust

EPCT Management Control System

Meridian Productivity



13.3 Treatment Plans

The case load allocation through 'Team Planner' is based on Treatment Plans and are used to plan how many visits and how long a patient is estimated to be on the caseload. Treatment Plans how often a patient should be reviewed by a senior nurse as to their suitability for discharge or additional treatments.

Treatment Plans define the progression of care for a patient incorporating the content, frequency and type of contact anticipated. Treatment Plans are located on the Intranet adjacent to this policy.

14. Safeguarding and Mental Capacity

14.1 Principle

The need for Extended Primary Care Team staff to have awareness of the vulnerability of patients to become the victims of abuse and neglect by other people, be they family, members of the public, or staff members is imperative.

Safeguarding and mental capacity are fundamentally different matters and different policies and procedures apply.

However, within the context of care provided by the Extended Primary Care Team, considering the ability of patients when they make decisions about their care in terms of mental capacity and applying the relevant procedures will support appropriate clinical decision making and prevent actions or omissions that could be interpreted as neglect and will ensure the team work within the appropriate legal framework.

14.2 Safeguarding Procedure

The Trust Safeguarding Vulnerable Adults at Risk Policy provides guidance for staff. Where abuse or neglect is identified or suspected, this must be immediately reported on the Datix incident database and a Safeguarding Adults Alert (SA1) completed and forwarded to the London Borough of Newham. Patients may need to be moved to safety or arrangements put in place that create a safe environment and safeguards their physical and emotional wellbeing.

14.3 Mental Capacity

The Trust's Consent to Treatment Policy provides guidance on when a patient's ability to make decisions needs to be assessed. It must be remembered that a patient's decision not to follow care that has been advised or prescribed does not automatically indicate that there are mental capacity issues and performing capacity assessments needs to be done in an advised manner. In the first instance, where a patient does not wish to comply with advice, the clinician needs to ensure that full explanations of the proposed treatment plans and the consequences of the choices made have been given and are fully understood. This can be achieved by undertaking a test of capacity, details of which are set out within the trusts 'consent to treatment' policy or in chapter 4 of the 'Mental Capacity Act Code of Practice'. Both are available on the intranet.

In the event that patients still do not wish to proceed, suitable alternatives must be explored. This needs to be fully documented in the health care record.

Where a mental capacity assessment has been performed and the patient has capacity, the clinician needs to proceed as described above and explore alternative solutions.

Where the mental capacity assessment shows that the patient does not have capacity to make the particular decision regarding their care and/ or treatment that needs to be made, the Consent to Treatment Policy needs to be followed to ensure that the patient's interests are maintained. The trust has a mental health law team who are available to provide further expert advice and support regarding the use of the mental capacity act in clinical practice. They can be contacted on 02076554046

15. Workforce Related Policies and Procedures

15.1 Principle

Extended Primary Care Team staff are subject to the Trust's policies relating to its workforce. Adhering to these policies ensures that all members of the Extended Primary Care Team discharge their duties in a competent manner and safe environment. There are a number of such policies which are supported by EPCT specific protocols or customisation:

15.2 Induction

Each substantively employed member of the Extended Primary Care Team will receive induction according to the Trust Induction Policy. Local induction will comprise the items set out on the local induction checklist as shown in **Appendix A**.

Staff employed on a temporary basis receives induction as set out on the local induction checklist for temporary staff, see **Appendix B.**

15.3 Lone Working Procedures

EPCT staff is expected to adhere to lone worker procedures as set out in the Extended Primary Care Team Lone Worker Protocol. Additional information is shown on the CHN Lone Worker Procedure and the Trust Lone Worker Policy. All documents are on the Trust Intranet.

15.4 Supervision

Extended Primary Care Team members will receive supervision according to the Trust Supervision Policy. All staff receives monthly management supervision and clinical supervision at least once eight weekly. This will be documented according to agreed processes.

Supervision will include checking on the standard of record keeping and that care plans are appropriate and followed.

15.5 Appraisal

Extended Primary Care Team members will be appraised according to the Trust Appraisal Policy and personal development plans and objectives developed. This will be documented according to agreed processes.

15.6 Service specific competency training

Extended Primary Care Team members staff will be undertaking mandatory training as set out for their staff group.

