Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Management of Referrals Accepted to the Public Health Nursing Service

☐ Policy ■ Procedure ☐ Protocol ☐ Guideline

HSE National Public Health Nursing Service
Community Operations: Primary Care

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Appendix XII Nursing Intervention Levels for Patient Dependency/Nursing Need within a Public Health Nursing Caseload

2.7 PART A: Outline of PPPG Steps

Title: Management of Referrals Accepted to the Public Health Nursing Service

2.7 The steps to be taken to manage referrals accepted to the public health nursing service (all age groups) from any referral source are;

2.7.1 Referrals accepted to the service

A1.1 Referrals to the service include the following; new referrals (including self-referrals) and referrals of patients transferred from other PHN service teams. (Dept. of Health, 2000, 2001, 1970 and 1966)

A1.2 Referral sources include; self, family member, patient advocate, hospital staff, General Practice staff, allied health professionals, frailty teams, community rehabilitation teams, Community Intervention Team (CIT), palliative care teams, mental health teams day care and respite units, voluntary services/organisations or from a member of the public.

A1.3 The RPHN/RGN may identify a new patient in the community who requires a public health nursing intervention (case-finding). This patient is accepted to the caseload and is recorded as a referral accepted for the purpose of primary care metrics activity returns.

A1.4 Referrals may be received by the following means; written referral, verbal referral or self-referral. Written referrals can be received via current local Liaison PHN hospital referral systems or via existing local primary care team referral forms until the development of the national primary health care team ehealth referral form under development has been finalised. Referrals from health professionals are requested /received in written format.

A1.5 Written referrals when received are date stamped on the date it is received by the receiving RPHN/RGN or designated officer. This is recorded as the date the referral is received. Self-referrals (person presenting directly to the service) should be documented in the desk diary, on a primary care referral form or via other local agreed systems used to record this information.

A1.6 If the referral has been received verbally, unless a self-referral, the RPHN/RGN requests a written referral from the referrer. The RPHN/RGN must use their professional judgement as to whether a nursing action is required in the interim until the written referral has been received.

A1.7 Referral information should contain the following patient demographic details; full name and address, eircode, telephone no., date of birth, contact person name and telephone number, GP and medical card number. The information should indicate whether the patient is aware of and consents to the referral. Additional information available from the patient regarding specific entry requirements to the property should be included as appropriate. Eg. gate codes, directions to obscure rural properties, aggressive animals etc. The referral should also include the name, professional grade and contact details of the referrer.

A1.8 The RPHN/RGN must be satisfied they have sufficient information in order to proceed to preliminary screening/nursing assessment. Additional background information where required by the RPHN/RGN is sought from the referrer or from the person directly for self-referrals. If the clinical information on the written referral received is insufficient the RPHN/RGN should contact the referrer requesting that complete information is provided.

A1.9 Following the receipt of a referral a process of preliminary screening is carried out by the receiving RPHN/RGN to determine if nursing intervention is required. Where a nursing need is identified, the patient is accepted to the caseload. Preliminary screening of referrals received should be undertaken in a timely manner and may take place via direct face to face contact or by telephone (refer to section 1.6).

A1.10 The referrals accepted are then prioritised (refer section 1.6) in accordance with the reason for referral, nursing intervention required, professional judgement and relevant local agreed policy.

A1.11 Referrals not accepted can include inappropriate referrals (refer to section 1.5), referrals for patients that do not require a PHN service and situations where the referred person declines the service (refer to section 1.2).

A1.12 If it is determined that the referred person accepted to the caseload was previously known to the PHN service, the RPHN/RGN retrieves the record from archives and continues to document in this existing clinical nursing record. If it is a new patient the nurse starts a new clinical nursing record.

A1.13 If the patient has transferred into the area from any other RPHN area where they have been in receipt of a service, to ensure continuity of care the clinical nursing record is formally requested through local agreed systems with the patient's knowledge. If the patient has moved to a new area in a short-term temporary capacity ie holidays, a letter out-lining the current nursing needs and care plan is requested/supplied by the previous RPHN. All clinical information should be provided in a timely manner.

A1.14 While waiting for the record to transfer the RPHN/RGN commences a new record and combines with the original record once it is received in accordance with GDPR requirements. If the original received is in an older format a new record is created and the old record received is added into the newest format.

A1.15 In the interests of patient safety and continuity of care the RPHN/RGN may contact the previous nurse/caseload holder to discuss the care plan while awaiting the receipt of the original record.

A1.16 A lone worker risk assessment is completed in accordance with the national *HSE Policy on Lone Working* (2017a) and with local PHN department policy for new patients unknown to the PHN service based on the information supplied and on individual judgement. Completion may be required for patients previously known to the services where risk factors have changed. Any concern a RPHN/RGN has in relation to lone working must be discussed with her ADPHN/line manager (Appendix X and XI for supplementary guidance).

A1.17 On accepting a referred patient to the caseload a nursing assessment is carried out. The RPHN/RGN will contact the referred person to clarify if they are aware that a referral has been made to the PHN service and seek their view of their nursing need. The nurse seeks verbal consent to conduct a nursing assessment, the consent is documented in the clinical nursing record and an appointment time is agreed. The patient is informed by the RPHN/RGN that they can withdraw consent to a nursing intervention at a later stage if this is their choice.

A1.18 The RPHN/RGN will commence a comprehensive and holistic nursing assessment of the patient in their home/or most appropriate setting

using the model of nursing and evidence-based assessment tools as provided for within the community clinical nursing record.

A1.19 The nursing action and the nursing plan of care is discussed and agreed between the RPHN/RGN and the patient and/or carer/named contact person where appropriate. Discussion with the patient should include self-management goals. A care plan is prepared and documented in the patient's clinical nursing record. Referral onwards to other health and social care services is completed following discussion and agreement with the patient and/or carer.

A1.20 The RPHN/RGN agrees a care review date with the patient. The frequency of visits will be based on current assessed nursing need.

A1.21 All nursing equipment supplied is documented in the clinical nursing record and on the caseload register.

A1.22 The RPHN/RGN should document the date the patient is accepted to the caseload, the source of the referral and the care review date agreed in the clinical nursing record, in the nurse's/team diaries and on the caseload register.

A1.23 All activity on referrals accepted to the caseload is included in the relevant monthly primary care activity metrics in accordance with the definitions within the Primary Care Metrics Definitions Workbook. (HSE, 2019)

A1.24 The RPHN/RGN must follow the additional guidance of the current HSE Safeguarding of Vulnerable Persons procedures for the management of nursing referrals received in relation to vulnerable adults with identified safe-guarding needs (HSE, 2014a). Children First guidance and procedures (HSE, 2018b) will be followed as required for all patients under 18 years of age. All nursing concerns in relation to the care of vulnerable persons must be discussed with the relevant ADPHN/line manager. A risk assessment incorporating best available evidence may be required.

A1.25 To facilitate Integrated Discharge Planning the RPHN/RGN should as required liaise with the acute hospital service discharge/patient flow co-ordinator, bed manager, the Liaison PHN, or other relevant personnel to

identify all issues pertinent to likely discharges home. An interdisciplinary plan of care for the patient is agreed where appropriate.

A1.26 All referrals of postnatal mothers received are accepted and prioritised for early home visiting (Department of Health, 1966, 2000). In line with HSE key performance indicators (HSE, 2012a) this first visit should occur within 72 hours of discharge from the maternity service and home birth service.

2.7.2 Referral when the person (with capacity) has not given consent to a service

A2.1 A new person referred may choose not to consent to a nursing service that has been recommended by the RPHN/RGN following preliminary screening. The person's decision to not consent to a nursing service is respected and the person's autonomy is recognised. (HIQA, 2016)

A2.2 The benefits of accepting and the risks of not accepting the care intervention are discussed where possible with the person referred and/or carer where appropriate. The RPHN/RGN clarifies that all this information has been understood. The RPHN/RGN's recommendation for nursing care, a summary of the discussion and the final outcome is recorded in writing in accordance with local agreed procedures.

A2.3 Contact details and information for the PHN service are given to the person and they are advised that they may make contact should they require a nursing service in the future. This information is documented and filed in accordance with agreed local procedures.

A2.4 A newly referred person that does not consent to a nursing service professionally recommended is entered as a referral not accepted onto the PHN caseload for monthly primary care activity metrics in accordance with the definitions within the Primary Care Metrics Definitions Workbook (HSE, 2019).

A2.5 Where deemed appropriate the RPHN/RGN should inform other primary care team professionals involved in the care of the person and discuss with the ADPHN/line manager as appropriate. The referrer is informed where possible, that the person referred has not given consent to a nursing service (Appendix IX). All actions are documented and filed in accordance with local agreed procedures.

2.7.3 Vulnerable Person referred who has not consented to a nursing service

A3.1 The RPHN/RGN must seek a balance in respecting the person's rights, assessing risk and protecting the person from harm in meeting his/her professional responsibilities. (HSE, 2014a) (HIQA, 2016)

A3.2 All nursing concerns in relation to the care of vulnerable persons must be discussed with the relevant ADPHN/line manager and a risk assessment incorporating best available evidence completed. (HSE, 2011c, 2009c)

A3.3 Where a referred person has not consented to a recommended nursing service and the RPHN/RGN's professional judgement deems that this person is vulnerable requiring safeguarding, the RPHN/RGN must discuss with their ADPHN/line manager. If following this discussion the person is deemed vulnerable as defined by the *HSE Safeguarding of Vulnerable Persons at Risk of Abuse National Policy and Procedures* the RPHN/RGN must report his/her concerns in writing to the safeguarding and protection team (HSE, 2014a), (NMBI, 2015b).

