Livewell Southwest

District Nurse Operational Policy

Version No.1

Review: November 2019

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

Author **Locality Manager**

Asset Number: **938**

Reader Information

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Document review history

Version no.	Type of change	Date	Originator of change	Description of change
0.1	New document	23/09/16	Locality Manager	New Operational Policy
1	Ratified	November 2016	PRG	Ratified with minor amends.

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Abbreviations

CCG	Clinical Commissioning Group
DN	District Nurse
MDT	Multi Disciplinary Team
CHC	Continuing Health Care
VTE	Venous Thrombo Embolism
TEP	Treatment Escalation Plan
LES	Locally Enhanced Service
SSKIN	This acronym is used to define a set of assessment tools to support wound care and assessment
CAUTI	Catheter-Associated Urinary Tract Infections
QueSTT	Quality, Effectiveness and Safety Trigger Tool
PEG	Percutaneous Endoscopic Gastrostomy

District Nurse Operational Policy.

1 Introduction

1.1 The footprint of the District Nursing service within the Western Locality of Northern Eastern Western Devon CCG (NEW Devon CCG) can be divided into three separate areas: Plymouth, South Hams and West Devon, although the service does not cover the whole of West Devon or South Hams it can be seen that the areas have some unique demographic statistics which can be used to shape the services of the health community to meet the needs of the population.

2 Purpose

2.1 This document exists to provide a comprehensive and clear framework for the operational procedures in relation to the District Nurse (DN) service.

3 Definitions

3.1 The **Policy Ratification Group** (PRG) is a multi-professional group of clinical and non-clinical leads or managers. This is a sub committee of the Safety, Quality and Performance Committee and was established to assure the quality and standardisation of LSW policies.

3.2 A **policy** states what staff must know or do. It is a formal, corporate statement of intent of LSW's position, and overall aims and objectives on an issue. There should be only one policy for a particular topic – there should not be, for example, separate nursing and medical policies.

3.3 A **procedure** describes how something should be done. Usually, but not always, a procedure supports a policy. Its length may vary, but it must be operational, and written for the staff that are to implement it. There are two types of procedure:

a) A protocol is the mandatory way of doing something, and must be followed.

b) A guideline is an indication of the course that is usually followed, unless there are good reasons for not doing so.

4 Duties and responsibilities

4.1 This Policy was devised by the Senior Management Team.

4.2 The **Chief Executive** is ultimately responsible for the content of all Policies and their implementation.

4.3 **Directors** are responsible for identifying, producing and implementing Livewell Southwest (LSW) Policies relevant to their area.

4.4 The **Locality Manager** will support and enable operational Clinical Team

Leads and Managers to fulfil their responsibilities and ensure the effective implementation of this Policy within their speciality.

4.5 The Modern Matron will support the team managers to define and assure high standards of quality care, through their clinical presence and vision for the development of community services for all staff and those who use the services.

4.6 The **Team Manager** is responsible for ensuring that the development of local procedures / documentation doesn't duplicate work and that implementation is achievable.

4.7 **Clinical staff** have a responsibility for ensuring they have read, understood and adhere to local Protocols and Policies.

5 Aims and objectives of the DN Service

5.1 **To provide**:

- A responsive service to meet the needs of people who are 18 and over and registered with a GP within the Western Locality of NEW Devon CCG to remain in their own homes, maximise their independence and improve their health outcomes and quality of life.

- A pivotal role in assessment, Case Management and provision of general nursing care and delivering tailored care plans to meet individual health needs.

- Quality care for all adults referred to the service, working in an integrated way with primary care and social care to deliver patient centred care.

5.2 **Footprint**

- The footprint of the District Nursing service within the Western Locality of Northern Eastern Western Devon CCG (NEW Devon CCG) can be divided into three separate areas: Plymouth, South Hams and West Devon, although the service does not cover the whole of West Devon or South Hams.