The optimal functioning of the EPCT Management Control system relies on staff members having an identified set of competencies which for District Nurses include as a minimum:

- Compression bandaging for leg ulcer
- Doppler assessment and interpretation
- Venepuncture
- Pressure ulcer dressings
- Intravenous therapy
- Male catheterisation
- Female catheterisation
- Syringe driver operation
- Ear syringing

EPCT members are expected to undertake training for these clinical procedures and keeping themselves updated as required. The grading of individual District Nurses depends on achieving all required competencies.

16. Care Planning, Care Delivery, Handover and Record Keeping

16.1 Principle

A care plan outlines the services to be provided to a patient under the care of the Extended Primary Care Team. It is a set of actions team members will implement to resolve/support the diagnosis made at admission and identified by one or more assessments appropriate to the patient's condition. The creation of the plan is an intermediate stage of the care intervention process. It guides in the on-going provision of care provided by the Extended Primary Care Team and assists in the evaluation of that care.

The continuity of care delivery hinges on robust hand over procedures between those delivering care.

The documentation of the delivery of the care set out in the care plan is important so that progress can be measured. Health care records completed to a satisfactory standard after each care delivery episode are the basis upon which care planning and review are based. Record keeping thus forms an essential part of the care delivery process. Record keeping also informs measuring of performance and achievement of quality targets.

16.2 Care Planning

The care plans for patients admitted to the Extended Primary Care Team consist of a diagnosis relating to nursing/medical/therapist/social/psychological/mental health needs with defining characteristics (subjective and objective data that support the diagnosis), related factors or risk factors, expected outcomes/goals, and interventions as relevant from different members of the EPCT.

1. Its focus is holistic, and is based on the clinical judgment of the practitioner, using assessment data collected from an agreed framework.
2. It is based upon identifiable diagnoses (actual, risk or health promotion) - clinical judgments about individual, family, or community experiences/responses to actual or potential health problems/life processes.

3. It focuses on client-specific care intervention outcomes that are realistic for the care recipient
4. It includes care interventions which are focused on the etiologic or risk factors of the identified diagnoses.
5. It is a product of a deliberate systematic process.
6. It relates to the future.

16.3 Specific considerations for care planning and care delivery

All members of the EPCT are required to ensure that suitable care plans are in place that reflects the needs associated with the original referral but also additional needs as part of a holistic assessment. The initial care plan as well as all subsequent changes are explained to and agreed with the patient as well as any relevant carers or family. All members of the EPCT are required to escalate to their line managers any issues that impede on the optimal delivery of the care plan.

- All Waterlow Assessment will be carried out for all patients on admission and the care plan will be based on the Waterlow Score.
- The ability of patients or their carers to communicate requires specific consideration and members of the EPCT need to assure themselves that the chosen method employed to overcome communication difficulties is effective. Language Line should be engaged where there is any doubt that informal translation arrangements are ineffective.
- Goals that are expected to be achieved as a result of the care intervention will be discussed and agreed with the patient and this will be documented in the health care record and if appropriate, on the care plan.
- When carrying out care interventions such as skin assessments or pressure area checks, members of the Extended Primary Care Team will be making their own observations rather than relying on statements from carers.
- Where patients require changes to their pain control, this is pro-actively managed on behalf of the patient by contacting the relevant prescriber and the effectiveness of any changes made followed up.
- A copy of the care plan is kept at the patient's home and patients are aware of this.
- Members of the Extended Primary Care Team will ensure that comprehensive handovers are given, with urgent issues highlighted. That handovers have been given/received will be documented in the health care record.
- Within a time band, the time of visits is agreed with patients and/or carers. Where a visit is delayed, the patient and/or carer is notified as much in advance as possible.

