SERVICE OPERATING POLICY
COMMUNITY NURSING OPERATIONAL POLICY

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Services	Applicable	Comments
Bedfordshire CHS	✓	

The Director responsible for monitoring and reviewing this policy is Director of Bedfordshire Community Health Services and Lead Nurse

EAST LONDON NHS FOUNDATION TRUST

SERVICE OPERATING POLICY FOR COMMUNITY NURSING OPERATIONAL POLICY

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SERVICE OPERATING POLICY FOR COMMUNITY NURSING OPERATIONAL POLCY

1.0 Service Aims

The overall aim of the Community Nursing Service is to provide evidence based nursing care in the community setting to enable people to improve, maintain, manage and/or recover from health related issues.

The main service aims are to:

- Reduce unnecessary hospital admissions through the provision of timely care for people in their own homes or place of residence including residential homes
- Facilitate timely hospital discharge
- Prevent complications associated with immobility, disability or disease
- Empower and support people to make informed choices and manage their conditions effectively

2.0 Objectives

- To provide nursing care to people who are predominantly housebound or have complex nursing needs
- To act as a key worker ensuring that service provision is seamless and wrapped around the person
- Reduce unnecessary hospital admissions through the provision of timely care for people in their own homes or place of residence including residential homes
- Facilitate timely hospital discharge
- Prevent complications associated with immobility, disability or disease
- Empower and support people to make informed choices and manage their conditions effectively

3.0 Referral Criteria

To be accepted onto the nursing caseload, people must be over 18 years of age, registered with a Bedfordshire GP, be predominately housebound or have a complex nursing need where their care is best provided in the home base setting. See appendix 1 for housebound definition.

The service accepts a referral from a range of sources including ELFT clinicians, GP's, EEAST Ambulance service, acute hospitals, other professionals such as social

workers, private providers including the hospice and care agencies, residential homes and people and carers. Referrals into the service should be received via the Single Point of Access Hub (SPoA). See appendix 3 for community nursing criteria referral criteria

4.0 Service Provision

Whilst this list is not exhaustive and an individual person's needs should be considered on a case by case basis, the following forms the broad categories of interventions provided by the community nursing service:

- Holistic nursing assessment to include full use of screening and assessment tools and recording in SystmOne
- Co-ordination of care with other providers and the multi-professional team
- Support the Rapid Response team responding to referrals falling under Urgent Community Response within 2 hours.
- Bladder and bowel care
- Administration of medication where nursing support is required, excluding oral medications
- End of life care & Palliative care
    - Comprehensive assessment and liaison with specialist teams
    - Attendance at GSF meetings
    - Symptom control
        - Management of pain relief including syringe drivers and injectable medication
        - Co-ordination of anticipatory medication
- Wound care
    - Leg ulcer management
    - Management of post-surgical wounds including pilonidal sinuses
    - Management of chronic wounds
    - Management of fungating tumours
    - Management of diabetic ulcers
- Management of pressure ulcers/relief
    - Comprehensive assessment/screening
    - Provision of appropriate equipment
    - Management of ulceration
    - Provision of advice and support for at risk patients
- Management of diabetes
    - Support and education to enable self-administration of insulin
    - Monitoring of blood sugars including HbA1c
    - Provision of dietary advice and support

Liaison with specialist services

5.0 Hours of Operation

The service is available 24 hours a day 7 days per week, 365 days per year.

The core service is provided between 08:00 – 20:00 hours.

6.0 Response Times

The community nursing service will respond to urgent referrals within two hours of referral. For all referrals contact will be made with the person to agree an appointment time that is clinically appropriate. See appendix 5

7.0 Discharge Criteria

Patients will be discharged from the service in the following circumstances:

- Discuss with the person the estimated date of discharge on admission to the caseload
- When the episode of nursing care is complete and no follow up care is required
- When the person is admitted to hospital
- When the person is admitted to a nursing home
- When the person transfers out of area (in this situation care will be transferred as appropriate)
- If care is transferred to another agency e.g. local authority, carers etc.
- The person refuses care or discharges themselves from the service
- On the basis of a risk assessment where the home environment is deemed unsuitable/unsafe
- On the basis of unreasonable behaviour or the failure to provide a safe working environment for visiting staff

Patients must be informed they are being discharged from the service with an explanation. They should also be provided with details of how to refer back into the service if their condition or needs change via SPOA. Where domiciliary care is also involved in patients care, they should also be notified.