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5.3 Days/hours of operation:

Plymouth has a 24/7 District Nursing Service; core hours are 0830-1700 Monday to Friday.

There are 4 Locality District Nursing Teams in Plymouth with 1 District Nursing Treatment Clinic Team on two sites and a Twilight/Overnight District Nursing Team who cover the Western Locality of Northern Eastern Western Devon Clinical Commissioning Group (NEW Devon CCG).

Two other localities are sighted within the areas of Tavistock and Kingsbridge, a 24/7 District Nurse Service is also available with core hours 09:00 to 19:00 however, this is under review.

6 Local defined outcomes

Domain 1: Preventing people from dying prematurely

- The DN service will work as part of the multi-disciplinary team to reduce the number of hospital admissions and in facilitating early supportive discharge.
- The DN service will take part in the Department of Health Immunisation programme for Influenza vaccination as commissioned by Public Health England.

Domain 2: Enhancing quality of life for people with long-term conditions

- The DN service will work as part of the multi-disciplinary team to achieve preferred place of care for people at end of life.
- The DN service will work with partners to minimise the effects of disease and reducing complications for patients on their caseloads.
- wound care, prevention and tests and investigations for housebound patients.

Domain 3: Helping people to recover from episodes of ill-health or following injury

- The DN service will provide post-op or post-injury care. Examples include: Evidence based wound care, venous thromboembolism (VTE) prevention and tests and investigations for housebound patients.
- The DN service will provide medication through an individual prescription in line with local and national guidance.

Domain 4: Ensuring people have a positive experience of care

- The DN service aims to achieve a score of 90% patient satisfaction using the Meridian patient feedback system and will put in action plans for any areas not achieving this level.
- All DN teams will undertake the DN patient satisfaction survey annually, the percentage of which will be agreed between the operational manager, DN Matron and Patient Experience Lead
- The DN service will meet the requirements of the friends and family. The DN service will monitor performance on a monthly basis through LSW Safety and Quality Committee.
- Feedback and learning from patient satisfaction surveys will be shared with teams and action plans agreed and implemented by the DN managers.

Domain 5: Treating and caring for people in safe environment and protecting them from avoidable harm

- The DN service will participate in the harm free care agenda and benchmark practice using the safety thermometer.
- The DN service will ensure all staff are trained in children's and adult safeguarding.
- The DN service will provide holistic assessments for all patients on caseload and provide a personalised care plan. The service will offer joined up working

with primary care through Multi Disciplinary Team (MDT) meetings.

- The DN service will deliver care using the principles of Compassion in Practice.
- The DN service will participate in national trials and research projects.
- The DN service will, where appropriately identified as the most competent practitioner, case manage people who are eligible to receive NHS Continuing Health Care funding (CHC), whether they live in their own homes or within a care home (with or without nursing).

7 Referral and inclusion Criteria

7.1 Acceptance/Referral Criteria:

The DN Service is available to patients over 18 registered with a GP within the Western Locality of Northern Eastern Western Devon Clinical Commissioning Group (NEW Devon CCG) who are defined as housebound and require DN care under one or more packages of care. This includes temporary residents and Continuing Health Care (CHC) eligible people living in care homes where the DN is identified as the most appropriate community team member to undertake case management.

Patients under 18 will be considered for the DN service with the support of a Children's community nurse through transition.

7.2 The definition of housebound pertains to:

- Those people with a long term condition that prevents them from leaving their home.
- Those people who are **medically** compromised in the short term for a prescribed period and are unable to leave their home.
- Those people who for medical reasons are unable to attend the surgery due to their health needs and/or clinical risk to the patient. For example immuno-compromised patients due to chemotherapy.

7.3 Case management for people who are in receipt of CHC funding within Care Homes. The role of the case manager is supporting the person by ensuring the care environment is suitable to meet the individual's needs. This may include signposting the provider for training, equipment needs and specialist support.

