Standard Operating Procedures

Patient Pathway
District Nursing Services

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Document profile

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Policy Amendments

Version Number	Amendments

Contents

Introduction

These standard operating procedures (SOPs) have been developed to guide the practice of staff working in the District Nursing Services. They also provide a framework for the provision of safe and effective care.

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

Principles

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

- The standard operating procedures do not replace professional judgement which should be used at all times

- A clear rationale should be presented/recorded in support of all decision making

- Practice should be based on the best available evidence

- Appropriate escalation when care needs require this.

- The 'default position' should be to accept all reasonable referrals, assess the patient first then make an informed decision about the most appropriate team/service to care for the patient.

- Discharge planning should commence at the point of admission.

- Where care is delegated to a Non-Registrant, the Registered Nurse remains accountable for the appropriateness of the delegation and for ensuring that the care has been given. They are also responsible for the overall management of the service user that includes a regular review of the care.

- Where potential safeguarding issues are identified, FNHC will adhere to the Jersey Safeguarding Partnership Board's adult safeguarding procedures.

- Staff will be alert to the identification of patients who may be in the last year of life and will follow the Gold Standard Framework where this is required.

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

Referral and Triage (District Nursing Services)

Purpose

To promote robust referral and triage processes through having access to clear and concise patient information in order to make safe and effective decisions about the patient's care.

Scope

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

Core Requirements

- When a referral is received by the District Nursing Service, the Clinical Services Administrator (CSA) places an addressograph label into the appropriate team folder and also puts a hard copy of the referral form into the folder.

- The CSA checks the archive for existing patient records

- Where required, addressograph labels are printed off.

- No self-referrals can be accepted – see 2016 Service Specification for permitted referral sources

- Where a referral is for the provision of care to a visitor to the Island, liaise with the Operational Lead for District Nursing and Finance Director as such patients will be expected to pay for their care including for consumables and dressings.

- Where referral information is unclear or insufficient, the necessary clarification should be sought from appropriate sources:
  - If *demographic information* is missing the District Nursing Administrator to access this from Trakcare or other appropriate source.
  - Where there is *missing/unclear clinical information* required to safely determine/deliver care, the triaging nurse will return the referral to the originator with the standardised response cover letter/fax sheet

- Several times a day, the identified Triaging Nurse reviews the 'referral folders'

- Patients should be categorised by the triaging nurse into the following response time categories:

Referral Category	Timeframe	Examples
Urgent	Contact will be made with the patient within 2 hours and a visit made (if necessary) within 4 hours. Consider if patient should be advised to go to the Emergency Department	blocked catheters pressure trauma terminally ill patient in pain or with other distressing symptoms
Non-urgent	Contact will be made with the patient within 24 hours.	renewal of routine dressings postoperative assessment

Referral Category	Timeframe	Examples
Routine	Contact will be made with the patient within 48 to 72 hours, or on a stated date.	flu vaccinations continence assessments

- The triaging nurse will decide if the patient is to be seen at home or whether they can be given a clinic appointment (see relevant Clinic SOP). (N.B. home visiting is only offered to the housebound or patients in the early stages of a painful procedure or a procedure better suited to being undertaken in the home environment e.g. Trial Without Catheter (TWOC))

- Where there is a lack of clarity about the most appropriate service/team to deal with the patient, efforts should be made, in the first instance, to gain better clarification. Where this is not possible, the patient **must not** be passed backwards and forwards between service areas/teams, instead the patient should be assessed and a decision made then as to the most appropriate team/service to care for the patient.

- The grades 6 and 5 are responsible for reviewing all referrals to the caseload on a timely basis

Admission to the District Nursing Team

To promote a robust assessment of the patient's needs to inform appropriate care planning.

Scope

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

Core Requirements

- Review any existing records for information regarding previous admissions. If appropriate, archive unnecessary documentation making it clear in the records that this has been done. Only in exceptional circumstances should a new record be commenced.

- Obtain past medical history from an appropriate source

- Ensure all relevant equipment and documentation is available for the home visit

- Professional judgement should be exercised when determining the data obtained during the first visit however this data should comprise as a minimum:
    - Completed Staff Safety Checklist
    - Waterlow Pressure Ulcer Risk Assessment
    - Client Handling Risk Assessment – (if there is a client handling need)
    - NEWS
    - Any other necessary risk assessments

  By the end of the first week, it is expected that a comprehensive assessment of need, using the core documentation in the patient records relevant to the service area, will be completed including any additional assessments deemed necessary. N.B. short term records are not appropriate.