16.4 Formal Carers and Shared Care Agreement

Where formal carers supplied by London Borough of Newham are engaged as part of care packages, the Extended Primary Care Team acknowledges a responsibility to ensure that there is effective liaison. This includes

- Implementation of the Shared Care Agreement **(Appendix C).** Carrying out training such as monitoring skin for pressure areas and escalating any concerns
- Proactively obtaining progress updates or information from formal carers about patients
- Giving instructions on care activities

16.5 Informal Carers

Where the patient or their family or friends wish to carry out care activities for patients under the care of the Extended Primary Care Team, the EPCT acknowledges a responsibility to ensure that there is effective liaison. This includes

- Monitoring that care activities carried out are of sufficient standard to safeguard the well-being and safety of the patient at all times
- Carrying out training such as monitoring skin for pressure areas and escalating any concerns
- Carrying out training for specific care activities and assuring that these are carried out competently
- Obtaining contact details for those carers that do not live on the same premises as the patient
- Agreeing with those carers that they are present to give access to the patient on a pre-agreed schedule
- Proactively obtaining progress updates or information from formal carers about patients

16.6 Access Issues

Where care activities cannot be carried out as scheduled because members of the EPCT cannot gain access, they will follow the No Access Action Protocol **(Appendix D)**

16.7 Electronic RIO Record

The electronic RIO record is the health care record used for all patients admitted to the Extended Primary Care Team or Virtual Ward. All visits and care interventions need to be documented in the RIO record either on the same day but no later than 24 hours, all healthcare records need to be comprehensive enough to facilitate appropriate care by all EPCT team members as well as other CHN services.

The Trust RIO Policy will be followed by all EPCT staff. Access to RIO is only allowed by those staff having ownership of the appropriate smart card. The smart card must be kept on the person or a safe lockable drawer. If the card is lost it must be reported immediately.

Where temporary staff have carried out care and do not have access to RIO, the Team Leader will ensure that such staff are buddied up with a team member with RIO access and ensure that a healthcare record is completed for each care episode carried out by the temporary member of staff.

Any paper based forms or assessments have to be uploaded on the RIO record.

16.8 Healthcare Records Kept at Patients Homes

Patients and their carers will have a current version of their care plan that is kept the patient's home. A copy of the discharge summary will be added either before or at the point of discharge.

16.9 Pressure Ulcer Prevention and Management Documentation

The members of the Extended Primary Care Team will be using forms and matrices as set out in the Prevention and Management of Pressure Ulcer Policy to document care interventions such as risk assessments, skin assessments, pressure area checks, pressure damage and pressure ulcer treatments.

17. Performance Data Recording Capture

17.1 Key Principle

This policy recognises that the quality of community based delivery of the Extended Primary Care Team and effective outcome based measurement of its level of achievement will be central to the successful transformation of our services. It strongly recognises the qualitative framework set out by the "Transforming Community Services" and will encompass the principals within the QIPP programme.

17.2 Key Performance Measures

The Extended Primary Care Team will collect patient reported outcome measures (PROMs) and patient reported experience measures (PREMs) and that results are monitored with a view to continually improving on the patient experience by means of action plans.

There are a number of Commissioning for Quality and Innovation Indicators (CQUIN) that apply to the Extended Primary Care Team and Virtual Wards these are currently in proposal stage

- PROMs and PREMs uptake and outcome performance (as above)
- Supporting the delivery of Flu vaccinations to housebound patients on the VW caseload
- Electronic discharge letter/notes are sent to the GP Practise within 48 hours of the patient being discharged from Extended Primary Care Team including Virtual Ward
- Care plans for all patients that are reviewed at appropriate intervals

Extended Primary Care Teams will collect information for the Safety Thermometer and review the results to identify deficiencies in the care provided and devise and implement remedial action plans. Safety Thermometer is a snapshot of harms taken one day each month and is collected by the 4 localities. All patients seen on this day, who are not also seen by another community service, should be included in this anonymised snapshot. Commissioners review an EPCT/VW KPI Schedule on a monthly basis. This includes the following activity requirements broken down by the 4 original localities (North East, North West, South and Central.