7.4 Any acceptance and exclusion criteria and thresholds

Essential Referral criteria:

The consent of the patient should be gained prior to any referral to the service. Referrals may be made by Health and Social Care Professionals, Statutory agencies and the general public.

Referrals are made following the process as attached in appendix 2.

7.5 Referrals need to include the:

- Patient's name
- Gender
- Date of birth
- Patient's full address including postcode and the address to where they are being discharged (if different) and access details e.g. keysafe
- NHS number
- Telephone/emergency contact numbers
- Next of kin contact details
- Name/telephone number of patient's GP practice
- If known already to the District Nurse(s)
- Time/date visit required and reason for referral indicating diagnosis
- Name of referring person and contact number
- Previous medical history that is relevant to the person's current needs, to include current medication, allergies and infections
- Any advance decisions and Treatment Escalation Plan (TEP)
- Relevant social circumstance(s)
- Any known contra-indications to lone visiting and/or safety/risk issues
- Reason for referral

The Community Nurse will negotiate the timing and frequency of visits with the patient and/or carers. Times of visits are not routinely offered, but can be negotiated when necessary.

8 Exclusion Criteria

- Any patients who do not fulfil the referral criteria.
- Any procedures which are commissioned and the responsibility of other providers.
- Where a patient has social needs only (it is accepted that this may not become apparent until after the initial assessment has been completed), the patient should be appropriately referred onwards to Social Services and discharged from the district nursing service.
- If a patient has been referred for a 'one-off' intervention and the patient is not on the caseload of a district nurse and intervention would normally fall within the remit of the primary care team, commissioned under separate arrangements e.g. complex wound, post-op, diagnostic and Locally Enhanced Services (LES).
- Cover for practice nurses in cases of sickness and absence it is the responsibility of general practices to make their own arrangements with their chosen Provider(s).
- New procedures which are outside the normal scope of practice, for example new procedures commissioned within acute care which may impact upon the DN service but have not been negotiated with LSW.
- Routine delivery and collection of prescriptions and bloods.
- Emergency responses e.g. 999 or 111.
- Patient not registered with a GP within the Western Locality of NEW Devon CCG.

- The DN service does not provide Doppler studies for diagnostic purposes for patients without ulceration.
- Referrals for where provision is not described in the care packages **Central Venous Access Devices-assessment**, support, flushing of lines and blood taking will be undertaken by the Acute Care at Home Team.
- **Continence Referrals -** The Continence Specialist Service will receive all continence referrals and undertake assessments and reviews as per Continence Operational Policy. Patients who are mobile and those residing in care homes (residential and nursing) should also be referred to the Continence Service for continence assessment and management.
- Equipment requests where there is no identified nursing needs or not on DN caseload.

9 Service Provision:

9.1 **A comprehensive patient centred holistic assessment -** of patients accepted by the service, including the agreement of personal goals (outcomes) and the creation of an individual care plan. The care plan will determine the best environment for the delivery of the nursing care package, whether this be in the patient's home, care home or in a community setting. The assessment will be in consideration with LWS Equality and Diversity Policy version 2.4.

9.2 **Ongoing assessments -** including relevant diagnostic monitoring and treatments for patients with Long Term Conditions as required as part of their on-going package of care.

9.3 **NHS Continuing Healthcare assessments –** Contribute to CHC assessments, reviews and case manage patients on the caseload adopting the best practice principles described within the National Framework for NHS Continuing Healthcare.

9.4 **Assessment for equipment through the Community Equipment Service (CES)** – Assess and review equipment needs for patients on the DN caseload in line with the CES guidance.
On-going maintenance and servicing of equipment is provided by the CES provider in accordance with the contract held by Plymouth City Council.

9.5 **Wound Management** - evidence-based, high quality assessment, treatment and advice for patients with wounds. The service will refer to LSW specialist Tissue Viability and Vascular services as required.