- Where it has not been possible to complete any of the admission process within the set timeframes, reasons must be documented and a plan put in place for its completion.

- Develop care plans for the identified care needs and obtain consent for care. Care planning and prioritising of care needs should be made in conjunction with the patient and where appropriate, family/carer.

- Commence discharge planning at the admission stage

- Admissions undertaken by a grade 4 must be discussed with Grade 6 or 5 within 48 hours of the first visit. Where the grade 4 has any concerns, it is their responsibility to raise this in a timely fashion with the Grade 6 or 5.

- Determine appropriately skilled staff to visit the patient

- Determine most likely venue for ongoing care i.e. home or clinic. Discuss early transfer of care to clinic setting with patient if appropriate. Home visiting is only offered to patients who are housebound, in the early stages of a painful procedure or having care better suited to being undertaken in the home environment.

- If the patient is being seen at home due to no clinic appointments being available or whose plan of care includes transfer to clinic within a maximum of 3 visits, it is appropriate to use 'Clinic Notes' as opposed to a Community Adult Client Held Record (CACHR)

- Determine the 'RAG rating' (see SOP for 'RAG Rating') and frequency of visits

- Generate a T-card (see SOP for 'Caseload Management')

- Send liaison letter to GP and any other relevant professionals involved in the patient's care e.g. Social Worker, Respiratory Team having first obtained verbal consent to do this which should be documented
    - Generate the letter from Trackcare using the appropriate template, print it off and send it to any recipients who do not have Trackcare access.
    - File a copy of the letter in the 'Liaison' section of the Community Adult Client Held Records

- Give and explain the following patient information leaflets (in time these will all be part of a 'Welcome Pack'):
    - 'How we use your records'
    - 'Working Together to Keep Everyone Safe'
    - 'We are here to help from birth to end of life'
    - New service leaflet – awaiting development
    - 'Preventing Pressure Trauma'

Caseload Management (District Nursing - Home Visiting Teams)

Each home visiting adult nursing team will have their own caseload management board to manage daily service delivery and communication within the team. There will be consistency across the service of the management of workload planning to ensure that staff can move easily between areas and understand the process.

Scope

This SOP pertains to patients who are in receipt of District Nursing home visiting. It encompasses how to complete and use the 'T-card' to manage the caseload and forward plan visits.

Core Requirements

- Each Patient will have a T card completed on admission to the caseload by the admitting Nurse.

- Patients who require daily care will have a red card for daily visits Monday-Friday and in addition will have a blue card for visits at the weekend. This is to allow the red card to be forward planned for the following Mondays visit on a Friday.

- Patients who require care on different days Monday -Friday will have a white card that can then be used to forward plan a visit for the next week on the last weekday care.

- Those patients who require care over the weekend will have a blue card which is only used to forward plan weekend care.

- All information on the T card will be completed in full or a note stating not known where appropriate.
    - **PMH:**
        - Document all relevant medical history directly under the patient label.
        - Telephone number:
        - Landline and mobile if available
    - **Next of Kin:**
        - Include name, relationship to patient and telephone number(s) – landline and mobile if available.
        - Patient and next of kin contact details must be updated as they change.
    - **Diagnosis** section to include**:**
        - Admission date to caseload (to inform review period)
        - Reason for admission. This needs to be specific. If the patient has been admitted to the caseload for wound management, information must include:

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- type of wound (eg pressure/trauma/postsurgical) and site of wound (e.g. medial aspect of left lower leg).
- If the wound is due to pressure trauma the grading must be documented. Include the date ASSURE was completed for all pressure trauma.

- **Care notes**
  - Document the frequency of visits i.e. daily; Mon/Thurs. Initial and date this. If the visit needs to be timed (e.g. diabetics or to coincide with carers for M&H reasons) include this and the reason.
  - Include high risk of pressure trauma.
  - In the case of catheters, the frequency of planned catheter change must be documented.

- **Directions and access arrangements:**
  - If the address is difficult to locate, provide details of directions and/or landmarks.
  - Document any Key Codes.

- **Risks and hazards:**
  - Include any allergies (if none known this must be documented rather than left blank), any risks/hazards e.g. MRSA, C.diff, Hep B/C
  - Any lone worker risks will be noted in the risks section.