8.0 Exclusion Criteria

- Patients who are under the age of 18
- Patients without a Bedfordshire GP
- Patients who reside in private nursing homes

9.0 Monitoring

The service is subject to a range of internal and external monitoring including the following:

- Monthly dashboard/key performance indicators
- Service Performance Quality review

- Audit
- Complaints and Incidents
- InPhase reporting
- Patient reported experience measures (PREMS)

10.0 Reference to Other Trust Policies / Procedures

- The Royal Marsden Manual of Clinical Nursing Procedures
- NICE guidance
- Community Nursing service specification
- Relevant clinical guidance and policies

STANDARD OPERATING PROCEDURE FOR COMMUNITY NURSING SERVICE

NEW PATIENT ASSESSMENT

Objective	To ensure standardisation of new patient assessment process and the initial patient visit carried out by the Community Nursing Service (CNS)
Scope	**Area of Work Covered:** Confirming suitability of person for caseload, explaining the community nursing service, arrangement of visit, consent, performing a first assessment, gathering person's history and information, assessment, documentation on the patient record, care planning, agreeing personal goals, arranging follow up and review dates, RAG recording, keyworker.
Responsibilities	**Admin/SpoA Team** task/ring DN to inform of new patient referral. SPoA Admin obtains a patient summary/transfer of care form from referral source (see Appendix 1), checking, NHS number, name, date of birth, address, postcode, ethnicity, next of kin, questionnaire and contact telephone number. If the referral is urgent (see Appendix 3) then the admin team, contact the relevant DN team by phone. The person is registered on SystmOne by Single Point of Access (SPoA) admin, if routine then tasked out to relevant team. If person referred through UCR Stack or triage phone follow pathway for UCR. (see appendix 8) *NB: (At weekends/bank holidays/post 1600hrs SPoA ring the main phone holder direct)* If DN/RN confirms person not suitable for caseload – they contact referrer advising that person does not meet criteria for DN caseload (see Appendix 3). Referral closed on SystmOne by DN/RN. **District Nurse/Nurse in charge of shift** Confirms if person accepted or declined for the service and notifies referrer by phone and recording decision on SystmOne. If accepted onto service, verbal consent from patient is obtained by phone and a date for initial visit agreed within 24 hours. At first visit obtain consent and consent to share records, perform

	nursing intervention required, assess & gather person history and information, document fully on patient SystmOne record, agree with person a suitable review date, and discuss planned date for discharge, where appropriate Liaise with and refer to any other relevant health care professionals & explain patient folder including contact numbers and service leaflets e.g. sepsis, pressure ulcer. Apply relevant care plans to electronic record. Ensure the following templates are completed on initial assessment: DN Navigation Template & baseline clinical observations. This is documented direct onto SystmOne at time of visit. Ensuring that electronic records are fully updated within 24hours of the visit. **Healthcare Assistant (HCA)** to visit patient following initial DN/RN assessment and carry out planned nursing care which could include: capillary blood glucose testing, urinalysis, MUST screening, Waterlow and aSSKINg bundle, venepuncture, basic wound care, bowel care, personal care for palliative patients. Feedback outcome of visit to DN/shift lead. The DN may request joint review with HCA where the patient is known to have restricted mobility, to assist clinical examination or where concerns have been raised re lone working safety. Health Care Assistant visits will be delegated by the caseload holder and the patient reviewed by a RN every two weeks or on third visit. **Agency Nurse (RN)** can complete first assessment visits, visiting nurse should handover to caseload holder in full within 24 hours of the visit. The patient will be reviewed by a substantive RN every two weeks or on third visit. **Interpreter Worker** may help contact the patient initially to explain the service and arrange a suitable visit date. The interpreter worker may also be required to carry out a joint visit for the purpose of interpretation and patient support at the initial assessment
Process Stages	**Step 1** DN/Shift leads to check and confirm suitability of patient for DN caseload including risk assessment if required. This may involve discussion with the GP or referring professional. Referrals should be prioritised & completed as per the service spec. Urgent = 2hrs Non urgent = 24-48hrs **Step 2**