Extended	First Attendances (Face to Face)
Primary	Follow up Attendances (Face to Face)
Care	Total Face to Face Contacts
Teams	Non Face to Face direct (Telephone)
	Non Face to Face indirect (3rd Party)
	Total Non-Face to Face
	All Contacts
	Sources of referral - GP
	Sources of referral - NUHT
	Sources of referral - Other

	Total Referrals
	Total Discharges
Virtual Wards	Acute Admissions
	End of Life Admissions
	Early Supported Discharge Admissions
	Total Admissions
	Acute Discharges
	End of Life Discharges
	Early Supported Discharge Discharges
	Total Discharges
	Admissions per month by Referral Source GP
	Admissions per month by Referral Source NUHT
	Admissions per month by Referral Source Other
	Total Admissions in Month

There are also some specific KPI's with targets aligned, for the VW teams. These are as follows:

There is also the Community Information Data Set (CIDS) which is a mandatory dataset. Formal data submission is yet to commence but MONITOR require quarterly submissions of data compliance (9%). CIDS looks at the compliance rates of various electronic data fields, such as personal identification, referral and activity details. Items specifically linked to EPCT VW also include the following:

- Leg ulcer (both venous and pressure)
- End of Life Care (preferred place of care/actual place of care)

18. Surge and Business Continuity Planning

18.1 Key Principle

The Extended Primary Care Team is a flexible approach to clinical intervention in community settings, reducing the need for the occupation of acute hospital beds and ensuring the delivery of resources at the point of need. Where demand for staffing resources in acute settings out stretches capacity as a result of emergency and crises situations staff within the Extended Primary Care Team will recognise this point of need may change. This is described in the ELFT NUH LBN Accelerated Discharge Policy (shown on Trust Intranet).

18.2 On confirmation of surge

Where beds or staffing alert occurs at Barts Health Trust, the Extended Primary Care Team managers will be notified of the crisis and will be expected to work in a co-ordinated way to offer support where possible.

This may include:

- Suspension of admission of all new patients to the Extended Primary Care Team and its Virtual Ward in the event of staff resources being redeployed to support emergency cover in other clinical settings
- Demand led redeployment of staff with special skills into other working environments where applicable
- Suspension of referral of patients from those community settings covered by the Extended Primary Care Team into East Ham Care Centre.
- Early discharge of patients on to the Extended Primary Care Team and its Virtual Ward from acute settings.
- Early discharge from the Virtual Ward to its related Extended Primary Care Team
- Redeployment of staff and resources of Extended Primary Care Team in line with escalation and business continuity agreements between Barts Health NHS Trust and Community Health Newham.
- Any other conditions and agreements that ensure the continued delivery of acute and community based care at the point of need.

18.3 Business Continuity Planning

The Extended Primary Care Team will engage in the business continuity management system as required by the Trust Business Continuity Policy and have business continuity plans in place that are regularly (at least six monthly) updated.

- Relevant EPCT staff will participate in exercising business continuity and emergency plans.

19. Clinical Governance

19.1 Key Principle

The Extended Primary Care Team recognises that in order to deliver safe and effective care and support continuous service improvement, both the Extended Primary Care Teams and the Virtual Ward Teams will be fully engaging with the Trust's Clinical Governance Strategy and the Trust's Quality Improvement Initiative.

19.2 Clinical Governance

The EPCT will participate with trust wide audits and develop and implement remedial action plans where shortfalls have been identified.

The EPCT will develop an annual local audit calendar that is tailored to specific activities or issues identified within the Extended Primary Care Teams or Virtual Wards and implement remedial action plans where shortfalls have been identified.

The Community Matrons will be leading on the reflection on issues identified in complaint and incident reports with their team members to facilitate service improvements.

The Community Matrons will be leading on evaluating patient feedback (PROMS and PREMs) with their teams and identify and implement remedial actions.

Locality General Managers will gain assurance from the Community Matrons that action plans have been implemented.

19.3 Governance Measures

Measure	Data collection/ frequency of reporting	Reported to/monitored by
Incident reports on Datix	Ad hoc/ two monthly reports	Quality and Assurance Group
Complaints	Ad hoc/quarterly reports	Patient Experience Group/ Quality and Assurance Group
PALS	Ad hoc/quarterly reports	Patient Experience Group/ Quality and Assurance Group
Risk register	Ad hoc	Locality Manager for inclusion into Locality risk register
Patient Reported Outcome Measures	First and last appointment/two monthly reports	Quality and Assurance Group
Patient Reported Experience Measures	Last appointment/two monthly reports	Quality and Assurance Group
Clinical Audit	As per Directorate/Trust audit plan	Quality and Assurance Group
Infection Control audit	Initial and then per trust audit plan	Quality and Assurance Group/CHN Infection Control Group
Safeguarding children/adults	Ad hoc via ELFT Datix incident database reporting and Trust safeguarding processes	Safeguarding Boards
Health, Safety and Security	Via Datix	Locality General Manager/DMT
Business Continuity	n/a	Via Locality arrangements

CQC Essential Standards	Ad hoc, part of mock visits	Quality and Assurance Group

20. Policy Audit

20.1 Key principle

The Extended Primary Care Team recognises the any policy and procedure is a live document and should reflect the operational realities of delivery. Any audit and review of this policy should be driven by the needs of the service, its users and professionals integral to its success.