- **RAG Rating:**
  - Following your assessment you should RAG rate the complexity of the patient's needs (see RAG rating SOP).
  - Place a red, orange or green square on the LEFT hand side of the card. This must be placed at the top of the card so that it is visible when the card is on the board.
  - Write anticipated number of care units on the coloured square.

- **Specific care needs:**
  - On the RIGHT hand side of the card place any of the following that are appropriate to the patient:
    - Red dot: diabetic on insulin/BM monitoring
    - Yellow dot: catheter
    - Blue dot: pressure trauma/ulceration (grade 1 and above)
    - Gold dot: palliative
    - Blue square: Fentanyl
    - Yellow square: Vitamin B12 injection

- **Senior Health Care Assistant:**
  - If the patient's care has been delegated to a SHCA place a green dot on the patient label barcode and indicate period of review i.e. 1 for

weekly review, 2 for fortnightly review and up to 4 for monthly review by the registrant.

- Where a card is damaged /full/illegible the clinician who fills the card or who finds it to be illegible/damaged is responsible for completing a new card.

- Do not write notes in pencil on the card. These are legal documents.

- If you need to communicate a message for future visits please complete an entry in the team's communication/handover diary. Please check this diary for messages relating to the patients scheduled to you prior to leaving the office to ensure that you take the relevant stores, photographs, documentation etc.

- **Taking scheduled visits/prior to visiting:**
  - as you take your visits for the next day, place your initials on the back of each card next to the date of the visit.

- **On return to base following visits:**
  - Check that all the details on the T card are correct and up to date.
  - Check that the frequency of visits documented in the CARE NOTES section has not changed following your visit. Does the patient's RAG rating need to be reviewed?
  - If the frequency of visits is to be changed, put a single line through the current frequency and enter your initials and the date of the amendment next to it.
  - Document the new frequency underneath.
  - Put the date of the next visit on the back of the card and place it in the appropriate date.

- **At handover:**
  - the clinician who has delivered the care is responsible for forward planning their patients' care.

- **PRN area:**
  - Place T cards in this area for patients who are not actively visited but are able to contact the service when required.

- **Patients in Hospital/Hospice/Nursing Home:**
  - Place T cards in this area if patient is an inpatient in a nursing care facility.

- **Monthly area**
  - Check the appropriate month area weekly and forward plan for the following week.

- Each member of staff aligned to a locality is responsible for forward planning their own patients or ensuring that another team members takes responsibility for doing so in their absence

RAG Rating for the Complexity of Patient Care Needs
(District Nursing - Home Visiting Teams)

Purpose

There is a belief that the need for District Nursing (DN) services exceeds the staffing levels that are available to meet those needs. The shift from secondary to primary care means that more people, with increasingly complex needs, are being nursed in the place they call home.

The current system for recording DN activity is based on units (15 mins per unit) to reflect care that is given rather than the care that the patient requires. Care could last 5 minutes or 70 minutes.

An increase in delivering more complex care to more dependent patients could mask growing pressures on the service.

RAG rating is one of the factors used to describe the complexity of patients' care needs based on their social and clinical care requirements. Complexity RAG rating is not a rigid tool that replaces clinical assessment/judgement and should never be used in isolation.

Complexity tools will guide the registrant in their decision making and support consistency of language across adult services.

The RAG rating will highlight when a patient's care needs are changing and trigger a discussion with a Senior Nurse or a review by a Senior Nurse.

The RAG rating can also be used to describe the dependency of the patients on each team's caseload to inform resource allocation and prioritise workload during periods of high demand for the service e.g. due to inclement weather.

Each home visiting adult nursing team will have their own caseload management board to manage daily service delivery and communication within the team.   There will be consistency across the service of the management of workload planning to ensure that staff can move easily between areas and understand the process.

Scope

This SOP pertains to patients who are in receipt of District Nursing home visiting and encompasses rating the complexity of a patient's care needs including reassessment when these needs change and escalation of problems identified.

Core Requirements

- RAG rating the complexity of a patients care needs is to be considered at every contact to reflect any changes in their clinical/social care needs

- Clinical score X social score = overall score to determine complexity of care needs i.e. initial assessment scores 3 for clinical and substance misuse scores 3 for social = RAG rating =9

- The RAG rating is one of the factors that can inform decisions about time allocated to care needs. There are a number of factors to consider including unpredictable events affecting care needs, challenges in the environment, travel time and patient cooperation/concordance.

