Standard Operating Procedures

Client Pathway
Home Care Service

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Contents

Introduction

These Standard Operating Procedures (SOPs) have been developed to guide the practice of staff working in the Home Care service.

Principles

The following are overarching, guiding principles for safe and effective service delivery within the Home Care service.

- FNHC Home Care aims to provide a consistently high-quality community home care service spanning the hours of 7 a.m. to 11 p.m. seven days per week. The service will be supported by a robust governance framework and clear planning, admission, assessment, care delivery and discharge processes.
- FNHC will at all times adhere to the Health & Social Services (HSS) Specification for Approved Home Care Providers and Long Term Care Law.
- FNHC Home Care will provide skilled staff to meet clients' physical needs, but will also identify and support clients' social, cultural and spiritual needs and the role of the family.
- The objective of Home Care is to continually develop and improve in order to be the preferred provider of expert care delivery to clients with dementia, long-term conditions, pressure trauma risk, equipment and safe handling requirements and complex needs.
- The Home Care service is led by a team of highly-trained and experienced Senior Health Care Assistants (SHCAs) on duty seven days per week to support service delivery. The SHCAs are not responsible for managing client's changing needs, but will aim to identify and report in a timely manner any changes, un-met needs or risks within client's health or care package to the appropriate Health or Social Care professional.
- FNHC Home Care will follow the Gold Standard Framework (GSF) for the identification and support of clients who may be in the last year of life, and provide skilled and compassionate HCAs to meet the needs of palliative and end-of-life clients managed by the District Nursing teams.
- As a partner service, FNHC will at all times follow the guidelines of the Safeguarding Partnership Board and ensure any potential safeguarding issues are identified and reported.

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

Referral Process for Home Care Service

Purpose

To promote safe management of referrals into the service and ensure clients who meet FNHC Home Care criteria are accepted onto the service via a robust Referral Process and other referrals are re-directed to alternative sources of care or support.

Scope

All patients referred to Home Care service from a range of sources

Core Requirements

- When a referral is received by the Home Care service it should be forwarded to the Home Care Locality Co-ordinator.
- If the referral does not meet FNHC Home Care Criteria, the Locality Co-ordinator should contact the referrer, (this could be the client who has self-referred), and advise referrer of alternative options, i.e., private agencies as per Approved Provider list on HSS website.
- Should the Locality Co-ordinator be concerned that the Referral is urgent and the client may be at risk without immediate intervention, the Locality Co-ordinator should contact the client/referrer to obtain further details; if client is in need of immediate support, the client should be referred to the appropriate agency for urgent assessment, e.g. G.P., District Nurse team, Reablement team or Social Worker. All referrals to Home Care should be listed on the monthly Spreadsheet, whether accepted or not.
- If the Referral meets FNHC Criteria, the Supervisor will then ascertain if FNHC has the resources within the Home Care service to provide the care package requested. The Home Care service will have availability to accept a referral if there are (i) HCAs/SHCAs available to provide client visits at the requested time and for the requested length of time **and** (ii) there are SHCAs available to provide assessment and care planning as per SOPs (see below).
- It is hoped that FNHC would have availability to provide the entire care package for client, which may be up to 4 or 5 visits per day. However, if FNHC is able to provide a substantial part of a care package, but not all the visits needed, then this should be offered to the Referrer/Commissioner, thus creating the possibility of sharing the care package with an alternative service provider in the short term (until FNHC can provide the entire care package).
- If FNHC Home Care has the resources to accept the referral and provide the care requested, this should be confirmed with the Referrer by telephone if appropriate, then followed by e-mail, detailing the exact care which will be provided, i.e., the time of visits, no. of carers needed, the units at each visit and the cost of the care package per unit**. A completed Referral Form should also be requested from the Referrer at this time.**
- If the Referrer is the client or family, then a telephone referral will suffice and details can be confirmed at the initial assessment visit and once agreed, confirmed to client by the written contract.