	If patient identified as suitable, DN/shift lead/RN/HCA makes contact with patient or next of kin (where patient is unable to communicate) and explains the DN service and arranges a mutually convenient appointment for the initial assessment (with assistance from interpreter if required) and records this conversation on SystmOne. Obtain access details in line patient property policy on ELFT intranet. **Step 3** DN/RN collects patient notes folder (Red Folder), prior to the first visit. **Step 4** DN/RN undertakes first visit following lone working procedure, as prioritised on referral, explains the DN service allowing the person (or advocate where relevant) opportunity to ask any questions and seek clarification. This will include the role of the DN, anticipated length of stay on caseload and planned discharge date, introduction of Priorities of Care (ACP) if appropriate, follow up visits & teaching patient to self-care if appropriate. First visit must include obtaining verbal consent to share records on SystmOne, Check and ensure next of kin contact details and essential patient demographics are complete and correct. **Step 5** DN/RN to discuss and record patient's past medical history and chronic diseases using patient referral details. **Step 6** DN/RN checks current medication including any over the counter medications and herbal remedies the patient may be using. Document any known allergies. **Step 7** DN/RN to enquire as to any other services used and document details on SystmOne including names and numbers where possible. **Step 8** DN/RN to undertake and record a full nursing history (using the Navigation Template on SystmOne) which includes completion of: Risk assessments, holistic assessment, first line observations and Key Performance Indicators (KPI). Any wounds / pressure damage identified MUST be photographed and a

	wound assessment completed. Consideration is given to the person's capacity, ability to retain information and act on advice given. **Step 9** DN/RN to give opportunity for the person to ask any questions regarding their condition and advise appropriately with any relevant health promotion advice, identify any current health or social issues arising from the visit and discuss any necessary referrals or action with the patient, i.e. social services, safeguarding team, smoking cessation. **Step 10** DN/RN to ensure all relevant paperwork in the person's record is completed, including record of your signature, record of visit date, heading on the relevant section of the index card, including DN telephone number and how and when to seek help and support from the DN service. **Step 11** DN/RN to document personal goals/aims of treatment and create care plans in collaboration with the person and their next of kin or care giver (as appropriate). Review appropriateness of care plan and frequency of visits regularly in collaboration with wider team. Pathways of care to be used e.g. leg ulcer pathway / care of dying person. **Step 12** DN to ensure patient RAG (Red Amber Green) rating is correctly recorded on SystmOne according to which caseload, appendix 6. **Step 13** DN to inform person, how to care for patient held record and alert any other professionals involved in their care to its existence. **Step 14** DN to liaise with any other professionals involved in the person's care, ensure SystmOne share of record is requested. Agree with person and record the next review date on paper record and SystmOne.
Other Useful Information e.g. Audit, References	Aide memoires/templates on SystmOne. (appendix 7) SPoA internal processes Process for discharging/transferring patients.

	Self-administration of medication leaflets (appendix 11)
Alternative Pathways	**DN Caseload Reviewed Weekly** Team Lead reviews appropriateness of patient for DN service. DN and Team Lead to review patients on caseload for patients who may be suitable for discharge and discuss with GP or refer on to other services documenting in patient record. DN to follow process for discharging patients. **DN/Caseload Holder on long-term sick leave/AL** Caseload is allocated to named deputy & support provided by Team Lead. **One Off Assessment** If the patient only requires one/two interventions by the community nursing service then the following needs to be completed: First visit template which includes - MUST, Waterlow, GULP, Observations, aSSKINg bundle, risk assessments, KPIs. SystmOne record completed. **Holistic Assessment** If another member of MDT has completed the Holistic Assessment within the last 6 months then the first visit assessments must be reviewed to ensure they are still accurate and any additional assessments undertaken. **Formal and Informal Care in Place** Document the verbal advice given to carers (both formal and informal) on SystmOne and in the person's carers notes. Advise visiting staff to take a photo of any notes left in person's home and attach to SystmOne record of care. Document when advice has been demonstrated such as applying a 30' tilt, the four-way slide sheet system or free floating a limb. Provide turning chart. **No Access to Property** If staff member unable to gain access to property, check for key safe, contact home phone number with mobile, contact alternative numbers given, liaise with referrer to confirm patient's whereabouts, check with GP practice, check with local hospital that patient not admitted. If concerned regarding patient safety, contact see flowchart for welfare (appendix 10). Post calling card. **SOS Call**