A3.4 The referred person is informed of this referral to the safeguarding and protection team. The GP and other key health professionals involved in the persons care are informed as appropriate of the referral and made aware that the referred person has not consented to a nursing service. A professional team meeting that includes the RPHN/RGN, the GP and other relevant primary care team professionals should be considered to safely address concerns arising.

A3.5 The RPHN/RGN documents the following in accordance with local agreed procedures; the RPHN/RGN's professional recommendations for care intervention, the discussion with the referred person in relation to these recommendations, the referred person's understanding of this discussion where appropriate and that the referred person has not consented to the service. It is documented if a referral has been made to the safeguarding team and that the GP and other key health professionals were informed on a need to know basis. A copy of any referral letter sent to the safeguarding and protection team is filed with this record.

2.7.4 Referrals from third parties (non-Health Care Professional)

A4.1 The RPHN/RGN establishes from the referrer if the person has consented to this nursing referral on their behalf. If the referred person has not consented, the reason for the referrer's concerns is clarified. It is not appropriate for the RPHN/RGN to discuss the details of the referred person's health circumstances with third parties.

A4.2 The RPHN/RGN must seek permission from the referrer to disclose the referral source to the referred person and document this in accordance with local agreed procedures. If the referrer is making this referral in confidence for the benefit of the referred person, the contact details and any identifying factors should be held confidentially and not disclosed to the referred person. The referrer is informed that confidentiality cannot be guaranteed in the event of legislative proceedings.

A4.3 In the absence of permission to disclose the referral source the RPHN/RGN must exercise professional judgement on how to proceed. This may include a discussion with the ADPHN/line manager where required. All actions are documented in accordance with agreed local management procedures.

2.7.5 Inappropriate referrals (referrals not accepted)

A5.1 Following preliminary screening the RPHN/RGN may have received referrals which are deemed inappropriate i.e. a person not requiring a nursing intervention.

A5.2. If no nursing need is identified following preliminary screening the referred person is not accepted to the caseload. The rationale for the decision not to accept a referral to the service is explained to the referred person. This decision is documented and filed in accordance with local agreed procedures (Appendix VIII). Guidance is provided to the referred person about other primary care services available where relevant. Contact details for the PHN service are given in writing should they need to self-refer at a future date.

A5.3 When no written referral documentation is received, a record of the face to face contact and/or referral telephone call received is documented and filed in accordance with local agreed procedures. The professional reason for the decision that the referral is inappropriate should be noted.

A5.4 The nurse should note that the decision that deems the referral inappropriate is based on the information received from the referrer and on the nurse's professional judgement. (NMBI, 2015b)

A5.5 Where a referral to the PHN service is deemed inappropriate following preliminary screening, the source of the referral (referrer) is informed of this outcome in accordance with local agreed procedures.

A5.6 The contact details of other relevant health or social care services are provided to the referred person where appropriate.

A5.7 All activity on referrals not accepted to the caseload is included in the relevant monthly primary care activity metrics in accordance with the definitions within the Primary Care Metrics Definitions Workbook (HSE, 2019).

2.7.6 Timely management of referrals accepted

A6.1 Preliminary screening of referrals should be undertaken in a timely manner and a decision is made to accept or not accept the referred person to the service based on the outcome of assessed nursing need. This decision is based on the nurse's professional judgement (NMBI, 2015b) which is guided by local agreed management policy.

A6.2 The following principles should guide the timely management of referrals accepted to the PHN service; professional autonomy and accountability (NMBI, 2019, 2015a, 2014) equity of access to the service based on clinical need, a person-centred approach to care, best practice evidence available and consistency with Department of Health (2017) and HSE policy (HSE, 2018a). Referral criteria for the PHN service has not been included within this procedure at this time until the scope and impact of Slaintecare implementation plans on eligibility and access to Irish healthcare are determined.

A6.3 In circumstances where the demand for nursing service exceeds the available nursing resource at a given point in time, referrals accepted will be prioritised. Prioritisation decision making is based on the nurse's clinical assessment and professional judgement which is guided by agreed local management prioritisation policy. The RPHN/RGN informs the ADPHN/line manager of periods of excess demand. A collaborative plan is prepared and implemented to safely manage service delivery during this period.

A6.4 The PHN service *Referrals Accepted Prioritisation Guidance Document* (Appendix VII) provides illustrative examples for each priority level.

Priority 1 Referrals Accepted: Seen within 0-7 working days based on professional judgement

- patients referred requiring an essential nursing intervention; ie medication administration, wound care, indwelling urinary catheter care etc
- patients referred for end of life care and palliative care
- frail patients under care of specialist geriatric services
- patients referred deemed vulnerable requiring safeguarding
- patients referred for home supports with limited social supports in

place
- patients with chronic complex medical conditions for nursing support
- children with complex medical need requiring direct nursing intervention
- high dependency patients requiring multiple nursing interventions
- patients referred for continence management impacting on skin integrity
- Direct Observational Therapy for patients with Tuberculosis not following prescribed treatment
- first visit to mothers of new born babies

Priority 2 Referrals Accepted: Seen within 8 working days and 12 weeks based on professional judgement

- patients who have had convalescence with relatives, now returned to own home
- patients referred for routine primary preventative care and health promotion activity
- patients referred for Common Summary Assessment Record (CSAR), Home Supports Services (HSS) assessment with social supports in place
- patients with chronic stable medical conditions
- patients referred for general continence management support
- children with complex medical need where parents require nursing support
- routine referrals to avail of day care, respite services and other support services

A6.5 The above are illustrative examples for each priority level only and are based on normal staffing levels within the service. It should be noted that professional judgement on individual clinical cases is required and this may necessitate further discussion with the relevant ADPHN/line manager.

A6.6 If a referred patient accepted to the caseload is placed on the PHN service waiting list for a nursing assessment by the RPHN/RGN, the patient's situation and clinical need is monitored by the RPHN/RGN as required relative to the length of the current waiting list. The patient is informed that they are on a waiting list. The national HSE target to see new patients is within 12 weeks (HSE, 2012a).

A6.7 Details of accepted patients assigned to a waiting list for assessment must be maintained by the RPHN/RGN and discussed with the relevant ADPHN/line manager. A risk assessment should be carried out by the RPHN/RGN as required in line with agreed local management policy to highlight the potential clinical impact on the patient and on service

provision.

2.7.7 Requirements from the referral source

A7.1 To facilitate advance and integrated discharge planning from the acute hospital services, where required, the referring professional should contact the community nursing service through the established communication systems to discuss nursing needs and care planned. The liaison PHN should be included in hospital discharge planning discussions and meetings as appropriate where this liaison post is available. The RPHN/RGN should be invited to the hospital discharge planning meeting for patients with complex health needs. A written record of the discharge plan agreed in partnership with the patient/family is shared with the assigned RPHN/RGN and this is inserted into the patient's community record.

A7.2 The protection and safety of the public health nursing team is of paramount importance. It is essential that any factual information known relating to a specific referral that poses a risk to the personal safety of the RPHN/RGN is disclosed in an appropriate manner (HSE, 2018d Page 11).

A7.3 Patients referred from acute hospitals that require prescribed medication administration or prescribed wound therapy should have essential items provided to meet the patient needs that are not immediately available locally in service/pharmacy. Specialised essential nursing equipment is not available locally in the community and time will be required to seek funding and arrange order and delivery.

A7.4 Public health nursing team members have a wide range of expertise and skills but certain specialised procedures may not be carried out on a regular basis and therefore time may be required to complete the necessary refresher training. DPHN's cannot accept clinical governance in these situations until the relevant up-skilling occurs and the RPHN/RGN is professionally competent to deliver the prescribed intervention.

A7.5 Where no prior discussion and agreement has taken place with the referring professional, time, frequency and location for nursing intervention will be determined following assessment by the RPHN/RGN and this will be agreed directly with the patient.

A7.6 Community nursing services may be withdrawn from patients who are verbally or physically aggressive or where family members/carers present in the home are verbally or physically aggressive. (HSE, 2018d) These situations are discussed with the line manager, a risk assessment (HSE, 2011c, 2009c) completed and agreed local management procedures are followed.

2.7.8 Framework for the Management of Patients Accepted/Caseload Profile

A8.1. The following dependency framework has been adopted from the *Population Health Information Tool (PHIT)* (HSE/ONMSD, 2011). This framework is similar in structure to the one devised by Freeman et al, (1999). Each patient is assigned a dependency score from a four item scoring list which includes: health promotion, short term care, chronic stable care and chronic complex care. Rates of low to highly dependent patients can then be ranked within each PHN caseload.

A8.2. Patient dependency may be physical, psychological or social. *"the level of nursing intensity has a direct impact on the level of nursing workload and is influenced by the dependency of the patient on the nurse, the severity of the patient's illness, the time taken to administer patient care and the complexity of the care required in order to care appropriately for the patient"* (Morris et al., 2007 *cited in PHIT 2011).*

A8.3. This framework (Appendix XII) is utilised to assist the nurse in categorising the dependency of the patient on the PHN caseload, facilitating effective caseload management and allocation of nursing resources. A dependency score is allocated based on the nursing needs identified on assessment. It reflects the level of nursing intervention required and the patient's dependency on the PHN service. The patient may move from one level of dependency to another as their condition changes. The dependency score will be recorded in accordance with local agreed management procedures. The score will be revised and recorded following any subsequent assessments/reviews. Patients may move from one level of dependency to another as their condition changes.