20.2 Audit and Review

The General Locality Managers will ensure that this policy is reviewed as follows:

First year from sign off: At four monthly intervals

Thereafter: at six monthly intervals.

APPENDICES

Appendix A

LOCAL STAFF INDUCTION PROFORMA

First Name:		Surname:	
Job title/ Grade:		Department & Location:	
Line Manager:		Name & Grade of staff member conducting local induction:	

This form has been developed to ensure that all staff receives a local induction within the service/ department in which they work.

Newly appointed staff should be given this induction checklist by their Manager on commencement. The Manager should ensure that it is completed and signed within four weeks.

The Manager, and/ or those delegated, will facilitate and assist the new member of staff through all the topics listed in this checklist.

In order to get your name badge, please ensure that each of the headings is signed and dated and that once completed a copy of this page and the next page is returned to the Training and Development Department on the last day of your Induction.

Induction Confirmation

I have a clear understanding of the topics covered in induction and agree to abide by Trust Policies & Procedures. If in doubt about any of this, I know to ask.

Signed by new staff member…….. Date ……..

I am satisfied that all the subjects in induction have been completed to my satisfaction and that of my staff member.

Signed by line manager …….. Date ……..

Training Nominations

In order for the Trust to be able to report on training compliance we need you to let us know if newly appointed staff need to attended the following training courses. Please type yes to nominate your staff and no to exempt staff.

Course Name	Details of Specialist Group	Training Date (s) Requested
Fire Marshall Training	All Staff Appointed as Fire Marshall	
Systematic investigation using Root Cause Analysis	All members of staff involved in incident investigation	
Investigation of Complaints	Staff with responsibility for investigating complaints	
Immediate Life Support	Duty Senior Nurses	
Clinical Risk Assessment	All care co-ordinators and clinical staff in multidisciplinary teams except Consultants and Senior Trainees in Forensic Services	
Staff Supervision	All staff who supervise other staff, except doctor with train the trainer programme	
Health & Safety for Risk Officers & Facilitators	All risk officers	
Equality & Diversity Level 2	All Managers Band 6 and above	
Consent to Treatment, Capacity and Deprivation of Liberty	All professionally qualified clinical and social care staff	
Receipt & Scrutiny of statutory forms	Qualifies staff who accept statutory forms (must have 1 year post registration experience)	
CPA	All clinical staff in the community and inpatient settings with delegated responsibility	
Food Hygiene	Any Clinically based staff who	

	handle food or drink	
1 Day Breakaway	All staff with patient contact who are not required to undertake 3 or 5 Days PMVA	
5 Days PMVA Acute & Forensics	Ward based nursing staff in forensic and Acute Services	
3 Days PMVA MHCOP	Ward based nursing staff in Older People Services	
Safeguarding children Level 2 & 3	All clinical staff except HQ staff nominated by HGC Chair	

Please provide us with Budget Code _____

Supervisor: Please Date and Sign following training

New staff Member: Please Sign to acknowledge training

Area	Date	Employee Initials	Supervisor Initials
1. GENERAL			
Staff identity card and swipe card for ward door issued			
Introduction to colleagues and multidisciplinary team			
Allocation of mentor/ preceptor			
Lines of communication			
Accountable to and reports to:			

Conditions of employment/ contract explained			
Hours of work, arrangements for breaks/lunch. Catering arrangements			
Shift times/ duty roster/ requests for duty roster explained			
Shift co-ordinator – role and responsibilities			
Daily ward routine			
Standard of appearance and behaviour			
Smoking policy			
Requests for annual leave entitlement and study leave bookings			
Completing unsocial hours and bank timesheets			
Trust induction day			
Keys to locker/ changing room			
Staff meetings/ staff supervision			
Ward/ office/ drug keys			
Reporting sickness and absence. Self-certification and when to obtain a doctors certificate			
Special leave request			
Arrangements for returning to work			