	RN must complete the first visit assessments including full skin bundle, Waterlow, MUST, GULP and document on SystmOne for any unplanned/unscheduled visits including catheter calls. **Routine/Scheduled Visits** RN must complete relevant care plans & up-date risk assessments at each visit & record clearly on SystmOne. Ensure the care plan is linked to the current episode of care and has been reviewed. **Wound Assessments** Wound assessments should be completed in full and reviewed four weekly or more frequently if wound deteriorates. If patient is visited and a new wound, change in skin integrity, new or deteriorating pressure damage, is identified: risk assessments should be updated and a wound assessment completed. InPhase completed for new or deteriorating pressure damage. If the visit is undertaken by a Band 4 the wound assessment, wound photograph and plan of care should be reviewed by RN/DN and visit followed up by RN/DN at next planned visit. **Routine Reassessment of Long-Term Patients** DN/RN must complete DN Navigation template and full reassessment if the patient remains on the caseload for longer than 6 months. If there have been no changes during this time, then the nurse can document that they have been re-assessed & that there have been no changes since the last assessment on ……and insert this date. **Continence Assessments** People that have been referred to the Continence Service, for a continence assessment and are on the District nurses' caseload will be completed by the District nursing team. **Domiciliary Bloods** If person is actively on the caseload then Community Nursing teams are expected to complete blood sampling as requested. **Practice Nurse Visits** These visits can be completed by an HCA provided the care has been delegated by a Registered Nurse. District Nursing service does not provide practice nurses sickness / vacancy cover.

	Residential Home Adhoc Visits HCAs can complete the first visit if already in attendance.
Validation Date	November 2018
Review Period	Yearly
Authors	[redacted]
Reviewed March 2022	
Reviewed April 2023	
Reviewed May 2024	
Reviewed July 2025	
Electronic File Path	District Nursing Folder

APPENDIX 1

NHS DEFINITION OF HOUSEBOUND

A patient is housebound if they are unable to leave their home at all, or if they require significant assistance to leave the house due to illness, frailty, surgery, disability, mental ill-health, or nearing the end of life.
A patient is not considered housebound if he or she is able to leave their house with minimal assistance or support. For example: unassisted/assisted visit to the Doctor, dentist, hairdresser, supermarket, social events or hospital outpatients.

Some patients may not be housebound permanently but rather are housebound temporarily as a consequence of an episode of illness/surgery.

Minimal assistance would be described as a person who can leave their own home and travel to a clinic appointment in a vehicle such as a personal car, taxi or public transport which may or may not be adapted for their use. This journey may be with or without the use of a wheelchair either by themselves or with an escort.

To avoid confusion any person who requires a specialist vehicle (Ambulance) or a two person escort would be regarded as housebound.

References:
https://rydalgp.co.uk/housebound-patients
https://www.locala.org.uk/services/district-nursing/what-is-meant-by-housebound
https://int.sussex.ics.nhs.uk/clinical_documents/audiology-aqp-direct-access-adult-hearing-services-for-patients-aged-55-years-and-over/
https://www.nice.org.uk/guidance/ng21
https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf

APPENDIX 2

REFERRAL

Referral is made into the service via Single Point of Access 0345 602 4064

From SystmOne using the BCHS Referral Template

The link below for users who do not have access to SystmOne

https://www.elft.nhs.uk/blcshub

ELFT - blcshub

Please note that after completing the initial form, you will be given the option of which Bedfordshire Community Health Service you require. This will generate a second form for you to complete.