9.6 **Leg Ulcer Management** - evidence-based, high quality assessment and treatment for patients presenting with a leg ulcer. Doppler studies will be undertaken as part of the leg ulcer management of patients on the DN caseload.

The DN service does not provide Doppler studies for diagnostic purposes for patients without ulceration. These patients will be seen in general Practice in line with the diagnostic LES.

9.7 **Pressure Ulcers** – prevention of pressure ulceration in line with the Western locality (NEW Devon CCG) joint pressure ulcer strategy between commissioners, health and social care providers. Evidence-based, high quality assessment using NICE guidance, and the SSKIN Bundle and treatment for housebound patients who are at risk or have developed a pressure ulcer.

9.8 **Medication -** assessment, support and advice to patients to safely administer their prescribed medication, enabling the patient to remain at home. Administration and monitoring of medication by appropriately trained and competent District Nurses in the patients home, residential care setting. Non-Medical Prescribing by appropriately trained, experienced and competent DN's who are required to prescribe against a clearly defined formulary.

9.9 **Continence Management** – The DN service works closely with the LSW Continence service. Trial without catheter (TWOC) will be undertaken for patients on caseload as part of the Catheter-Associated Urinary Tract Infections (CAUTI) harm free care agenda.

9.10 **Long Term Conditions (LTC) Monitoring** – The Community Matron (Long Term Conditions) Service undertakes case management for patients with LTC's meeting their referral criteria. The DN service will undertake LTC monitoring such as tests and investigations and administration of medication for housebound patients on the District Nurse caseload.

9.11 **Diabetes Management and Treatment** – regular home visits to provide diabetes treatment to those who are not able to self-administer injected medication. This would include administration of medication, monitoring, advice and support to promote independence for patients with diabetes in the patient's own home or residential care setting. This excludes the annual diabetic review.

9.12 **End of Life Care –** on-going holistic assessment of patient condition and provision of pain management and symptom control for terminally ill patients. Delivery of End of Life Care which supports and ensures the use of End of Life tools including advanced care plans.

Where appropriate, referral to the Continuing Healthcare Hub using the National Framework for NHS CHC and fast-track documentation. Referral to the Specialist Palliative Care Team may be required for specialist advice and support.

9.13 **Phlebotomy** - Venepuncture for patients at home and in residential settings where there is regular and on-going District Nurse intervention as part of patient's on-going package of nursing care.

9.14 **Diagnostic tests -** a range of diagnostic tests relevant to the package of care delivered and required by the medical practitioner for patients on the DN caseload. These include but are not limited to: blood glucose, blood pressure, bladder scanning, swabs, urine samples.

See care package 9 in appendix 1.

9.15 **Ear Care** -assessment and treatments for housebound patients as described in care.

Not commissioned by the CCG - For information only
Immunisation programme delivery for influenza and pneumococcal infections for housebound patients at home and in residential settings as commissioned by Public Health England. See care package 3 in appendix 1.

10 Response times and prioritisation details

- Urgent – Urgent: All urgent referrals will be by telephone. Triaged by the receiving nurse within 4 hours of documented receipt of referral.
- Non-urgent – will be clinically triaged within 24-48 hours of documented receipt of referral and date for visit agreed.
- Routine – will be clinically triaged within 1-3 days of documented receipt of referral and date for visit agreed.
- Post-operative visit – access to service on specified date.
- Timed visits – for specified medication requests only.

Prioritisation to be re-assessed at each visit and the care plan modified as required based on the patient's needs.

11 Discharge process:

11.1 Patients will be discharged from the District Nursing Service when:

- The treatment and care received by the patient has achieved the desired outcome(s) set by agreed realistic aims in partnership with themselves.
- They can safely self-manage. All patients where capable will be supported to undertake self-management of their condition and discharged when this is achieved.
- They are transferred to another more appropriate service e.g. social services, podiatrist.
- They move out of area.
- Patient has died.
- They do not fulfil referral criteria following initial assessment.
- They are not willing to engage in a jointly agreed plan of care. In these instances patients should be referred back to the GP with the offer of a joint meeting to plan the way forward.
- Where they no longer require case management if determined not eligible to receive CHC funding, or where the DN no longer has the required skills to undertake the case management function.