- It is appropriate to offer a care package and also specify a date for the care package to commence, dependent on FNHC resources at the time. Every effort should be made to provide the care package as soon as possible but only if there are adequate resources to ensure a safe admission into the service. The Home Care service should not be pressurized into rushed discharges from hospital. A package of care which is adequately planned and prepared promotes safety for the client, reduces the risk of re-admission to hospital/placement, and a much improved chance of a successful and long-term care package.
- Should a care package require HCAs trained in advanced skills, e.g., P.E.G. feeds, bowel care etc., again the package should be accepted if there is availability within the service. The District Nurse team or Specialist Nurse will then train and sign as competent a pool of HCAs to perform the required care for that specific client; thus the time required for training HCAs needs to be considered before accepting such a package. The SHCAs will **not** need to be trained in the procedure.
- Once a Referral has been accepted and confirmed in writing, the Referrer/Commissioner must then forward a completed Referral Form with all relevant details documented. Most of the new clients referred to FNHC Home Care will have high-level or nursing needs & have received assessment from a Health & Social Care professional(s), for example, Social Worker, Physiotherapist, Occupational Therapist, Continuing Care Nurse etc., and the outcome of this assessment should be forwarded to FNHC Home Care.

  Historically, FNHC nurses have always performed their own nursing assessment for new Home Care clients and the expectation may remain that this will continue. Thus the Referrer must be informed that FNHC will not be able to provide care to clients without the completed written Referral/Nursing Assessment.

  Written referrals will be accepted in the following formats:

  - Completed FNHC Home Care Referral Form
  - Completed SPOR (Single Point of Referral) or alternative Referral document
  - Personal Support Plan (PSP) provide by Social Worker
  - PSP or Care Plan provided by Continuing Care Team (CCT)

- The Referrer should also identify if the client has been assessed for Long Term Funding (LTF) and where invoices should be sent.
- Once the Referral Form/Assessment/Care Plan has been received, it should be forwarded to the SHCA to commence the Admission Planning process.

Planning Process for Admission to the Home Care service

Purpose

To promote a thorough planning process for clients accessing FNHC Home Care service.

Scope

All clients accepted by the Home Care service who will receive a FNHC care package.

Core Requirements

- The SHCA will have received a completed Assessment/Care Plan/Referral Form from the designated Key Worker/Referrer. Further information should be obtained if possible from Trakcare, discussion with other agencies involved, discussion with the nurse caring for client on the ward, G.P., and with **client himself or family.**
- If client is new to FNHC and has complex needs, it would be useful, if possible, to meet and discuss care needs with client/staff on the ward, and observe any specific procedures needed on discharge, e.g., transfers with prescribed equipment.
- The SHCA should aim if possible to attend any Access Visit or Home Visit prior to client's discharge, along with the Multi-disciplinary Team (MDT), e.g. with O.T., Physiotherapist, CCT etc. **Any equipment needed will be assessed by the MDT.** If the SHCA does not agree with the appropriateness or safety of any equipment or procedure this should be relayed to the MDT and a review requested. FNHC can decline acceptance of a client if safe procedures are not in place.
- With the information obtained from the discharge planning process, FNHC Home Care records can be commenced prior to client's admission to the Home Care service.

Admission to the Home Care service and Initial Assessment

Family Nursing & Home Care

Purpose

To promote a robust admission process for clients accessing the Home Care Service and to provide a comprehensive and appropriate initial assessment. The purpose of initial assessment of client is (1) to ensure all client needs/goals/risks have been identified and a management plan is in place to meet such needs/goals/risks, and (2) to record client's current function/needs to inform future re-assessments where changes will be identified and escalated to the appropriate agency.

Scope

All clients accepted by the Home Care service who will receive a FNHC care package.

Core Requirements

- The initial assessment will normally be carried out by a SHCA of at the first planned HCA visit. Following a robust planning process, any risks or problems should already have been identified and managed by the MDT/Key Worker.