2. GEOGRAPHICAL ORIENTATION			
Familiarisation of the work area – ward/ office lay out where things are kept			
Introduction and orientation of the unit			
Introduction to other wards			
Location of bathrooms			
Location of staff car park			
3. COMMUNICATIONS			
How to use and operate the telephone system			
How to use the pager system			
The internal phone number is:			
Security number is:			
Cardiac Arrest Number is:			
Emergency fire number is:			

Any other special arrangements for emergencies explained (please state):			
Postal system delivery and collection			
E-mail and internet usage			
4. FIRE SAFETY			
Fire precautions			
Fire assembly point is:			
Actions in event of a fire:			
Actions to take when the alarm sounds:			
Trust fire policy			
Location of Fire Alarms			
Location of Fire Extinguishers			
Location of Fire Doors			
Location of Fire Exits and Fire Doors			
Location of emergency and fire equipment			

All staff must attend a fire lecture at least every 12 months: Course Date:			
5. FIRST AID			
The first aider on my ward is:			
Location of the first aid box:			
Resuscitation training (every 12 months): Course Date:			
6. SECURITY			
Security site and department			
Security of equipment and materials (including documents of all descriptions)			
7. ACCIDENT OR INCIDENTS TO PATIENTS, VISITORS OR STAFF			
Procedures for incidents/ accidents Action to be taken:			
Who must be informed:			
Recording of accidents/ incidents			

Reporting of serious untoward incidents			
8. THE MENTAL HEALTH ACT			
Informal patients			
Detained patients			
Patient rights			
Human Rights Act			

9. LIFTING AND MOVING IF PATIENTS OR LOADS			
I have been made aware of the hazards of incorrect lifting and moving techniques and shall not undertake any activities associated with lifting and moving without first receiving supervised instructions in the safe and approved methods. Signed:			
10. PATIENT CARE			
Medical records system. How to obtain/ return notes to the Medical Records Department			
Confidentiality of patients records			
The nursing process: Documentation/ storage/ disposal			
Admission and Discharge procedures/ documentation			
Administration of medicines – competence to be observed			
In the event of a death procedure and who to contact			
How and when to order supplies for the ward			
Chaplaincy service			

Procedure for contacting Duty Doctor			
On Call & Senior Manager system			
Policy for searching patients and their property – recording/ care/ disposal			
No fixed abode day – areas covered by each ward			
Contacting works services Department regarding repairs/ maintenance Number to call:			
11. PRIVACY OF PATIENTS			
Doors and windows			
Service users rooms and locks to their doors			

12. TRUST POLICIES & PROCEDURES **Please read and sign**			
Location of trust/ Ward policies			
Hospital/ unit policies			
Confidentiality/ data protection – application to patients/ Colleagues			
Procedures for Clinical Practice			
Human Resources Policies and Procedures			
Clinical risk assessment & management			
Clinical Policies			
Trust policy on handling money/ personal property			
Illicit drugs & alcohol			
Cardiopulmonary resuscitation			
Safe working for staff working			
Supervision			
Observation			
Policy for children visiting parents			
Seclusion			
Admission policy for acute adults			
AWOL			
Complaints procedure			
Arranging outpatient appointments			
Care programme approach			
Refer to other agencies e.g. Drugs dependency unit, Alcohol advisory service			
Training facilities available to staff			

e.g.: student induction/ mentorship			
Night Reports			
Ordering and storing medication			
Ordering and storing of provisions/ supplies			
Ordering transport e.g.: taxi/ ambulance			
Delegation of work according to grade			
OTHER (Please list)			

Appendix B

Local Induction Checklist for Temporary Bank/Agency Staff

To be completed by all Bank and Agency staff when working on the ward/in the department for the first time or following a gap of three months or more. The checklist is to ensure that all aspects of your induction are covered in a timely and effective manner. It should be completed on arrival of the place you have been appointed to undertake work. If you feel that any area has not been covered adequately or missed, please bring it to the attention of your line manager.