- It is anticipated that all initial assessments will be allocated at least 4 units to ensure a robust assessment informs care planning and future care decisions.

- The patient's RAG score is determined as part of the initial assessment/reassessment and again as the patient's clinical and or social care needs change.

- A change from green to amber or amber to red will prompt a discussion at the daily handover with a plan agreed and documented.

- A change from green to red will prompt a review by a grade 5/6.

RAG rating	Clinical	Social																	
		Green 1	Amber 2				Red 3												
		Independent Established Package of Care	Residential care	Dementia Care for by spouse	Unstable package of care	Complex family dynamic	Social breakdown	Carer breakdown	Package breakdown	Substance misuse	Discharge <48hours	Multiple frequent admissions to hospital	Environmental - unsafe / unsanitary	Multiple readmissions for similar issues	Lone worker issues	Social compliance/concordance	Social isolation issues	Multi-agency involvement	Initial assessment
Green 1	Simple wound care i.e. skin tears	1	2	2	2	2	3	3	3	3	3	3	3	3	3	3	3	3	3
	Long term stable diabetes	1	2	2	2	2	3	3	3	3	3	3	3	3	3	3	3	3	3
	Injection (clexane/Bi12 etc)	1	2	2	2	2	3	3	3	3	3	3	3	3	3	3	3	3	3
	Fentanyl patch	1	2	2	2	2	3	3	3	3	3	3	3	3	3	3	3	3	3
	Eye drops	1	2	2	2	2	3	3	3	3	3	3	3	3	3	3	3	3	3
	Wound check post op	1	2	2	2	2	3	3	3	3	3	3	3	3	3	3	3	3	3
	Stable NEWS	1	2	2	2	2	3	3	3	3	3	3	3	3	3	3	3	3	3
Amber 2	Catheter change	2	4	4	4	4	6	6	6	6	6	6	6	6	6	6	6	6	6
	Stoma care	2	4	4	4	4	6	6	6	6	6	6	6	6	6	6	6	6	6
	Leg ulcer	2	4	4	4	4	6	6	6	6	6	6	6	6	6	6	6	6	6
	Pressure trauma prevention	2	4	4	4	4	6	6	6	6	6	6	6	6	6	6	6	6	6
	Stable palliative	2	4	4	4	4	6	6	6	6	6	6	6	6	6	6	6	6	6
	Stable COPD	2	4	4	4	4	6	6	6	6	6	6	6	6	6	6	6	6	6
	Intermediate wound care (Pilanidol)	2	4	4	4	4	6	6	6	6	6	6	6	6	6	6	6	6	6
	Large wounds - surgical/traumatic	2	4	4	4	4	6	6	6	6	6	6	6	6	6	6	6	6	6
	TWOC	2	4	4	4	4	6	6	6	6	6	6	6	6	6	6	6	6	6
	History of mental health issues	2	4	4	4	4	6	6	6	6	6	6	6	6	6	6	6	6	6
	Rise in baseline NEWS	2	4	4	4	4	6	6	6	6	6	6	6	6	6	6	6	6	6
	Venapuncture/cannulation	2	4	4	4	4	6	6	6	6	6	6	6	6	6	6	6	6	6
Red 3	EOL & Follow up bereavement	3	6	6	6	6	9	9	9	9	9	9	9	9	9	9	9	9	9
	Complex palliative symptom control	3	6	6	6	6	9	9	9	9	9	9	9	9	9	9	9	9	9
	Pressure management equipment	3	6	6	6	6	9	9	9	9	9	9	9	9	9	9	9	9	9
	Continence assessment	3	6	6	6	6	9	9	9	9	9	9	9	9	9	9	9	9	9
	Doppler assessment	3	6	6	6	6	9	9	9	9	9	9	9	9	9	9	9	9	9
	Review risk assessment - Falls, Waterlow	3	6	6	6	6	9	9	9	9	9	9	9	9	9	9	9	9	9
	Initial assessments	3	6	6	6	6	9	9	9	9	9	9	9	9	9	9	9	9	9
	Review assessments	3	6	6	6	6	9	9	9	9	9	9	9	9	9	9	9	9	9
	IV therapy	3	6	6	6	6	9	9	9	9	9	9	9	9	9	9	9	9	9
	Unstable condition /change	3	6	6	6	6	9	9	9	9	9	9	9	9	9	9	9	9	9
	Active mental health issues	3	6	6	6	6	9	9	9	9	9	9	9	9	9	9	9	9	9
	NEWS 3+	3	6	6	6	6	9	9	9	9	9	9	9	9	9	9	9	9	9
	Clinically non compliant	3	6	6	6	6	9	9	9	9	9	9	9	9	9	9	9	9	9

Nurses Delegating Care to Non-Registrants

Purpose

To provide guidance for nursing staff who are delegating care to non-Registrants and assessing the competence of non-registrant staff to perform specific interventions.