- The initial assessment of client by SHCA should take place at the time of the first planned HCA visit (the SHCA will take the place of the HCA) and should build on the information gained during the planning process. FNHC is **not** able to provide a 'meet-and-greet' or extra visit to assess suitability of equipment etc.

- The Home Care Records should be commenced prior to the initial visit and completed within the first two visits. All sections of the Assessment tool should be completed along with the following supplementary tools:

    - Waterlow Pressure Ulcer Assessment Tool

    - Falls Risk Assessment Tool (FRAT)

    - Nutritional Screening Tool

    - Medication Assessment (see Medicines Policy)

- If client has a Waterlow Score over 10 and/or is at risk of skin breakdown, a specific care plan should be completed plus a skin bundle.

- If client has a history of, or is at risk of falls, the FRAT should be completed. For any identified risk, action taken should be documented on the FRAT form. If there is no space on the FRAT form, write 'see communication' and complete details of action in communication section of the records. Refer to the FRAT Guidance Sheet for action required. The SHCA is able to manage the risk if the action required is advice to client or minor adjustments such as removal of rugs etc. Otherwise a referral is likely to be needed, e.g. to G.P., O.T., Physiotherapist. Falls Clinic, Community Rehabilitation Team or Key Worker. (SPOR referral required except to G.P.)

- If client has Nutritional Score of 7 or above, a management plan should be documented on the back of the Nutritional Screening Tool. Client may require referral to the Dietician as nutritional supplements may be needed.

- It client has a diagnosis of dementia or has mental health issues, it should be confirmed that the G.P., Key Worker and/or Mental Health team are aware. Client's dementia should be considered when care planning for client and HCAs made aware of client's dementia.

- If client has continence issues which have not already been assessed, a referral should be sent to the appropriate DN team requesting a continence assessment.

- The management plan for administration of medication should be documented on the Medication Assessment Tool (e.g. self-administration, family support). Should client require prompting or administration of medication, refer to the FNHC Medicines Policy.

- If mobility or safe handling needs are identified on assessment, an urgent referral should be sent to O.T/Key Worker requesting assessment of equipment needs. This could be a joint assessment with FNHC if Home Care have staff availability to attend, but will not always be possible. Referral should be by a telephone call due to urgency of matter, followed by an e-mail to confirm and by a SPOR if requested.

- If it is considered by the MDT that client is in his/her last year of life, the appropriate District Nurse team should be informed to enable client to be discussed at the next Gold Standard Framework meeting.

- Within the first two visits to client, a copy of the Service Contract should be given to client, listing times, costs etc. A signed Service Contract constitutes client agreement to the conditions of the care package. (This will also include charges incurred if client is admitted to hospital or a period of respite). A copy of the Contract should also be sent to the Commissioner of client's care if appropriate. (Contract pending)

- If not already provided, give and explain the following patient information leaflets:
    - 'Information, confidentiality & comment'
    - 'Working Together to Keep Everyone Safe'
    - 'Here to help, from birth to end of life'
    - 'Preventing Pressure Trauma'
    - 'FNHC Home Care Service'
- Once admitted to the Home Care service, a letter should be sent to client's G.P. using the Trakcare template, detailing the care package provided by FNHC. This letter will be saved on Trakcare for access by other HSS health professionals. A copy of the GP letter should be put in client's records.

Care Planning for Home Care Clients

Purpose

To promote clear, precise and unambiguous Care Plans which enable safe and effective care delivery.

Scope

All Home Care clients.