A8.4. **Nursing Intervention 1 – Low Dependency (Code Green)** Patient assessed and has **no** direct clinical nursing need. Patient has a care plan that may include the following; provision of aids and appliances, health promotion activity, receipt of continence wear, risk reduction (pendant

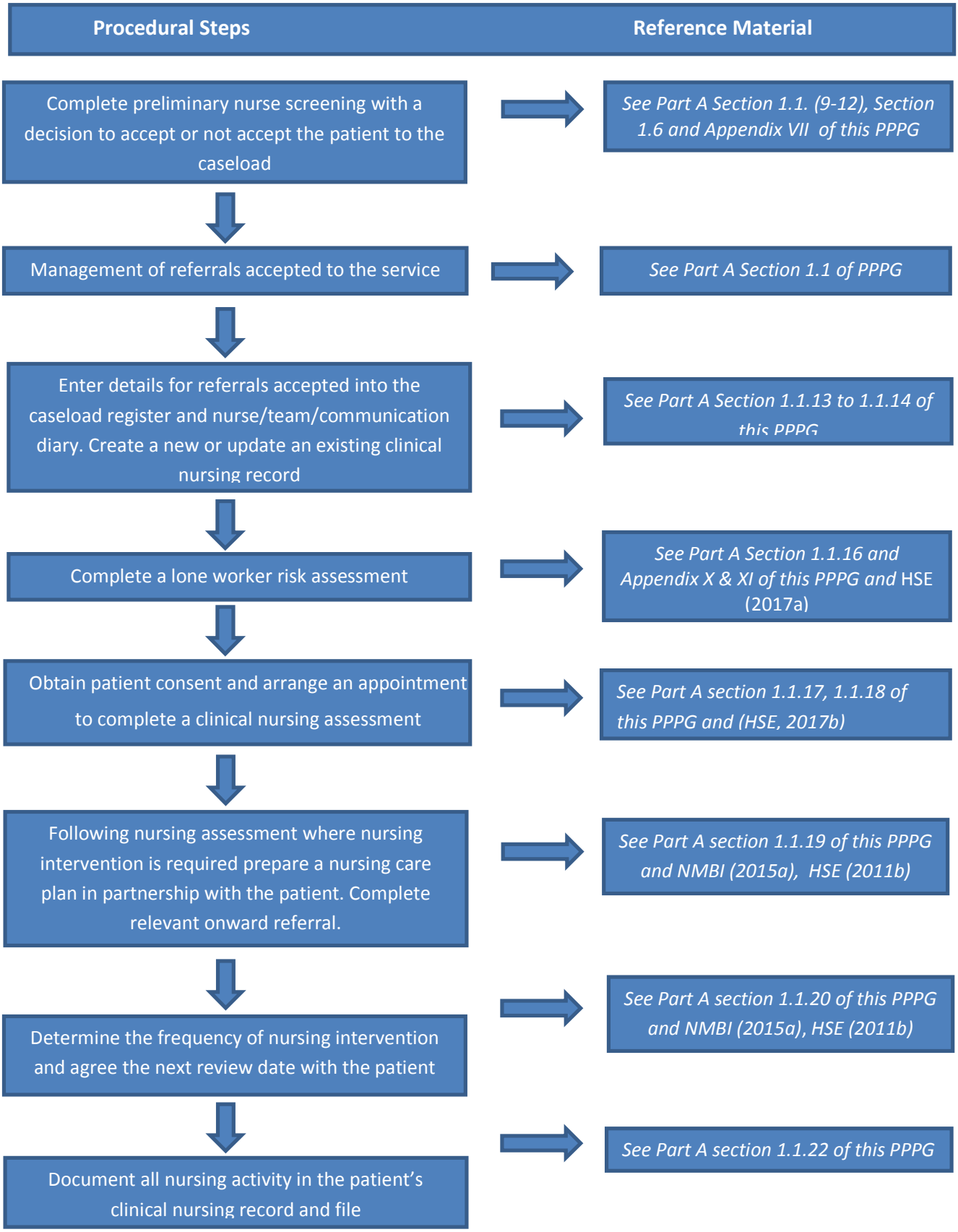
alarm), day care, assistance with personal care from Health Care Assistant /Home Help.

A8.5. **Nursing Intervention 2 – Medium Dependency (Code Blue)** Patient assessed as having an estimated length of care of up to 12 weeks, short term direct or indirect nursing care in the clinic or home. The patient has a care plan in place that may include the following; administration of medication, wound care, community rehabilitation. Any nursing intervention required beyond 12 weeks is re-assessed and re-ranked as Nursing Intervention 1, 3 or 4. (with the exception of any medication required on a three monthly basis Eg. vitamin B 12 injection).

A8.6. **Nursing Intervention 3 – High Dependency (Code Yellow)** Patient assessed as having a continuing need for direct nursing care but their condition is stable. The patient has a care plan in place that may include the following; nursing management of chronic stable conditions, a palliative care condition requiring psychosocial care/nursing interventions.

A8.7 **Nursing Intervention 4 – Maximum Dependency (Code Red)** Patient assessed as requiring continuing nursing intervention for complex needs that involves high dependency care, case management, co-ordination and advocacy in a constantly changing environment. The patient has a care plan in place that may include the following; end stage palliative care.

2.7.10 Process map of procedure



PART B: PPPG Development Cycle

1.0 INITIATION

1.1 Purpose

The purpose of this procedure is;

1.1.1 To provide guidance to RPHN's and RGN's working in the community on the appropriate procedure for managing referrals accepted to the Public Health Nursing service that is underpinned by a person centred approach. This procedure applies to situations where the nursing resource within the service is at normal staffing levels. (A separate guideline is available applying to situations when nursing resources are not at normal staffing levels. (HSE, 2017c))

1.2 Scope

The scope of this procedure identifies what will be covered by the procedure

1.2.1 **Target users;** this procedure applies to registered nursing staff in the Public Health Nursing service nationally. This includes Directors of Public Health Nursing, Assistant Directors of Public Health Nursing, Public Health Nurses, Registered General Nurses, Registered Midwives and locum/agency nurses working in the community.

1.2.2 **Population to whom it applies;** this procedure applies to all children referred for a clinical nursing service and all adults referred, including postnatal mothers. It excludes children referred as part of the National Child Health Screening Programme and referrals in relation to child welfare/protection concerns. This procedure does not apply to nurses working in specialist services or to their patient caseload. e.g. specialist palliative care, specialist continence service, specialist tissue viability service, specialist disability services or community rehabilitation teams.

1.3 Objectives

1.3.1 To ensure all referrals accepted are managed appropriately, to promote positive clinical outcomes and the delivery of an equitable service to patients underpinned by a person-centred approach.

1.3.2 To ensure all referrals accepted are dealt with in a timely manner based on a prioritised system of greatest clinical need.

1.3.3 To promote the effective management of PHN caseloads, leading

to more efficient use of nursing time and resources.

1.3.4 This procedure aims to ensure that the nursing needs of the patient are identified and a comprehensive nursing plan of care is formulated in partnership with the patient, carer and/or named contact person to meet the patient's needs.

1.4 Outcomes

1.4.1 The implementation of national standardised processes on the management of referrals accepted to the PHN service locally, increasing the effectiveness of PHN caseload management.

1.4.2 The reason for accepting a referred person is clear, it is directly linked to the care plan and the clinical nursing record contains documented evidence on all aspects of the referral process.

1.4.3 Standardised and accurate national nursing activity metrics will be available to facilitate HSE service planning.

1.5 PPPG Development Group

1.5.1 See Appendix II master copy for Membership of the PPPG Development Group.

1.5.2 See Appendix III master copy for PPPG Conflict of Interest Declaration Forms.

1.6 PPPG Governance Group

1.6.1 See Appendix IV master copy for Membership of the Approval Governance Group.

1.7 Supporting Evidence

1.7.1 **Relevant Legislation and PPPGs;**

Department of Children and Youth Affairs (2015) *Children First Act*
Department of Health and Children, (1970) *Health Care Act*
Department of Health and Children, (2001) *Primary Care: A New Direction*
Department of Health and Children, (1966) *Circular 27/66* District Nursing Service
Department of Health and Children (2000) *Circular 41/2000*
Department of Health and Children (2000) *Job description of the Public Health Nurse*
HSE (2019) Primary Care Activity Metrics Workbook: PHN/CRGN Definitions 2019

HSE (2014) *Safeguarding Vulnerable Persons at Risk of Abuse: National Policies & Procedures*

HSE (2011) *Population Health Information Tool Changing Practice to Support Service Delivery*

Nursing and Midwifery Board of Ireland (2015) *Recording Clinical Practice Professional Guidance.*

Nursing and Midwifery Board of Ireland (2015) *Scope of Nursing and Midwifery Practice Framework.*

Nursing and Midwifery Board of Ireland (2014) *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives.*

1.7.2 Existing local CHO procedures on the referral of a patient to the PHN service informed the development of this procedure. This national procedure replaces any previously developed local procedures. (See Section 8.0)

1.7.3 **Related Legislation and PPPGs;**

Department of Health (2018) *Slaintecare Implementation Strategy*

Department of Health (2018) *Towards a Model of Integrated Person-centred Care*

European Parliament and Council (2016) *General Data Protection Regulation (EU) 2016/679*

Government of Ireland (2018) *Data Protection Act*

Government of Ireland (2017) Houses of the Oireachtas Future of Healthcare Committee – Slaintecare – a plan to radically transform the Irish health service