Scope

The assessment of competence of FNHC and non- FNHC staff by Registered Nurses

Core Requirements

- Nursing staff should be clear about the principles of accountability and delegation and should refer to The Nursing and Midwifery Council's (NMC) code (2015) in relation to this. The Royal College of Nursing also provides guidance on accountability and delegation.

- Prior to delegating care the Registrant must ensure that the non-registrant has the necessary skills and competence to safely perform the delegated task/s.

- Prior to the assessment of competence, the non-registrant must have received appropriate training that includes theoretical and practical components.

- Full records of training (including dates) should be recorded and sent to the Education and Development Department.

- The assessment of competence should be documented, ideally against recognised standards e.g. National Occupational Standards (www.skillsforhealth.org.uk) and should include assessment of the non-registrant's knowledge as well as of their practical skills.

- Wherever possible QCF accredited modules should be utilised and Nurses should encourage other organisations whose staff they may be delegating care to, to consider this training.

- The Registrant remains responsible for developing a care plan for the delegated care. This plan should be explicit regarding the expectations of when the non-Registrant should report deviations from acceptable parameters e.g. blood sugar levels above or below a certain level.

- Care plans must explicitly indicate that the care can be delegated to a non-registrant and the frequency for review by a Registered Nurse.

- T-cards should be used to flag the date/s when reassessment of competence of the non-registrant/s is due. (DN Home Visiting Service)

Delegating care to FNHC Non-Registrants

- When the undertaking of a QCF module has not be appropriate/possible, the document 'Competence in Clinical Skills (Family Nursing & Home Care staff only)' should be completed for any non-registrants to whom FNHC Nursing staff are delegating an intervention, when they have been deemed competed to carry out the intervention. An electronic copy should be sent to the Education and Development Department and the original kept in the portfolio of the non-registrant.

- Competence to carry out a specific intervention should be reassessed annually or more often if required.

- Once deemed competent to carry out a specific intervention, FNHC non-registrants do not have to have their competence re-assessed every time the care of a new patient is delegated to them. However, it is good practice to accompany the staff member the first time they visit the patient to ensure that they are fully aware of the care required and how this is carried out.

Delegating care to Non-Registrants not employed by FNHC

- **N.B.** *Care can only be delegated to a non-registrant not employed by FNHC if they are employed either by an 'Approved Provider' or a Registered Care Home.*

- Before training and assessing the competence of non-FNHC staff, Registered Nurses must be aware of the position of the individual's employer in relation to the delegation of the intervention and their requirements for the recording of competence.

- The nurse must gain written permission from the non-FNHC staff member's manager/employer to delegate the task. This should be done on the document 'Competence in Clinical Skills (Staff not employed by Family Nursing & Home Care)

- Wherever possible, delegates should be encouraged to undertake the appropriate 'QCF' module.

- The document 'Competence in Clinical Skills – (Staff not employed by Family Nursing & Home Care)' should be completed, when the non-registrant has been deemed competed to carry out the intervention.

- The original, fully completed 'Competence in Clinical Skills – (Staff not employed by Family Nursing & Home Care)' document should be filed in the patient's care records.

- The assessment of competence must only be undertaken on a **patient-specific basis.**

- **N.B.** FNHC staff cannot 'sign off'/deem competent non-FNHC staff where an intervention is not being delegated by a FNHC Registered Nurse.

- Competence to carry out a specific intervention should be reassessed annually or more often if required.

Visiting Patients in Residential Care Homes

Purpose

To promote safe and appropriate care for patients in a residential care home.

Scope

All patients on the District Nursing (home visiting) caseload who are in a residential care home.

Core Requirements

- All patients in a residential care home must be treated <u>as if they are in their own home</u> i.e. Nursing staff should not assume that the care home is meeting all the care needs of the resident.