Core Requirements

- Care Plans will be written by SHCA following the planning and assessment process, including pre-printed care plans where appropriate, e.g. for equipment.
- All Care Plans should be discussed, negotiated and agreed with client. This is stated in each Care Plan template. The written contract will also state that client is consenting to care plans held in the home-held records.
- A Care Plan Index should be completed
- Instructions in Care Plans should be clear and simply stated and typed with double-spacing to promote ease of reading and understanding by HCAs.
- Multiple Care Plans should be avoided.
- Care Plans should not document aspects of care which would be expected as standard practice for HCAs, e.g. wearing apron and gloves, ensuring dignity and privacy for client.
- Hand-written additions to Care Plans are permitted and must be signed and dated. If there are more than two additions to any one Care Plan, the plan should be re-typed, a line scored through the old care plan and the discontinued care plan filed at the back of the CACHR records.
- All care plans must be signed and dated.
- Care plans should be goal-centred and patient-specific and **should reflect the individualized client goals as identified on initial Assessment.** However, it must be acknowledged that to achieve certain goals, some procedures or 'tasks' may need to be performed by a HCA skilled in such procedures, e.g., catheter management.
- A care plan should be written for each HCA visit as a 'checklist', e.g. there should be plan for morning visit, lunchtime visit, twilight visit etc. and each plan should contain client's goals/need in all appropriate areas, e.g. continence, medication, skin care etc. The HCA should re-read the Care Plan prior to leaving client and ensure all tasks on the Care Plan have been completed to client's satisfaction.
- Each Care Plan should contain instructions regarding client's mobility, e.g. use of zimmer frame, wheelchair.

- A separate Care Plan will be needed if client is prescribed supplementary medication to be administered. (see FNHC Medicines Policy).

- When a client requires specific equipment for safe handling client will need (i) a separate Manual Handling Care Plan which lists client's specific needs, e.g., hoisted onto bed in lounge, etc., plus (ii) a pre-printed generic Care Plan for each piece of equipment and (iii) a completed Sling Form if appropriate. The Manufacturer's Manual for each item of equipment should be supplied by the equipment provider and should be easily accessible in client's home.

- Each Care Plan should state the length of the time allocated for the visit (and to be charged). The HCA will be expected to remain with client for that length of time.

- If a Care Plan is discontinued, a line should be drawn through the Care Plan, dated and signed, and the plan should be filed at the back of the records.

Service Delivery for Home Care Clients

Purpose

FNHC Home Care does not have a responsibility to manage client's changing needs, but to provide a high-quality Home Care service and identify and report in a timely manner any changes or problems within client's health or care package to the appropriate Health or Social Care Professional or identified Key Worker.

Scope

This SOP pertains to all clients who are in receipt of Home Care services.

Core Requirements

- For new care packages or changes to care, the HCAs should be supported to become familiar with client's needs, particular in relation to equipment/safe handling. The SHCA as Key Trainer should meet with HCAs at client's home to demonstrate transfers etc. until the SHCA is satisfied that all the HCAs are fully skilled in the safe handling procedures for each client.

- When a client is new or needs have changed, *we should not rely solely on care plans to communicate important changes*; the HCA(s) should be telephoned by the SHCA and informed of changes.

- HCAs should adhere at all times to the H.S.S. Code of Conduct for Health Care Assistants.

- HCAs should remain in the client's home for time designated in the care plan and service contract.

- The HCA should deliver all aspects of the care plan thoroughly and efficiently and check again at the end of her visit that all procedures listed on care plans have been completed. If care plans cannot be completed for any reason, this should be documented and reported to the SHCA.

- If HCAs are uncertain about the service required or the Care Plan is unclear, they should check with the SHCA before providing care.

- If the HCA is not familiar with a piece of equipment required by client, she should inform the SHCA and gain support and training in use of the equipment before continuing to provide the service.

- If the HCA is unable to manage a task identified in the care plan or is at all unsure of any procedure, she should inform the SHCA and be given training in that procedure before providing the service.

- All care given must be documented as stated in the Record Keeping policy and the SOP.

- It is essential that the care plans are followed at all times and no care is provided which is not documented in a care plan. If the HCA has concerns that client's needs are not being met, this should reported to the SHCA.