HIQA (2016) *Supporting Peoples Autonomy: a Guidance Document*

HIQA (2015) *Guidance for Providers of Health and Social Care Services: Communicating in Plain English*

HIQA (2013) *Guidance on Developing Key Performance Indicators and Minimum Data Sets to Monitor Health Care Quality* Version 1.1

HIQA (2012) *National Standards for Safer Better Healthcare*

HSE (2017) Guideline for the Prioritisation of the Public Health Nursing Service in the event of Vacant Caseloads/Cross-cover DRAFT

HSE (2017) National Consent Policy

HSE (2017) Policy on Lone Working

HSE (2013) Record Retention Periods: Health Service Policy

HSE (2012) *Key Performance Indicator Guidelines Based on National Service Plan 2012 Version: 3rd*

HSE (2011) Risk Management in the HSE: an Information Handbook

HSE (2011) Developing and Populating a Risk Register: Best Practice Guidance
HSE (2011) Standards and Recommended Practices for Healthcare Records Management

HSE (2008) Code of Practice for Integrated Discharge Planning
HSE (2003) Data Protection and Freedom of Information Legislation Guidance for Health Services Staff

NMBI (2015) Public Health Nursing Education Programme Standards and Requirements

1.8 Glossary of Terms

1.8.1 Abbreviations:

ADPHN –	Assistant Director Public Health Nursing
AHP-	Allied Health Professional
CHO –	Community Health Care Organisation
CIT -	Community Intervention Team
CNSp –	Clinical Nurse Specialist
CSAR -	Common Summary Assessment Record
DOH-	Department of Health
DPHN –	Director Public Health Nursing
GP –	General Practitioner
GDPR -	General Data Protection Regulations
HIQA -	Health Information and Quality Authority
HCP -	Home Care Package
HSS -	Home Support Services
HSE-	Health Services Executive
ICT-	Information Communications Technology
NMBI-	Nursing and Midwifery Board of Ireland
NPDC-	Nursing Practice Development Co-ordinator
ONMSD-	Office of the Nursing and Midwifery Services Director
PC -	Primary Care
PCT-	Primary Care Team
PPPG-	Policy Procedure Protocol Guideline
RPHN –	Registered Public Health Nurse

RGN – Registered General Nurse working in the PHN service

1.8.2 **Definitions:**

Care plan: is the written record of the care planning process which incorporates identifying the patient's holistic needs, selecting the interventions that would improve the patient's condition and evaluating the patient's progress; assessment, diagnosis, intervention and evaluation.

Carer: is someone who is providing an ongoing significant level of care to a person who is in need of care in the home due to illness or disability or frailty. (DoH, 2012)

Case finding: is a one to one intervention for surveillance, disease or other health event investigation. It is frequently implemented to locate those most at risk. (Population Health Interest Group: ICHN, 2013)

Caseload: The number of persons / clients / patients managed by a health professional at a particular time. (NMBI, 2019)
For the purpose of this procedure the RPHN caseload is defined as the number of patients admitted to the PHN service who require continuing care, have a current nursing care plan and have a date for review by the nurse within the next 12 months. The caseload includes individuals within all categories and care groups: over 65 years, under 65 years, patients with disability and children. It includes all patients in receipt of home help support/home care package who may have no direct nursing intervention needs but require a regular nursing review in line with national and local policies, those in receipt of continence products and postnatal mothers and children receiving clinical care. For the purposes of this procedure it does not include children from birth to 4 years 11 months in receipt of the National Child Health Developmental Screening Programme. The area PHN has overall accountability for the caseload but works collaboratively with the RGN to actively manage the caseload.

Caseload Holder: for the purposes of this PPPG this is a RPHN or a designated community RGN that manages and carries the clinical responsibility for the delivery of community nursing services to an identified population within a defined geographic area.

Caseload Register: held by each RPHN/designated caseload holder this register includes demographic details of all patients on the caseload noting date of admission and date of discharge. This may also be referred to as the "Caseload Profile". As HSE national ICT systems develop the caseload register may be incorporated into a HSE Patient Information Management System.

Champion: individuals who dedicate themselves to supporting, marketing and driving through an innovation. (Greenhalgh et al., 2005)

Dependency Framework: this framework has been adopted from the Population Health Information Tool (PHIT) ONMSD (2011). Each patient is assigned a dependency score from a four item scoring list which includes: health promotion, short term care, chronic stable care and chronic complex care. The dependency of the patient on the caseload is rated from low to high. (refer to part A section 1.8)

Diary: in the context of this procedure the term diary refers to individual nurse's diary and/or team desk diary that are issued by the HSE each year to all nurses in the PHN service. The diary assists nurses to plan clinical interventions, manage resources, delegate activity, record scheduling of care and it assists effective communication among the nursing team. As HSE national ICT systems develop electronic scheduling systems may replace manual held diaries.

Direct Nursing Care: the nurse has direct (face to face) contact with the patient to provide a nursing intervention.

Evidence Based Practice: The conscious consideration and application of the best available evidence together with the nurse or midwife's expertise and a person's values and preferences in making health care decisions. (NMBI, 2019)

Health Care Record: All information collected, processed and held in either manual and / or electronic formats pertaining to a person under the care of a registered midwife or nurse or health care team, including personal care plans, clinical data, images, unique identification, investigation, samples, correspondence and communications relating to the person and his / her care. (NMBI, 2019) For the purposes of this procedure the health care record will be referred to as the clinical nursing record. As HSE national

ICT systems develop the clinical nursing record may become part of a shared interdisciplinary clinical electronic patient record.

Indirect Nursing Care: the nurse remains the case manager but delegates the care of the patient to another grade or agency.

Must: Commands the action a nurse or midwife is obliged to take from which no deviation whatsoever is allowed. (NMBI, 2019)

Nursing Intervention: Nursing is the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems and to achieve the best possible quality of life, whatever their disease or disability until death. Nursing interventions are concerned with empowering people and helping them to achieve, maintain or recover independence. It includes the identification of nursing needs, therapeutic interventions, personal care, information, education, advice and advocacy; physical, emotional and spiritual support. (Royal College of Nursing, 2003)

Patient dependency: may be physical, psychological or social. *"the level of nursing intensity has a direct impact on the level of nursing workload and is influenced by the dependency of the patient on the nurse, the severity of the patient's illness, the time taken to administer patient care and the complexity of the care required in order to care appropriately for the patient"* (Morris et al. 2007, cited in PHIT ONMSD 2011).

Person: A person means an individual who uses health and social care services. In some instances, the terms 'client', 'individual', 'patient', 'people', 'resident', 'service user', 'mother', or 'baby', 'child', 'young person' are used in place of the term person depending on the health or social care setting. (NMBI, 2019) For the purposes of this procedure the term patient will be used throughout.

Preliminary screening – this is an examination by the nurse of all information received both verbal and written from the referring source and phone or face to face contact with the patient/carer to assist in determining the appropriateness of the referral and the nursing intervention required.

Professional Judgement: For the purpose of this guideline, a nurse/midwife's professional judgement is based on the principles of responsibility, accountability and autonomy, as outlined within the NMBI's Scope of Nursing and Midwifery Practice Framework (2015, pages 17-18)

Referral received: A referral is defined as: 'an act of referring someone or something for consultation, review or further action' (Oxford English Dictionary (online), 2019). For the purpose of this procedure referral implies a request to the public health nursing service and this referral is completed when the nurse receives the referral communication, written or verbal and has taken appropriate follow up action.

Short-term Nursing Care: for the purpose of this procedure this is a short interval of care up to 12 weeks that involves direct/ indirect nursing care in the clinic or at home. This care may be continuous or it may consist of a series marked by one or more brief separations from care. ie wound care, medication administration.

Should: Indicates a strong recommendation to perform a particular action from which deviation in particular circumstances must be justified (NMBI, 2019)

Vulnerable Person: an adult who may be restricted in capacity to guard himself /herself against harm or exploitation or to report such harm or exploitation. Restriction of capacity may arise as a result of physical or intellectual impairment. Vulnerability to abuse is influenced by both context and individual circumstances. (HSE, 2014a)

2.0 DEVELOPMENT OF PPPG

2.1 List the questions (clinical/non-clinical)

Will the implementation of a national standardised process to manage referrals accepted to the PHN service promote a safer, more efficient and person centred community nursing service?

- What constitutes an appropriate referral of a patient to the service?
- How will referrals accepted be managed in an efficient and safe manner?

- How to ensure a person centred approach is evident during the referrals accepted process?

2.2 Describe the literature search strategy

Current local PPPG's on caseload management/patient referral to the PHN service were requested from DPHNs nationally. Seven guidelines were returned from five CHO areas. These were reviewed and relevant references within these local documents were sought and reviewed. (See Section 8.0)

The following websites were accessed between December 2017 and March 2018 to identify publications and guidelines that related to the subject area; Nursing Midwifery Board of Ireland, Health Information Quality Authority and Health Service Executive. These documents were reviewed.

A search was performed on the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database using the following search terms "*community nursing/district nursing*" AND "*referral criteria/guidelines*" and "*caseload management*" AND "*community nursing*" for articles of relevance. The search terms "*prioritising/prioritisation*" and "*community nursing*" were included too.

Only English language articles published after 2010 were initially included. This search produced only a small number of relevant articles. A number of articles specific to acute hospital referral criteria and referrals from community nursing identified in the search process were excluded for the purpose of this procedure. These documents were reviewed and references cited within were sourced and the search was extended to articles published after 2000. Twenty two articles relevant to this procedure were appraised; six Irish, eleven British, four American and one European. Five published reports from the UK and one Irish report relevant to the topic were also considered.