- The same holistic approach to care should be taken as would happen if they lived in their own home.

- Communication with care home staff is essential and FNHC staff should work collaboratively with the care home to provide optimal standards of care.

- FNHC staff should advise the appropriate person in the care home of their arrival and departure and if required should sign themselves 'in' and 'out'.

- The resident's list of medication can be obtained from the pharmacy generated 'MAR' chart.

- When documenting the communication of specific information/actions with care home staff, FNHC staff must record the name of the care home worker and their job title. For example, "Spoke to Senior Healthcare Assistant Julie Smith and asked her to …"

- FNHC staff should write in the Care Home's patient records wherever appropriate e.g. whenever there are clinical concerns, information to share, equipment required.

- Nursing staff are responsible for the outcome of any intervention they request to be carried out by the Care Home staff e.g. if care home asked to provide equipment, the nurse must check that this request has been carried out and take appropriate action if it has not happened. Registered Care Homes are responsible for ensuring that the patient has access to relevant equipment and consumables.

- FNHC staff are responsible for ensuring any ongoing care needs, including equipment and preventive measures e.g. turning schedules, are documented in the care home's records and relevant information such as a copy of the preventing pressure trauma leaflet is provided.

- Before leaving, FNHC staff should, wherever possible, communicate in person with the appropriate care home staff.

- Staff should be aware of the requirements of the FNHC Medicines Policy for medication administration in Care Homes

Provision to Nursing Homes

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

Scope

Requests from Nursing Homes for advice and support to manage patient care

Core Requirements

- All requests to the DN Teams must first be discussed with the Grade 6 or in their absence a grade 5

- If the request is deemed appropriate the DN service can provide *generalist* advice and support to Nursing Homes if the patient's needs fall outside of what would reasonably be expected from Registrants in a Nursing Home*.*

- Clinical Nurse Specialists may be called upon to offer *specialist* advice and support where the requirements fall outside of the remit of the generalist team.

- Family Nursing & Home Care staff must make it clear to Nursing Home staff and the patient that they are not assuming any clinical responsibility for the patient in question. Direct patient care should only be undertaken if part of teaching a skill to others.

- Family Nursing & Home Care staff cannot sign off staff from another organisation as competent in a skill.

- Family Nursing & Home Care staff should document their actions/advice/guidance in the Nursing Home's patient care record.

- All contacts must be recorded in the nurse's diary and recorded on their daily activity data form.

- **N.B.** It is the Nursing Home's responsibility to ensure that the learning needs of their staff get addressed in order to meet the care requirements of patients within their care. Where FNHC staff have concerns regarding this, the issue can be escalated to the Registration and Inspection Team and if necessary through the Safeguarding process.

Discharge from the District Nursing Service

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

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

- Check all assessment review dates and plan how to manage any that have been set for a future date e.g. if at risk of pressure trauma – does patient have to be reviewed again? Can this be managed through patient education and direct re-referral?

- Review all care plans to check if goals have been met. Ensure all care plans are appropriately evaluated and the 'problem/issue' does not require ongoing care. If ongoing care is required, ensure that there is a documented plan in place to address this need. For example, a high Waterlow score – plan might include patient information leaflet given and explained, information about referral back to the service if concerns arise.

- Discuss all planned discharges with the Grade 6 or 5 prior to the patient being discharged from the caseload and record the discussion and outcome with the Grade 6/5 in the patient's nursing records.

- Complete GP Liaison letter and where appropriate, copy in any relevant services involved in the patient's care (with patient agreement)

- Complete the 'patient letter' on Trackcare to include recommendations on care needs. Print off, send the original to the patient and file a copy in the patient's care records.

- Complete all relevant sections of the Community Adult Client Held Records

- Every care plan must have a clear evaluation indicating its outcome.

- Indicate on all care plans that the plan is no longer in use by scoring through with a single diagonal line, adding the date, time and your signature.

- Patients in care homes - FNHC staff are responsible for ensuring any ongoing care needs, including equipment and preventive measures e.g. turning schedules, are documented in the care home's records and relevant information such as a copy of the preventing pressure trauma leaflet is provided.

- Ensure all base-held patient information is filed correctly in the patient records before it is sent for archiving.

- File all documents in the appropriate section – no documents should be in the back 'patient labels' flap.

- Check the chronology (significant events) section is completed.

- Send records back to Le Bas for archiving.