- The HCA must always report back any concerns whatsoever to the SHCA. The concern must be documented in the records and the name of the person they have reported to must also be documented in the records.

- The SHCA must respond to any concern reported by the HCAs. This may entail a visit by the SHCA or a referral to another agency. The nature of the response will be a clinical judgement by the SHCA. The following is a guide only:

    - In an emergency an ambulance should be called & the HCA should remain with client until the emergency services have arrived.

    - If client is acutely ill, the G.P. should be called. (The SHCA should confirm that the G.P. will be visiting and if client declines a GP visit, the SHCA should discuss with client and with senior staff if needed). It is not adequate to request that a family member calls the doctor. It must be confirmed that the GP has been called and will visit.

    - If client has a nursing need, e.g., a blocked catheter or laceration to skin, a referral should be sent to the geographical District Nurse (DN) team.

    - If client develops continence issues, a referral should be sent t the DN team for a Continence Assessment. A referral should also be sent to the DN team if the prescription for pads (if receiving subsidised products) needs to be renewed.

    - A referral should be sent to the D.N. team immediately if client commences antibiotics for a urinary infection (the DN may need to change catheter).

    - If client's needs have changed and a review of his care package is needed, the Key Worker/Commissioner should be informed and an urgent re-assessment requested, e.g. by CCT, Social Worker.

    - If equipment prescribed is no longer appropriate for client or is unsafe, an O.T. referral should be sent and Key Worker informed. The SHCA can provide a joint assessment with OT/Nurse when equipment needs are assessed or re-assessed, but the SHCA is not expected to assess for equipment alone.

    - If a pressure ulcer or skin breakdown is identified or suspected, the SHCA should visit and (i) initiate a management plan/skin bundle as appropriate or (ii) refer to DN. Team for assessment. Any pressure ulcers Grade 1 or above should be documented on the ASSURE system.

    - If client is unwell or needs have changed suddenly, and the equipment/care package is no longer appropriate, consideration should be given to a Referral to the Reablement team (crisis client). This should be discussed with G.P. and it will be the G.P. or Nurse to make the referral to Reablement. It must be confirmed that client is accepted by the Reablement team.

- Any referrals or escalation of concerns must be agreed with client and documented in the records.

- The SHCA must be aware that if there are signs of abuse or neglect reported or identified, which may constitute a potential safeguarding concern, this should be discussed with the DN or Safeguarding Lead. A copy of the THRESHOLDS document should be available for reference to guide actions, but if there is any doubt whatsoever the concern should be escalated.

- The SHCA is responsible for re-assessment of clients. Re-assessments will occur if problems or risks are identified or if client has had a period of time in hospital. If no unexpected issues arise, each client should be reviewed approximately 6 weeks after a care package is set up. Thereafter each client should be re-assessed yearly. On re-assessment of client, the assessment tool should be used to identify any changes and all care plans re-assessed and re-written if needed. If care plans remain unchanged, they should be signed and dated at the time of re-assessment.

Record Keeping for Home Care Clients

Purpose

To promote clear and accurate record keeping and ensure client information is kept up-dated, safe and accessible. To promote fast and accurate statistical analysis of Home Care service when needed.

Scope

All clients in receipt of FNHC Home Care service.

Core Requirements

- On admission to the Home Care service, client details should be entered onto CARE PLANNER as follows:
    - name & address
    - date of birth
    - URN number
    - case Manager/Key Worker
    - G.P.
    - global Needs Score
    - days of week & times client is visited
    - if client receives domestic support
    - long-term funding status
    - key pad number
    - diagnosis
    - environmental alert
    - last re-assessment date
    - re-assessment date due
    - NFR status

It is essential above details are kept up-to-date

- A manual Base Card will also be completed for each client with above details and kept in the office where it is easily accessible. It is essential that details are kept up-to-date.