www.elft.nhs.uk

APPENDIX 3

BEDFORDSHIRE COMMUNITY NURSING REFERRAL CRITERIA

Does the patient fit the referral criteria? **Inclusion criteria;**	**YES**	**NO**
Patient is registered with an NHS Beds G.P		
GP is willing to take medical responsibility for the patient – if the referral is coming from GP it will be assumed this is a given		
Patient is housebound – immobile / unable to leave the house due to medical condition		
Patient is over 18 years		
Patient has a short term nursing care intervention		
Patient has a long term degenerative condition		
Patient has palliative care / end of life care needs		
Patients condition is unstable		
Exclusion criteria		
Patient is under 18 years		
Patient is mobile or is able to access transport to attend GP surgery, Walk in Centre or other clinic		
Domiciliary phlebotomy request to patients not on defined caseload.		
No practice nurse appointment.		
If the referral is received at the weekend and has already been declined.		
Ear syringing unless prior to an audiology appointment		
Topical treatments (application of creams)		
Eye drops (carers and family to support application)		
IS THERE SUFFICIENT REFERRAL INFORMATION INCLUDED IN THE REFERRAL TO ACCEPT / DECLINE?		
	Referral accepted	Referral declined
For patient's declined from DN service. Consider other possible services;		

Adult Social Care / Community Matron Service / Walk in centre nurse led service / Walk in Centre GP service (open at weekends)/Age UK.

APPENDIX 4

REFERRAL PRIORITAISATION

ALL PATIENTS REFERRED INTO THE DN SERVICE WILL BE CONTACTED WITHIN 24 HOURS OF THE REFERRAL TO ARRANGE A VISIT APPROPRIATE TO THE NURSING NEED.

SAME DAY
• FAST TRACK END OF LIFE PATIENT • DIABETIC PATIENT ON MORE THAN ONCE A DAY INSULIN • WOUND CARE PATIENT REQUIRING MORE THAN ONE VISIT PER DAY • ENEMA • CATHETER CARE PATIENT UNABLE TO MANAGE INDEPENDANTLY • IV THERAPY • MEDICTAION • SOME PALLIATIVE CARE PATIENTS REQUIRING MORE THAN ONE VISIT PER DAY • PATIENT WITH HIGHLY COMPLEX NEEDS MOST OUT OF HOURS REFERRALS WILL BE FOR SAME DAY RESPONSE OR A SPECIFIC DAY RESPONSE
NEXT DAY
• ROUTINE CATHETER PATIENTS • ROUTINE DRESSING • SOME PALLIATIVE CARE • ONCE DAILY TREATMENTS • NON URGENT ENEMA
SPECIFIC DAY
• REMOVAL OF SUTURES • ONCE/TWICE/THREE TIMES A WEEK TREATMENTS

ALL FIRST VISITS (NEW VISITS) WILL BE SEEN BY A DISTRICT NURSE OR IF THIS IS NOT POSSIBLE A SENIOR STAFF NURSE FOR AN INITIAL ASSESSMENT

APPENDIX 5

DISTRICT NURSE RESPONSE CRITERIA

HIGH PRIORITY

PATIENTS CONDITION REQUIRES AN URGENT VISIT WITHIN 2 HOURS ESTIMATED TIME OF ARRIVAL TO BE GIVEN TO PATIENT/RELATIVE

- PATIENT WITH BLOCKED CATHETER – IN RETENTION AND IN PAIN
- PATIENT WITH SYMPTOM MANAGEMENT PROBLEMS – UNCONTROLLED PAIN/VOMITTING
- HIGH RISK SEPSIS
- HYPO/HYPER GLYCAEMIC PATIENT
- SYRINGE DRIVER OCCLUSION ALARMING
- INSULIN DEPENDANT DIABETIC PATIENT/LOW MOLECULAR WEIGHT HEPARIN-MISSED DOSE
- EQUIPMENT FAILURE FOR HIGH RISK HIGH DEPENDANCY PATIENTS
- PATIENT AT RISK OF AUTONOMIC DYSREFLEXIA
- UNPLANNED CARE VISIT (HOSPITAL AVOIDANCE)