2.3 Describe the method of appraising evidence

This procedure draws on previous evidence appraisal, recommendations and PPPG revision work of local PPPG Development Committee's at CHO level.

There was plenty of evidence from an Irish context in relation to the Public Health Nursing Service in general terms but little that specifically related to referrals to the service and referral processes. Evidence was gathered from UK and international publications and the results produced a number of British articles concentrated between the period of 1999 and 2005 that specifically addressed referral criteria. This was as a result of the 1999 Audit Commission report "*A Review of District*

Nursing Services in England and Wales". The findings of the evidence for district nursing are relevant in an Irish context as while there are key differences in the scope of service provision between both services, the PHN service evolved from the UK's district nursing service which established in the late 1800's.

2.4 Describe the process the PPPG Development Group used to formulate recommendations

- What evidence is available to answer the clinical questions?
- What is the quality of the evidence?
- Is the evidence applicable to the Irish population and healthcare setting?
- What is the potential benefit verses harm to the population/patient?

A preliminary draft of this procedure was prepared based on existing local procedures approved and from evidence gathered in the literature review. The draft was circulated to all PPPG development Group members for review and agreed amendments made. The first draft of this procedure was circulated to all DPHNs nationally for consultation and feedback on recommendations. An assessment was made for the ability of the service to operationalise any new recommendations made and a final draft was prepared to include all the relevant feedback received. The final draft of the procedure was submitted to the National Community Operations Division and to the Office of the Nursing and Midwifery Services Director for approval.

Recommendations within this PPPG reflect the agreed definitions that govern the collection of primary care metrics. The clinical activity of the public health nursing service is recorded and returned monthly via nationally agreed primary care metrics. The National Primary Care Metrics Sub Group for Public Health Nursing developed a national metrics definitions workbook for the service to guide practice on recording this activity. Developing these definitions included a consultation process with all community nurses. Final definitions were approved by the HSE National Primary Care Metrics Technical Group.

Recommendations within the procedure are based on the national and international evidence found in the literature search set within the context of the current health programme underway in Ireland. For this reason, referral criteria for the PHN service has not been included within this procedure at this time until the scope and impact of Slaintecare implementation plans on eligibility and access to Irish healthcare are

determined.

2.5 Provide a summary of the evidence from the literature

Recent social and economic trends have placed increasing demands on community nursing services, not just in Ireland but internationally too. This has resulted in increasing caseloads, workforce pressures and associated risks.

A community nursing service to be effective must have defined service objectives, establish systematic methods to review caseloads and target available resources to areas of greatest nursing need. In order to do this effectively clear referral criteria must be agreed for the service. (Audit Commission, 1999, Health service Audit, 2001, Botting, 2003, Queen's Nursing Institute, 2002)

The UK's Audit Commission's report (1999) recommended that the number of patients on a community nurses caseload and the number of nursing contacts must be available to justify spending and provide value for money. Care being provided must be to the right patients. In the absence of a clearly defined scope inappropriate referrals will feature. This UK audit identified that one in ten referrals to community nursing were inappropriate. Three reasons were given; referral would have been more appropriate if sent to the GP practice nurse, discharged inappropriately to the District Nursing team as required local services not in place and the final reason was that no nursing care was required. District nursing teams reported at the time that information was inadequate in one in five referrals and misinformation occurred in one in ten cases. Incorrect personal information was problematic and it was not clearly stated in some referrals whether the patient was aware of their diagnosis. The 1999 Commission identified the lack of caseload review as a weakness within the service.

Following on from this audit the Royal College of Nursing District Nursing Forum was focused on referral criteria for the service. This Forum produced *Referral Criteria – The Way Forward for District Nursing Services*, as a step-by-step guide to referral criteria. Referral criteria assists stakeholders understand what a service can and cannot do and reduce the likelihood of false expectations. (Botting, 2003) Secombe has argued that defining a need for district nursing is not straightforward but there is a requirement for a service's objectives to be clearly stated if it is to manage its resources efficiently and effectively (Secombe, 1995). A study by Aitken found a lack of knowledge and confusion on the role of

the Macmillan nurse potentially affected referrals and established a need for the development of a referral criteria (Aitken, 2006). Another qualitative study by Arnold et al., found ineffective referral criteria were identified as a prohibitive barrier for district nursing against making a greater contribution to health improvement. (Arnold et al., 2004)

Bower and Cook describe defining a person's need for community nursing as a "*notoriously subjective and contentious subject*". (Bowers & Cook, 2012)

Recent Irish health policy reform, a focus on chronic disease management and demographic change has all driven a shift to a greater emphasis on improving service delivery within primary care. (CSO, 2016; Department of Health, 2012; Department of Health, 2013b; TILDA, 2016)

Standards promote responsibility and accountability for the quality and safety of services provided. Best available evidence is utilised to promote healthcare that is up to date, effective and consistent. Standards for healthcare provide a basis for planning and managing services, measuring improvements and identifying gaps in the quality and safety of the services provided. Key dimensions of quality in healthcare delivery include: patient-centredness, safety, effectiveness, efficiency, access, equity and promoting better health. This means a service should strive to ensure patients are treated with respect and have the information they need to make decisions. Service providers should minimise inconsistencies and variations in service provision. (HIQA, 2012, HIQA 2016)

The Nursing and Midwifery Board of Ireland provides guiding principles to all nurses on responsibility, accountability and autonomy in relation to patient care. These outline expectations in meeting the standards of care of the profession and include sound professional judgement, nursing actions and omissions of care. (NMBI, 2015 & 2014)

A radical health reform programme is underway in Ireland as outlined in the Slaintecare Report (2017) and Slaintecare Implementation Strategy. Built on cross party consensus Sláintecare is a ten-year programme to transform the Irish health and social care services. Over the next ten years it plans to: promote the health of the population to prevent illness, provide the majority of care at or closer to home, create a system where care is provided on the basis of need and not ability to pay, move the system from long waiting times to a timely service especially for those who need it most and create an integrated system of care, with

healthcare professionals working closely together (Department of Health, 2018). In July 2019, the Department of Health announced the planned establishment of six new regional integrated healthcare areas that will geographically align acute hospitals and existing Community Health Organisations and will be responsible for planning and delivering health and social care in their regions. These new regional bodies will have clearly defined populations and will plan, resource and deliver health and social care services for the needs of its population. (Department of Health, 2018 and 2019)

The concept of monitoring and evaluating healthcare is evident in published and grey literature for many years both within the nursing profession and within the wider health arena. Measuring activity provides an indicator to the quality of care provided, measures performance and outcomes, sets a benchmark for comparison between services, facilitates the efficient management of resources and assists in reviewing the patient's experience of the service they receive. It assists in ensuring that services are delivered based on assessed need, promoting equity and it informs workforce planning. Clear referral criteria and processes for accepting patients onto the nursing caseload facilitate the active management of the PHN caseload and assists caseload profiling. (Hanafin, 1997a; Kane, 2016; O' Dwyer, 2012; Pye, 2011; Thomas, 2006)

The **QNI (2014)** review on workforce planning for district nursing found that most referrals received were manual via paper hard copy and via faxing. Many referrals were sent locally to the practitioner but there was evidence of movement towards a centralised referral system within Trusts. The referral or the assessment did not include details of complexity and associated weighting time. There was also a lack of focus on patient outcomes and planned discharge from the service. Focus group feedback as part of this review expressed a desire to improve referral and discharge procedures for the service. Nurses wanted the service to be more patient focused looking at the patient journey, quality and reaching outcomes and not just focusing on the completion of nursing tasks.

A number of publications referred to the importance of utilising the "right nurse with the right skills" in relation to referrals to community nursing services. Standardising referral guidelines across teams/regions was deemed important as it offered better value for money, greater efficiencies, more equitable and promoted more innovation sharing than bespoke local approaches.

More recently, in 2014 the Auditor General on behalf of the Welsh Government completed a review of district nursing services across Wales. They issued a detailed report to each local health board on their findings and their recommendations for improvement. This was followed by a checklist for NHS board members in 2017 to support them in seeking assurance on the management of district nursing resources. One audit finding noted while there was documentation specifying services provided by health boards, many were out of date and not widely available to stakeholders referring patients to the service. Though referral criteria were in place these were out of date or inconsistently applied. Few regions used a referral form which resulted in key information about the patient was missing. Poor information can lead to ineffective visits, delay care and restrict the services ability to manage and monitor demand. The review found that many caseloads were not routinely reviewed, "*few caseloads closed but simply stretched to absorb new patients*".
Associated questions included on the Audit Office's 2017 checklist included; the availability of guidance on eligibility, referral forms and processes and whether this guidance had been shared and discussed with key stakeholder referrers. Another question addresses whether thresholds have been agreed for new referrals at times of high demand and if escalation procedures are in place for safety concerns. (Wales Audit Office, 2014 and 2017)

If activity metrics are valid they must measure what they were intended to measure and to be reliable they will produce the same result for different individuals carrying out this measurement. Accurate figures facilitate outcome measuring. (HIQA, 2013 & 2012)

Evidence gathered from existing local CHO procedures currently indicate there are variations in referral criteria and in how referral activity is currently measured nationally within the PHN service. This leads to variations of caseload size and the subsequent allocation of resources.

2.6 Detail resources necessary to implement the PPPG recommendations

Standardised systems need to be agreed at local level to support the retrieval of re-activated case notes for re-referred patients.
Measures will be taken to develop an electronic caseload register system that is capable of producing key statistical information as required on caseload activity to include referrals.