Once completed and signed, scan a copy and email it to training&development@eastlondon.nhs.uk or fax it to 0207 655 4027

I confirm that I have received the Trust Staff Induction Handbook and have read and fully understand the policies and procedures outlined in the booklet. I understand that failure to comply may result in immediate termination of a booking. Please tick if in agreement: ☐

I confirm that at the commencement of work, I have been shown and explained (please refer to overleaf and tick below. **Enter 'N/A' where not applicable**);

(See notes 1-14 overleaf)

Area Covered	**Clinical Staff**	**Admin Staff**
Identity Check		
Confirmation of mandatory training completed		
Hours of work/shift patterns/breaks		
Familiarisation of work area – where things are kept, bathroom, car park, canteen, post		
Cleaning, catering, facilities, waste disposal, postal system		
Email and Internet usage		
Location of Trust/ward/department policies		
Introduction to Team		

Emergency telephone numbers

On call and bleep system – Doctors, emergency

Alarm system – Fire, ward alarms, personal alarms

Observations ***(note 1)***

Fire ***(note 2)***

First Aid ***(note 3)***

Codes/keys/security pass/badge ***(note 4)***

Ward environment safety ***(note 5)***

Infection Control ***(note 6)***

Patient Care ***(note 7)***

Social Therapist ***(note 8)***

Medicines safety procedures – Sops, protocols

Incident reporting procedures/forms

Standards of behaviour ***(note 9)***

Manual Handling ***(note 10)***

Confidentiality/record keeping ***(note 11)***

Resuscitation procedures/equipment

Reporting to and contact details

Specific Duties and responsibilities ***(note 12)***

Local Lone Working Procedure ***(note 13)***

All other matters ***(note 14)***

SIGNED: _____

(Bank/Agency Staff)

NAME:_____

POST TITLE:_____

(NAME OF AGENCY EMPLOYED UNDER)

DEPARTMENT:_____START DATE:_____

SIGNED:_____

(Trust member of staff delivering induction)

DATE:_____

Please note: If your booking is extended for a further period, you will need to refer back to the checklist with your Manager, as any sections that may not be applicable now, may become applicable.

Note

1	**Observations:**	describe levels and identify patients on Level 1, 2, 3 and 4 and shown where and how to document observations and have had the reasons for observations explained to me.
2	**Fire:**	where the exits are, the fire procedure, equipment, alarms, telephone numbers and assembly points.
3	**First Aid:**	First Aider and location of box
4	**Codes/Keys/security pass/badge:**	the importance of keeping locked rooms locked at ALL times and not to give out codes to patients. Wear ID badge at all times.
5	**Ward environment safety:**	for example ensuring that no sharp or potential ligatures to be left around, trip and fall hazards.
6	**Infection Control:**	Hand hygiene, I.C. Status. Infection prevention and control. All ward areas to be kept clean and tidy. Toiletries and towels not to be left in bathrooms.
7	**Patient care:**	which patients allocated to you for your shift and ensure they are engaged with and their needs met and all interactions/interventions are documented in their notes.
8	**Social Therapist:**	To report ANY concerns regarding patients to the Nurse in Charge. Not to administer or dispense any medication.
9	**Standards of Behaviour:**	No back to back shifts, dress code, no alcohol, no smoking, no illicit drugs, no violent or abusive behaviours, gross negligence, inappropriate relationship with client.
10	**Manual Handling:**	Moving and handling procedures/equipment. Be careful when lifting heavy goods and handling clients.

11	**Confidentiality / Record Keeping:**	Lock computer when not in use, do not leave files unattended, keep filing cupboards locked when not in use, be careful who you disclose information to.
12	**Specific duties and responsibilities:**	Please indicate other post specific information given.
13	**Local Lone Working Procedure:**	Discuss potential hazards of working alone and assess the risks involved and put measure in place to avoid or control the risks.
14	**All other matters:**	If you are not sure about something then ask Nurse in Charge/Supervisor. *(if you are a Nurse in Charge, you will be told how to contact the Clinical Co-Ordinator)*

Appendix C

Shared Care Approach to Pressure Ulcer Prevention

SSKIN Bundle

Guidelines for Staff

1. Introduction

The purpose of this guideline is to provide health and social care staff working within community services with information in relation to a shared care approach to pressure ulcer prevention in the community.