- The Staff Safety Checklist form should be attached to the Base Card with and Action Plan for any risk identified. All staff visiting client must be made aware of any risk and action plan by verbal communication.

- Key pad number for client should **not** be written on the manual Base Card; a list of Key pad numbers should be kept separately so the Key Pad number is not documented with the address.

- Each client will have a completed set of records which will be kept in client's home while client is receiving the FNHC Home Care service.

- If client and G.P. have signed a 'Not for Resuscitation' (NFR) Form this should be filed at the front of client's records (with client's consent). Client's NFR status should be documented on the Home Care spreadsheet and the Base Card and **the expiry date of the NFR also noted**. Once the NFR Form has expired, discussions should follow with G.P. and/or DN regarding renewal of the NFR or otherwise. All staff visiting client must be told verbally that client has NFR status.

- It is essential that, where equipment is provided for client, the 'Equipment List' form is completed accurately including who to contact should the equipment malfunction.

- All information, referrals, letters etc. concerning client should be filed in the records.

- A small file should also be kept in the office for each client in order to document non-visiting intervention, e.g. telephone calls, reports from HCAs. Office-held records should be brief and factual and not contain speculative or subjective comment.

- Any issues which could potentially lead to safeguarding concerns should also be documented in the office-held notes

- Each HCA and SHCA will complete CARE PLANNER following each visit, to facilitate an accurate billing process and provide statistical evidence for the Home Care service. SHCAs should differentiate between (i) providing care as part of care package, i.e., which is chargeable and (ii) SHCA supervision/re-assessment visits.

End-of-Life and Palliative Care

Purpose

To identify clients who are potentially in the last year of life and promote high-quality palliative care to clients and their family when clients have palliative needs or are on the end-of-life pathway.

Scope

All Home Care clients who have palliative or end-of-life needs.

Core Requirements

- The SHCA should aim to identify any client who, because of a diagnosis of a terminal illness, the last stages of a long-term condition or increasing frailty and loss of function in advanced age, may be in the last year of life. Once client has been identified the G.P. and DN team should be notified so the Gold Standard Framework can be implemented.

- Clients who are identified as potentially in the last year of life **or** have a long-term condition which is unstable or symptomatic, should be referred to the DN service, for example, clients with Motor Neurone disease. or clients. SHCAs do not have the nursing knowledge or resources to continually respond to concerns which arise around unstable conditions. Escalation of problems with this client group should be to the designated DN team.

- FNHC should aim to accept any client managed by the DN team and/or Hospice who requires of end-of-life care. As this is likely to be a short-term care package, every effort should be made to accommodate such clients within the service.

- Clients with end-of-life needs will be managed by the District Nursing team and the nurses will write all care plans which are likely to change from day to day. (Alternatively changes to care may be documented in the communication sheet and the HCAs must be made aware that the communication sheet must be read). Frequent liaison between HCAs and the DNs should be encouraged and the SHCA may not be required to intervene with these clients.

- Care plans for use of equipment with end-of-life clients should also be written by the DN. Team, as the Nurses will be fully aware of client's symptoms, pain levels, moving and handling issues etc.

- If client requires supplementary visits or overnight care, FNHC should aim to provide this by using existing or bank staff to work overtime to provide the requisite service to end-of-life clients.

Discharge from the Home Care service

Purpose

To promote safe and appropriate discharge of clients from the Home Care service.

Scope

All clients discharged from the Home Care service.

Core Requirements

- Complete all relevant sections of the Records
- Complete G.P. Liaison letter on Trakcare and where relevant copy in any relevant services involved in client's care. File GP discharge letter in Records
- Discontinued Care Plans should have a line drawn through them and they should be dated and signed.
- The reason for client's discharge from the service should be documented in the Communication sheet and in the Significant Events section. If client continues to require care, the name of the new service provider should be documented, e.g. family, nursing home.
- All records should be returned to Le Bas for archiving.
- **All office-held notes should now also be filed in the Records and archived at Le Bas**