2.7 Outline of PPPG Steps/Recommendations

An outline of the procedural steps and recommendations to be followed are in Part A Pages 5 – 17.

3.0 GOVERNANCE AND APPROVAL

3.1. Outline Formal Governance Arrangements

This national procedure was commissioned by the HSE National Community Operations and the National PHN Primary Care Metrics Sub Group. Final approval of the procedure was issued from the sponsor and follow up reviews will be initiated from National Community Operations. Refer to Appendix IV for Membership of the Approval Governance Group. This national document will be submitted to the National Central Repository Office for referencing when this office is established.

3.2 List method for assessing the PPPG in meeting the Standards outlined in the HSE National Framework for developing PPPGs

National review of the draft procedure was undertaken with key stakeholders to identify any issues in presentation, clinical processes recommended within, recommendations for implementation and any further suggestions. These stakeholders included the following nursing professionals; frontline nurses in the PHN service, PHN service managers, HSE ONMSD, Higher Education Institutes (Nursing) and the Group Directors of Nursing Acute Hospital Service. The second draft of the document prepared following nursing service consultation was circulated to the Health and Social Care Professionals Office, GP National Clinical Advisor, the HSE Safeguarding Office, HSE Data Protection Office and HSE Community Operations Primary Care for review. All feedback received from the consultative process was considered by the PHN Referral Procedure Working Group convened specifically for this purpose (Appendix II). This working group consisted of members of the HSE National Primary Care Metrics PHN Sub Group and included all nursing grades in the service. Consensus was reached by this group on whether to accept or reject suggested amendments received. Subsequent changes were recorded and all feedback received is available with the master copy of the procedure. The PPPG Checklist (Section 3.4) was reviewed in conjunction with the final revised procedure to ensure compliance with the standards as outlined in the HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (2016). This completed checklist and the final draft of the procedure was submitted to the HSE National Community Operations and to the Office of the Nursing and Midwifery Services Director to confirm that all stages in the revision of the procedure had been completed and met the NCEC National Standards for Clinical Practice Guidance (NCEC, 2015). The procedure was approved for national implementation. A signed and dated master copy will be

retained within the Office of the Nursing and Midwifery Services Director (National PHN Service), Dr Steevens Hospital.

3.3 Attach any copyright/permission sought

No copyright or permissions are required in relation to this procedure.

3.4 Insert approved PPPG Checklist

Standards for developing Clinical PPPG	Checklist
Stage 1 Initiation	**Tick ✓**
The decision making approach relating to the type of PPPG guidance required (policy, procedure, protocol, guideline), coverage of the PPPG (national, regional, local) and applicable settings are described.	✓
Synergies/co-operations are maximised across departments/organisations (Hospitals/Hospital Groups/Community Healthcare Organisations (CHO)/National Ambulance Service (NAS)), to avoid duplication and to optimise value for money and use of staff time and expertise.	✓
The scope of the PPPG is clearly described, specifying what is included and what lies outside the scope of the PPPG.	✓
The target users and the population/patient group to whom the PPPG is meant to apply are specifically described.	✓
The views and preferences of the target population have been sought and taken into consideration (as required).	✓
The overall objective(s) of the PPPGs are specifically described.	✓
The potential for improved health is described (e.g. clinical effectiveness, patient safety, quality improvement, health outcomes, quality of life, quality of care).	✓
Stakeholder identification and involvement: The PPPG Development Group includes individuals from all relevant stakeholders, staff and professional groups.	✓
Conflict of interest statements from all members of the PPPG Development Group are documented, with a description of mitigating actions if relevant.	✓
The PPPG is informed by the identified needs and priorities of service users and stakeholders.	✓
Information and support is available for staff on the development of evidence-based clinical practice guidance.	✓

There is service user/lay representation on PPPG Development Group (as required).	X (Not required)

Stage 2 Development	Checklist
The clinical question(s) covered by the PPPG are specifically described.	✓
Systematic methods used to search for evidence are documented (for PPPGs which are adapted/adopted from international guidance, their methodology is appraised and documented).	✓
Critical appraisal/analysis of evidence using validated tools is documented (the strengths, Limitation's and methodological quality of the body of evidence are clearly described).	✓
The health benefits, side effects and risks have been considered and documented in formulating the PPPG.	✓
There is an explicit link between the PPPG and the supporting evidence.	✓
PPPG guidance/recommendations are specific and unambiguous.	✓
The potential resource implications of developing and implementing the PPPG are Identified e.g. equipment, education/training, staff time and research.	✓
There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care.	✓
Budget impact is documented (resources required).	**N/A**
Education and training is provided for staff on the development and implementation of evidence based clinical practice guidance (as appropriate).	✓
Three additional standards are applicable for a small number of more complex PPPG s: Cost effectiveness analysis is documented. A systematic literature review has been undertaken. Health Technology Assessment (HTA) has been undertaken.	**N/A**

Stage 3 Governance and Approval	Checklist
Formal governance arrangements for PPPGs at local, regional and national level are established and documented.	✓
The PPPG has been reviewed by independent experts prior to publication (as required).	✓
Copyright and permissions are sought and documented.	**N/A**

Stage 4 Communication and Dissemination	Checklist
A communication plan is developed to ensure effective communication and	✓

collaboration with all stakeholders throughout all stages.	
Plan and procedure for dissemination of the PPPG is described.	✓
The PPPG is easily accessible by all users e.g. PPPG repository.	✓

Stage 5 Implementation	Checklist
Written implementation plan is provided with timelines, identification of responsible persons/units and integration into service planning process.	✓
Barriers and facilitators for implementation are identified, and aligned with implementation levers.	✓
Education and training is provided for staff on the development and implementation of evidence based PPPG (as required). There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care.	✓

Stage 6 Monitoring, Audit, Evaluation	Checklist
Process for monitoring and continuous improvement is documented.	✓
Audit criteria and audit process/plan are specified.	✓
Process for evaluation of implementation and (clinical) effectiveness is specified.	✓

Stage 7 Revision/Update	Checklist
Documented process for revisions/updating and review, including timeframe is provided.	✓
Documented process for version control is provided.	✓

I confirm that the above Standards have been met in developing the following PPPG:

Name of PPPG: Referral of a Patient to the Public Health Nursing Service

Name of person signing off on the PPPG Checklist: Catherine Whitty

Title of person signing off on the PPPG Checklist:
National Practice Development Co-ordinator PHN Services
Signature of person signing off on the PPPG Checklist:

Date: 30th June 2019

This signed PPPG Checklist must accompany the final PPPG document in order for the PPPG to be approved.

4.0 COMMUNICATION AND DISSEMINATION

4.1. Describe communication and dissemination plans

A draft of the procedure was forwarded to all DPHN's nationally for review by their respective departments. Feedback was also sought from other key stakeholder groups such as General Practitioners, Higher Educational Institutions, HSE Primary Care and HSE Quality Improvement. All feedback submissions were analysed.

The PPPG working group established in November 2017 consisting of members of the National PHN Primary Care Metrics Sub Group reviewed all feedback received and a final draft of the procedure was prepared.

The final draft was submitted to HSE National Community Operations for operational approval and to the Office of the Nursing and Midwifery Services Director (ONMSD) for professional recommendation.

The approved document will be circulated to all DPHNs nationally for dissemination to their respective nursing departments and to other key stakeholders referring patients to the PHN service. A copy of the procedure is available on the HSE website to download at; National PHN Services: Primary Care; www.hse.ie/phn

Communication in relation to this procedure will clearly identify that it supersedes all previous referral procedures in place locally.

5.0 IMPLEMENTATION

5.1 Describe implementation plan listing actions, barriers and facilitators and timelines

As part of the exploring and preparing stage of implementation existing procedures in place in local CHO's were reviewed prior to preparing the first draft of this national procedure (See Section 8). The draft copy of the procedure prepared was circulated to all DPHN's for service review and feedback in February 2019. This assisted in assessing the ability of the service to implement the procedural recommendations made.

This referral procedure was one of two identified as key PPPG's to support the implementation of primary care metric activity collection and the standardisation of PHN caseload management. The second procedure developed was the discharge of patients from the PHN caseload. Referral of patients to the PHN caseload is a key clinical activity metric and this procedure supports the national standardisation of referral processes in the service.

On planning and resourcing, metrics champions were identified nationally in all CHO's from ADPHNs and frontline nurses. The role of the champion was to train and support nursing staff locally on the implementation of primary care metrics. Regional workshops to train champions were

delivered by the ONMSD PHN Service team. Champions once trained delivered workshops to local PHN departments under the direction of the DPHN and supported by the national PHN service team in the ONMSD. A data collection sheet and definitions workbook was developed that included specific detail to assist the accurate and standardised collection of referral data. National quarterly newsletters were disseminated to inform community nurses of all developments.

To implement and operationalize this procedure referral of patient activity will be monitored by the ADPHN on a monthly basis through metric activity returns. The ADPHN will assess the application of this procedure through team meetings, professional supervision sessions and through caseload audit reviews. Metric returns on referral activity will be monitored for completeness, consistency, accuracy; validity and timeliness to quality assure the data collected. The ADPHN will utilise this monitoring data to address any barriers to the implementation of the procedure and this will inform future revisions. Reports generated by the Business Information Unit on referral activity at CHO level and nationally will be circulated to frontline nurses and will inform quality improvement issues to be addressed locally in relation to implementation.