Joined up health and social care is essential to improve the quality of care people receive and to ensure 'harm free care'. Pressure ulcers are a key quality indicator and all staff involved in caring for patients in the community should ensure that care is appropriate, safe and in the best interests of the person.

Health and social care in the UK is undergoing rapid change as organisations restructure the delivery of services in order to provide the most efficient and effective care to service users. This has led to not only utilising health care workers in different ways to provide additional duties of care, but also has implications for informal/ formal carers in terms of the advice they are given and specific roles they are asked to perform as part of the actual care of the patient.

East London Foundation Trust and their partners in social care are committed to working together to ensure patients do not develop avoidable pressure ulcers and have produced this document to promote best practice in pressure ulcer prevention and support an integrated approach to care.

It is recommended that the community nurse/team leader works with the patient and their carers to identify the patients risk of developing pressure ulcers and puts in place a care plan to meet the patient's needs. This will involve ensuring that patients and carers have the necessary understanding to reduce risk factors and identify the early stages of pressure ulcer development. The following checklist should be used to support the discussions and observations of practice to ensure pressure ulcers are prevented.

Pressure Ulcer Prevention: Shared care checklist

Please indicate with ✓ if active and date and sign	✓	Date	Signed District nurse	Signed Social carer
Please ensure information and procedures specific to the patient's condition are explained, taught and observed. All aspects of specific care plan for pressure ulcer prevention discussed and explained to patient and carers. Ensure the patient has mental capacity to make decisions regarding their care.				
I have discussed with the carer: • The importance of undertaking a full skin inspection especially over bony prominences, looking out for any redness, discolouration, localised heat, odema or induration • The importance of regular repositioning, ensuring pressure relief • How to check the mattress and cushion to ensure it is functional • The importance of a healthy diet • How to contact the team if concerned about skin integrity • An information leaflet on prevention has been provided				
The carer has observed • The nurse undertaking a full skin inspection and what signs to look out for. • The nurse performing the basic repositioning techniques. • The nurse checking the mattress and cushion • They have a good awareness of what a healthy diet entails. • I have observed the carer performing a skin inspection and re positioning the patient. They feel competent to do this. I feel they are able to deliver this care with on-going support.				

Review Date:	Team Leader responsible:

Pressure Ulcer Prevention and treatment plan. Each patient should have an individualised care plan to address their needs. The community nurse will go through the care plan with the patient and carers following the check list below.

SSKIN BUNDLE
PREVENTION

Surface – Make sure your patients have the right support surface	S	• Appropriate mattress ordered from ICES and in place and being used? • Mattress calibrated to correct weight of patient if required • Appropriate cushion ordered from ICES and in place and being used? • Wheelchair user: check when last seen by wheelchair service • Patient education on use of equipment
Skin – Inspection	S	• Has skin assessment been completed and documented?
Keep Moving	K	• Does the patient have a repositioning chart?
Incontinence/ Moisture	I	• If patient is incontinent use of appropriate skin care • Does the patient have correct equipment to manage incontinence? • Refer to continence advisor if complex needs
Nutrition	N	• Is the patient eating and drinking • If Weight loss refer to GP/Dietician for supplement advice

SSKIN BUNDLE
TREATMENT

Surface – Provide the right surface	S	• The mattress/cushion is still being used • Check at each visit equipment is in working order • Review equipment as to its effectiveness
Skin - Inspection	S	• Pressure ulcer graded and reported and referred as per guidelines • Are skin assessments completed at each visit? • Wound size recorded at initial assessment and re-measured every 4 weeks • Care plan in place to guide treatment • Record pain and document effectiveness of pain relief if required
Keep – moving and repositioning	K	• Repositioning schedule document in care plan • Check carers are following the repositioning schedule • Does the patient understand the need for repositioning
Incontinence	I	• If incontinent is this addressed in the care plan • Is treatment effective?
Nutrition	N	• Check weight. Measure arm circumference if bed bound or immobile • Encourage balanced diet to aid wound healing • Refer to GP/Dietician if any concerns

Appendix D

Unexpected Access Problems Protocol