MEDIUM PRIORITY

PATIENTS CONDITION REQUIRES A VISIT WITHIN 2-5 HOURS ESTIMATED TIME OF ARRIVAL TO BE GIVEN TO PATIENT/RELATIVE

- PATIENT WITH BYPASSING CATHETER
- COMPLEX PALLIATIVE PATIENT REQUIRING ASSESSMENT OR REVIEW
- HIGH GRADE PRESSURE ULCER CATEGORY 3 / 4 or UNSTAGEABLE
- EXUDATING WOUND WITH SIGNIFICANT STRIKE THROUGH CAUSING CONSIDERABLE DISCOMFORT
- ACUTE CONSTIPATION REQUIRING AN ENEMA
- EXPECTED DEATH / VERIFICATION OF EXPECTED DEATH
- PATIENT WITH SYMPTOM MANAGEMENT PROBLEM
- PATIENT INJURY REQUIRING DRESSING WITHIN MEDIUM PRIORITY TIMEFRAME
- NEGATIVE PRESSURE THERAPY DEVICE ALARMING
- ANY PATIENT WITH A CONCERN RELATING TO THEIR INDWELLING DEVICE (EG ROCKET DRAIN, NEPHROSTOMY, FEEDING TUBE)

LOW PRIORITY

PATIENTS CONDITION REQUIRES SAME DAY/NEXT DAY RESPONSE ESTIMATED TIME OF ARRIVAL TO BE GIVEN TO PATIENT/RELATIVE

- LEAKING WOUND WITH STRIKE THROUGH
- PATIENT INJURY REQUIRING NON URGENT DRESSING
- PLANNED VISIT – FOR ROUTINE CARE

- ANY OTHER VISIT

APPENDIX 6

WHICH CASELOAD?

RED CASELOAD

A PATIENT THAT REQUIRES DAILY OR ALTERNATE DAY VISITS

- Daily injections for insulin
- Bowel care of patient at risk of autonomic dysreflexia
- Daily wounds- patient is at high risk of sepsis, high exudate
- Palliative care, rapidly deteriorating patient
- Patient with syringe driver
- Administration of daily medication IV antibiotics, Filgrastin, Tinzaparin etc.
- New patients for review (or assessment team for South)

AMBER CASELOAD

A PATIENT THAT REQUIRES TWICE WEEKLY VISITS

- Complex wound care
- Maintenance of central venous access
- Negative pressure devices (VAC pump etc.)
- Palliative patient requiring more than once weekly review of symptoms and care needs
- Twice weekly visits for wound care
- CHC Check list or fast track application
- Bowel care of patient not at risk of Autonomic dysreflexia
- Clip or suture removal
- Blood test
- Problematic catheter maintenance or patient that is requiring bladder instillations

GREEN CASELOAD

A PATIENT THAT REQUIRES WEEKLY OR LESS FREQUENT VISITS

- Three monthly maintenance injections e.g. Vitamin B12, Zoladex, hormone replacement
- Routine catheter change
- Weekly wound care
- Any patient who is due a once a week visit
- Ear irrigation
- Pessary change
- Palliative support visit
- Continence assessment
- Doppler reassessment

Assign patient to a caseload that reflects their current level of need and ensure this is reviewed weekly, encourage all staff to move patient appropriately as condition changes, discuss as part of daily handover.

Stop care plans that are no longer active.

Start a new care plan as condition changes, do not rename a care plan, for example if SDTI becomes Category 2 pressure damage, stop care plan for SDTI and start a new care plan for Cat 2.

Ensure PREMS post card is offered at point of discharge.

APPENDIX 7

AIDE MEMOIR FIRST ASSESSMENTS

Handbook (for assisting in completing the first visit assessments)


New Nursing Assessment Template

Holistic Template – Aide Memoir

APPENDIX 8

AMBULANCE STACK PATHWAY


ambulance stack pathway v12.pptx

APPENDIX 9

CASELOAD MANAGEMENT STANDARD OPERATING PROCEDURE

APPENDIX 10

WELFARE CHECKLIST


Bedfordshire Police RCRP Flow chart final.

APPENDIX 11

SELF ADMINISTRATION OF INJECTIONS

Final - A5 Flyer Supporting you or yo

Flyer - Supporting you to give your own