The implementation of this procedure supports nurses to ensure safe and timely caseload management and assists in monitoring individual and team performance against national metrics. This will be facilitated by ensuring that all community nurses understand and utilise this procedure.

5.2 Describe education/training plans required to implement the PPPG

Acceptance of referrals of patients to the PHN service was included as part of the training workshops delivered during the roll out of the national primary care activity PHN service metrics between June and August 2017. Communication with the Higher Education Institutes responsible for student PHN education occurred to ensure this procedure formed a component of the education module on caseload management. Local induction programmes for new nurses commencing employment will include briefing on all PPPGs approved for use within the PHN service.

5.3 Identify lead person(s) responsible for the implementation of the PPPG

The National Lead for Public Health Nursing and the National Practice Development Co-ordinator for the PHN service will lead on the national implementation of this procedure. An evaluation of the roll out of metrics occurred in November 2017 and this offered nurses an opportunity to provide feedback in relation to referral activity on caseloads. Post this

evaluation follow up national briefing sessions were delivered in early 2018 to frontline services. Further evaluation was conducted in 2018 with only minor amendments made to the wording of definitions in relation to referrals to provide greater clarity.

Within the Community Health areas the DPHN will be responsible in ensuring all nurses under her remit are aware of, have read and have signed the verification document (Appendix I) in relation to this procedure. Clinical activity within PHN caseloads to include referral activity will be recorded and monitored on a monthly basis by PHN management teams. All monthly activity will be reported to the Business Information Unit. Audit of the use of the procedure will be carried out as outlined in Section 6.1.2 of this procedure.

5.4 Outline specific roles and responsibilities

National Primary Care Metrics PHN Sub Group: The development of this specific PPPG is under the governance of this Group. On approval of this PPPG by HSE National Community Operations, the Group will ensure the final approved copies are circulated to all DPHNs nationally for dissemination to all PHN service teams. The procedure will be disseminated to key stakeholders within the acute hospital service and primary care. The Group will initiate an earlier review date for this procedure in the event of amendments to legislation, HSE policy or other related PPPGs.

National Governance Group for Quality Improvement in the Public Health Nursing Services: The National Governance Group established early in 2018 will be responsible for prioritising, developing, reviewing and recommending national PHN service PPPGs for use in the service and submitting these PPPGs to HSE Community Operations for approval. This PPPG will be reviewed as required on initial implementation based on feedback from local PHN departments via the National PHN Sub Group for Primary Care Metrics. The National Governance Group for Quality Improvement will take over this function when the Sub Group is disbanded. A review of this PPPG will be initiated as stated on the front page of the document. This Group will initiate an earlier review date in the event of amendments to legislation, HSE policy or other related PPPGs once the National Primary Care Metrics Sub Group is disbanded.

Director Public Health Nursing: The DPHN is responsible for workforce planning, implementing, managing and auditing this procedure within her area of responsibility. The DPHN will identify and support ongoing related

educational opportunities to further enhance knowledge and skills. The DPHN will ensure that all referral activity metrics for her department are returned in a timely manner to the designated person within the CHO.

Assistant Director Public Health Nursing: The ADPHN is responsible for the implementation of the guideline through ensuring that current documents are available to all nurses in health centres. The ADPHN is responsible for ensuring that all community nursing staff has knowledge of the procedures to be followed within the document. The ADPHN is responsible for ensuring new nurses are informed of the procedure on induction. The ADPHN is responsible for monitoring nursing referral practice in relation to the procedure and requesting amendments where appropriate. The ADPHN will ensure that all nurses are aware of any revisions to the procedure and ensure older versions of the procedure are removed from circulation. A database record of all nurses who have signed the signature sheet (Appendix I) will be maintained by the ADPHN and the DPHN will be notified of any noncompliance with sign-off of the procedure. ADPHN's are responsible for the collective return of referral activity metrics for their area of responsibility on a monthly basis to the DPHN.

Role of the RPHN and RGN: Each nurse is responsible for adhering to this procedure and to use it to guide their practice in the delivery of the service they provides. Each nurse is responsible for ensuring that they read and understand the document and sign the attached signature sheet. When areas of concern are identified, where legislation is known to have changed or where a health and safety risk is identified, it is the responsibility of each nurse to ensure that their ADPHN is informed in order to ensure appropriate review and amendments are made to the procedure. It is every nurse's responsibility to ensure they are working within their "Scope of Practice" at all times and that they identify their training needs to their manager to maintain standards of care. Within the procedure the nurse may have an educative/supportive, partial compensatory or total compensatory role (Orem, 1991) with the patient and family and must ensure that evidence based practice is implemented and documented. All nurses are responsible to return referral activity metrics on a monthly basis by the date deadline agreed with local nursing management.

Role of Nursing Practice Development Co-ordinator: The NPDC where in post support the development of excellence in the PHN service by promoting standardisation, quality assuring and evaluating nursing practice. They have a key role in the transfer of knowledge to frontline staff through the dissemination of current evidence based practice.

Role of Metrics Champion: Metrics champions are nominated nurses

from all nursing grades within the PHN service to provide local training, additional guidance and support with the role out of primary care clinical activity metrics. Referral of patients to the PHN service is one key metric activity. It is therefore important that nurses understand the criteria and management of referrals to the service.

6.0 MONITORING, AUDIT AND EVALUATION

6.1. Describe the plan and identify lead person(s) responsible for the following processes:

6.1.1. Monitoring of this procedure will occur by the ADPHN through professional supervision, caseload annual audit and monthly primary care activity returned.

6.1.2. Audit of the operation of this procedure will be initiated by the DPHN in consultation with the local audit lead at CHO or new regional integrated care area once developed. Good governance arrangements and an identified lead person are required to ensure systematic monitoring (HIQA, 2012). Audit will be carried out retrospectively by the designated person appointed by the DPHN. This designated person may be the area nurse, a nursing peer, the ADPHN or other. This procedure will be the standard for audit using the attached audit tool (Appendix V). The objectives of the audit will be to provide evidence of compliance to the national procedure, ensure standardisation of application of the procedure, identify areas for improvement, make recommendations and prioritise actions. Frequency of audit, sampling processes and timescales for completion will be determined at local level following the first initial audit.

6.1.3. Evaluation will be initiated by the DPHN/ADPHN and will occur through feedback at professional team meetings, direct patient feedback and through structured review surveys on the PHN service. Feedback from Your Service Your Say and through local formal complaints processes will be considered in any revision of the procedure.

7.0 REVISION/UPDATE

7.1 **Describe procedure for the update of the PPPG**

This procedure will be revised every three years on the date specified on the front page of the document. This review will be triggered by HSE National Community Operations and the National Governance Group for Quality Improvement PHN service.

7.2 **Identify method for amending PPPG if new evidence emerges**

Practitioners will assist in the revision of the procedure and also request an earlier review of this procedure where required if new evidence based practice is recommended.

7.3 **Complete version control update on PPPG Template cover sheet**
This is the first national version of a procedure for the management of referrals accepted to the PHN caseload.

8.0 REFERENCES

Aitken, A. (2006) District nurses' triggers for referral of patients to the Macmillan nurse. *British Journal of Community Nursing Vol. 11, No. 3 Pages 100 – 107*

Arnold et al., (2004) Exploring the contribution of district nurses to public health. *British Journal of Community Nursing Vol. 9 No. 5 Pg. 216-223*

Audit Commission (1999) *First Assessment: A Review of District Nursing services in England and Wales.* London, Audit Commission

Badger, F., Cameron, E. & Evers, H. (1989) District Nurses' patients-issues of caseload management, *Journal of Advanced Nursing,* 14(7), 518-527.

Begley, C., Brady, AM., Byrne, G., MacGregor, C., Griffiths, C., Horan, P. (2004) *A Study of the Role and Workload of the Public Health Nurse in the Galway Community Care Area.* TCD/HSE.

Botting, L. (2003) Referral Criteria – the way forward for district nursing services. *Primary Health Care*. *Vol. 13. No 6 Jul/Aug. pg 12-15*

Bowers, B. & Cook, R. (2012) Using referral guidelines to support best care outcomes for patients *British Journal of Community Nursing*, *Vol. 17, No 3 Pgs. 134 – 138*

Byrne, G. Brady, A.M. Horan, P. Macgregor, C. & Begley, C.(2007) Assessment of dependency levels of older people in the community and measurement of nursing
workload *JAN. Original Research* Blackwell Publishing Ltd.

Central Statistics Office (2016) Census 2016 CSO: Dublin.

Clark, D., Seymour, J., Douglas, H. et al. (2002) Clinical nurse specialists in palliative care. Part 2 Explaining diversity in the organisation and costs of Macmillan nursing services, *Palliat Med 16 (1), 375-85*

Coleman E., Boult C. (2003) Improving the quality of transitional care for persons with complex needs. *J Am Geriatr Soc* 51, 556-557.

Department of Health (2019) *Minister for Health confirms restructuring of health services and delivers key Sláintecare commitment.* Press Release 17/7/19: https://health.gov.ie/blog/press-release/minister-for-health-confirms-restructuring-of-health-services-and-delivers-key-slaintecare-commitment/ Accessed 19/7/19

Department of Health (2018) *Slaintecare Implementation Strategy* Government of Ireland: 2018 https://www.gov.ie/en/campaigns/slaintecare-implementation-strategy/ accessed 12th November 2018

Department of Health (2018) *Towards a Model of Integrated Person-centred Care. Findings from the Public Consultation on Geographic Alignment of Hospital Groups and Community Health Organisations.* Research Services and Policy Unit: Department of Health. Ireland

Department of Health (2013) Healthy Ireland – *A Framework for Improved Health and Wellbeing, 2013 - 2025.* Dublin: Department of Health.