11.2 The patient and DN will agree when no further nursing or case management visits are required and the patient will be given a contact number for the service should they experience problems related to the episode of care. The DN will be responsible for ensuring that contact is made with relevant professionals to advise on discharge from the service and that prior to discharge, if necessary,

the more appropriate practitioner has accepted the patient onto their case management list.

12 Governance

12.1 Professional Advice, Support and Education:
District Nurses have a role in educating and signposting patients, family and unpaid carers thus supporting the care of the patient in their own home for patients on their caseload.

The DN service does not provide education to paid carers as this is the responsibility of the care provider; however they will provide professional advice and information via referral to the service.

12.2 Residential and Nursing Care Home Responsibilities and Accountability:
Residential and nursing care homes have a named DN attached to them. The nurse is responsible and accountable for patients referred and on caseload for specific care packages.

The named DN is neither responsible nor accountable for patients not on caseload or for the general care delivery in the home however, it is expected that they would have a role if they witness poor care.

Where a care package is delegated to care home staff e.g. blood sugar monitoring, the named DN will provide patient specific training to care home staff, however it is the responsibility of the home to ensure that staff remain competent to undertake that specific task.

Support and advice will be offered via referral in order that the DN has the underpinning information required to be able to offer safe and appropriate advice.

Where a DN is responsible for case management of a CHC eligible patient in a care home, he/she will ensure the care home are aware of the contact details.

13 Workforce Requirements:

13.1 All staff will be appropriately skilled, experienced and competent in their designated roles. All staff will adhere to the mandatory training requirements.

13.2 Essential training identified for clinical staff within District Nursing. This is detailed in appendix 1 along with areas of continuing development. The essential training required will be identified at induction depending on band and skills required.

13.3 It is advised but not essential that all registered staff be supported to undertake the post graduate mentor module. All teams are required to have sign off mentors in the teams.

All staff are required to undertake supervision as per LSW policy.

All staff will have line management supervision as per LSW policy.

14 Improving Service Users and Carer's Experience:

14.1 The District Nurse Service will undertake Friends and Family Testing and Annual Patient Survey. These will be reviewed regularly to enable the service to proactively improve patient experience.

14.2 The District Nurse Team are committed to learn from Serious Incidents Requiring Investigation, complaints, safeguarding and other investigations or reviews. The teams will do this by:

- Sharing feedback from these investigations with individuals and teams.
- Applying additional training and support where appropriate.
- Clinical supervision or line management supervision as appropriate.
- Caseload reviews and audit to ensure learning is embedded.

15 Applicable national standards

- NICE Non-Medical Prescribing Guidance and Competencies
- NICE Guidance and Quality Standards
- The Care Quality Commission Guidance and Regulations
- Monitor Guidance
- End of Life Strategy
- Royal Marsden Clinical Guidelines
- NSF Documents
- National Dementia Strategy
- NHS Institute for Innovation & Improvement "Harm Free" Care
- European Pressure Ulcer Advisory Panel Guidelines on pressure ulcer prevention and management
- Care in Local Communities – A Vision for District Nursing
- Compassion in Practice
- Transforming Community Services
- DH Carers Strategy
- Care Act 2014
- Mental Capacity Act
- Deprivation of Liberty

16 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- Nursing and Midwifery Council Guidance
- Code of Conduct and National Minimum Training Standards for healthcare support workers
- Royal College of Nursing Publications

17 Applicable local standards

- LSW Policies
- End of Life Care Bundle
- Joint Pressure Ulcer Strategy
- LSW Standard Operating Procedures
- Community Equipment Service: Provision of Equipment in Care Homes Guidance

18 Monitoring compliance and Effectiveness

18.1 LSW will monitor and review this policy in partnership to ensure we are meeting the aims / objectives of the policy. The compliance and review processes will include:

- Caseload supervision
- Appraisal and Line management supervision
- Regular performance monitoring
- Friends and family testing and annual patient survey
- QueSTT monitoring
- Peer reviews
- Audits in line with LSW monitoring

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 15th December 2016

Appendix 1

Community Nurse Essential Skills and developing skills:

Essential Skill required depending on role to be defined at induction. **Study days to be attended where appropriate. Internal learning will be supported where there are no study days**
Queens Nursing Institute transition into community nursing programme Essential for new to community nursing and Associate Nurse
Assessment and holistic patient centred care
RAPID
Catheterisation, male, female, supra pubic Bowel Management Bladder scanning
Pressure ulcer prevention
Compression bandaging
Doppler assessments Investigate dopplex
Aseptic and clean technique
Ear syringing
Venepuncture
Medicines management and d rug calculations
Influenza and PGD update
Diabetes management,
Mental Capacity Act
Syringe driver, CHC Fastrack, end of life care
On-going skill required that will be supported through staff development
Investigating Serious Incidents
Verification of death
Percutaneous endoscopic gastrostomy (PEG)

Tracheostomy care
Pleural and peritoneal catheters
Leadership and management-working towards becoming a caseload holder
Enhanced medications- IM injections
Care of the dying patient end of life
Entonox
Non-medical prescribing and updates essential if NMP
Human resources (HR) toolkit sessions
Risk management and incident reporting

Appendix 2

In-hours (0830-1700) - Plymouth District Nursing Referral Process for 'New' referrals

Referral received via E-referral, NHS net or Telephone and triaged by DN (Review history on SystmOne)

Urgent – clinical triage within 4 hours of documented receipt of referral

Routine – clinical triage within 1 - 3 days of documented receipt of referral

Is referral suitable for DN service?

Y → Accept referral - upload onto SystmOne and complete referral screen.

N → Is the referral suitable LSW Service

Y → Onward refer to most appropriate service and advise GP/Referrer

N → Advise referrer – specify reason for return i.e. does not meet service criteria, or provide advice, signposting and/or guidance. **All referrals not accepted will be reviewed and returned by a registered nurse.**

Record triage outcome on SystmOne

Commence nursing SystmOne records i.e. Health Needs Assessment, Care Plan (set frequency to daily), Allocate to appropriate Caseload Holder.

Caseload holder will assign future visits within the team. (Same day visits will be assigned by the 'hub' on the advise of the caseload holder).

1430 everyday - DN clerk prints next day's caseload report.

Caseload holder and/or manager will review day's work. Visits requiring re-allocation will be actioned by the DN clerk.

DN uploads mobile working prior to commencing shift

DN nurse visit - records outcome of visit on SystmOne whilst with the patient and makes a note of the outcome on 'visit list' - ensuring to change the

Able to gain access

N → Follow 'No Access' visit guidelines

Y → DN nurse uploads mobile working at the end of their shift.

Are all visits complete?

N → Call Out of Hours Service between 1630 and 08:30 – handover to Devon Doc on **01392 822349.**

D-Doc handover to In-hours DN team via the 'Hub' from 0830. Routine handover via the generic NHS account; PCHCIC.localityhub@nhs.net. Urgent (same day) visits via telephone on **01752 434629**

Y → DN nurse returns 'visit list' to DN clerk during their next working day.

DN clerk will check nurse has set 'future visits schedule' and frequency on care plan. If no future visits are required – Discharge patient and commence Friends and Family process for patients who have been discharged from service

NB: Weekend (24 hours) and Out of Hours (1700-0830) - referral process will continue via D-DOC on 01392 822349

SH&WD referral process – follow current referral pathway.