Department of Health (2012) Future Health – *A Strategic Framework for Reform of the Health Service, 2012 -2015* Dublin: Department of Health.

European Parliament and Council (2016) *General Data Protection Regulation*: *Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016* https://eur-lex.europa.eu/legalcontent/EN/TXT/PDF/?uri=CELEX:32016R0679&from=EN

Accessed 9th May 2019

Fixen, D. L., Naoom, S. F., Blase, K. A., Friedman, R.M., & Wallace, F.. (2005) *Implementation Research: A synthesis of the literature* (FMHI #231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Freeman S, Shelly G, Gay M, Ingram B (1999) Measuring Service: A district nursing dependency tool. *Nursing Standard*, 13 (47) 39-41.

Greenhalgh, T., Robert, G., Bate, P., MacFarlane, F. & Kyriakidou, O. (2005)

Diffusion of Innovations in health service organisations: A systematic literature review Malden, MA: Blackwell

Government of Ireland (2018) *Data Protection Act (Number 7 of 2018*) https://data.oireachtas.ie/ie/oireachtas/act/2018/7/eng/enacted/a0718.pdf

Accessed 9th May 2019 and *General Data Protection Regulation*: *Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016*

https://eur-lex.europa.eu/legalcontent/EN/TXT/PDF/?uri=CELEX:32016R0679&from=EN

Accessed 9th May 2019

Government of Ireland (2017) *Slaintecare – a plan to radically transform Irish healthcare* Houses of the Oireachtas Future of Healthcare Committee: 2017 https://www.oireachtas.ie/en/press-centre/press-releases/20170530-future-of-healthcare-committee-publishes-slaintecare-a-plan-to-radically-transform-irish-healthcare/ accessed 12th November 2018

Government of Ireland (2015) *Children First Act 2015* Department of Youth and Children Affairs https://www.dcya.gov.ie/docs/EN/Children-First-Legislation/2758.htm accessed 12th November 2018

Hanafin, S. (1997a) The role of the Irish Public Health Nurse: manager, clinician and health promoter *Health Visitor Vol. 70 No. 8*

Health Information and Quality Authority (2016) Supporting People's Autonomy: a Guidance Document. Ireland HIQA.

Health Information and Quality Authority (2015) *Guidance for Providers of Health and Social Care Services: Communicating in Plain English.* Ireland HIQA

Health Information and Quality Authority (2013a) *Guidance on Developing Key Performance Indicators and Minimum Data Sets to Monitor Health Care Quality* Version 1.1 Ireland HIQA

Health Information and Quality Authority (2013b) *Guiding Principles for National Health and Social Care Data Collections.* Ireland HIQA

Health Information and Quality Authority (2013c) *National standard for patient discharge summary information*. http: www.hiqa.ie/publications/national-standard-patient-discharge- summary-information: accessed May 2016.

Health Information Quality Authority (2012a) *National Standards for Safer Better Healthcare.* Dublin: Health Information and Quality Authority.

Health Information and Quality Authority (2012b) *What you should know about Data Quality : A Guide for Health and Social Care Staff.* Dublin: HIQA

Health Information and Quality Authority (2011) *National Quality Assurance Criteria for Clinical Guidelines* Dublin, HIQA

Heath Services Audit (2001) *District Nursing Services in Northern Ireland.* Belfast, Health services Audit.

HSE (2019) Primary Care Activity Metrics and Definitions Workbook for the PHN Service 2019: HSE Community Operations/ONMSD

HSE (2018a) National Service Plan 2019
https://www.hse.ie/eng/services/publications/serviceplans/national-service-plan-2019.pdf Accessed March 2019

HSE (2018b) Children First Guidance
https://www.hse.ie/eng/services/list/2/primarycare/childrenfirst/
Accessed: 19th December 2018

HSE (2018c) *Nursing and Midwifery Quality Care Metrics: Public Health Nursing Research Report.* HSE Office of Nursing and Midwifery Services Director: Dublin.

Health Services Executive (2018d) *Policy on Management of Work-related Aggression and Violence* Accessed 7th May 2019
https://www.hse.ie/eng/staff/safetywellbeing/healthsafetyand%20wellbeing/policy%20on%20the%20prevention%20and%20management%20of%20work-related%20aggression%20and%20violence%202018.pdf

HSE (2017a) Policy for Lone Working
https://www.hse.ie/eng/staff/safetywellbeing/healthsafetyand%20wellbeing/policyonloneworking.pdf
Accessed March 2019

HSE (2017b) National Consent Policy QPSD-D-026-1.2 V.1.2 Dublin: HSE

HSE (2017c) *Guideline for the Prioritisation of the Public Health Nursing Service in the event of Vacant Caseloads/Cross-cover* ***Draft*** National DPHN Forum Working Group.

HSE (2016a) HSE National Framework for developing Policies Procedures Protocols and Guidelines (PPPGs) QPSD-D-015-1 HSE.

HSE (2016b) *The management of discharges of patients from a PHN caseload.* Public Health Nursing Services Co. Roscommon

HSE (2016c) *Policy on the Discharge of Patients from the Active Nursing Caseload* Public Health Nursing Services Co. Meath

HSE (2015) Discharging a patient from the caseload Public Health Nursing Services Carlow/Kilkenny; South Tipperary; Waterford; Wexford.

Health Services Executive (2014a) *Safeguarding Vulnerable Persons at Risk of Abuse: National Policy & Procedures Incorporating Services for Elder Abuse and for Persons with a Disability* Social Care Division HSE: Dublin.

Health Services Executive (2014b) *Discharge of Adult Patients from the Public Health Nursing Service* Public Health Nursing Services North Dublin

HSE (2013a) *Record Retention Periods: Health Service Policy*

HSE (2013b) Guideline: *Management of Referral of Patients from an Active PHN Caseload.* Public Health Nursing Service Longford & Westmeath

HSE (2013c) *Performance Management Framework and Service Plan 2014* Health Services Executive

HSE (2013d) Guideline: *Implementation of the dependency Framework in Public Health Nursing Clinical Caseloads* PHN 034 Version 2 January 2013 PHN Service Laois/Offaly and Longford/Westmeath

HSE (2012a) *Key Performance Indicator Guidelines Based on National Service Plan 2012 Version: 3rd*. HSE

HSE (2012b) *Performance Indicators* Kildare: Health Services Executive.

HSE (2011a) *Population Health Information Tool Changing Practice to Support Service Delivery* HSE Office of the Nursing and Midwifery Services Director: Dublin

HSE (2011b) *Standards and Recommended Practices for Healthcare Records Management* QPSD-D-006-3 V3.0 Dublin: HSE

HSE (2011c) *Risk Management in the HSE: an Information Handbook* OQR011 v5. Dublin: HSE

Health Service Executive (2009a) *Guideline for Nurse/Midwife Facilitated*

Discharge Planning, Dublin: Office of Nursing and Midwifery Services Director (ONMSD).

Health Service Executive (2009b) *Management of referrals into the Public Health Nursing Service*, Dublin: Health Service Executive.

HSE (2009c) Developing and Populating a Risk Register: Best Practice Guidance OQR010 Dublin: HSE

HSE (2008) Integrated Discharge Planning https://www.hse.ie/eng/about/who/qid/resourcespublications/indisdocs.html Accessed March 2019

HSE (2003) *Data Protection and Freedom of Information Legislation Guidance for Health Services Staff* Dublin: HSE

Holland D. Harris M. (2007) Discharge planning, transitional care, coordination of care, and continuity of care: clarifying concepts and terms from the hospital perspective. *Home Health Care Service Quality* 26, 3-19.

Instefjord M. Aasekjaer K. Espehaug B. Graverholt B. (2014) Assessment of quality in psychiatrist nursing documentation – a clinical audit *BMC Nursing,* 13, 32

Kane, K. (2016) Caseload analysis in district nursing: the impact on practice. *British Journal of Community Nursing* Vol. 13, No 12 pages 567 – 573

McDonald, A., Frazer, K. and Cowley, S. (2013) Caseload management: an approach to making community needs visible. *British Journal of Community Nursing*, Vol. 18, No. 3, pp. 140-47

National Directors of Public Health Nursing in partnership with Shannon, M. (2014) *Quality Integration and Collaboration: A Strategy for Community Nursing. Consultation Document* Dublin: Office of the Nursing and Midwifery Services Director, Health services Directive.

Naylor M. Aiken L. Kurtzman E. Olds D. Hirschman K. (2011) The importance of transitional care in achieving health reform. *Health Affairs* 30, 745-754.

Naylor M. Keating S. (2008) Transitional care *J Soc Work Educ* 44,

Supplement 65-73.

Newbury, J. & Hatherell C.A. (2004) Audit on discharging patients from community specialist palliative care nursing services*, International Journal of Palliative Nursing*, 10(1), 24-31.

Nursing and Midwifery Board of Ireland (2019) Standards & Guidance: Glossary of nursing and midwifery terms. https://www.nmbi.ie/Standards-Guidance/Glossary accessed March 2019

Nursing and Midwifery Board of Ireland (2015a) *Recording Clinical Practice Professional Guidance.* Dublin: NMBI

Nursing and Midwifery Board of Ireland (2015b) *Scope of Nursing and Midwifery Practice Framework* Dublin: NMBI

Nursing and Midwifery Board of Ireland (2015c) Public Health Nursing Education Programme Standards and Requirements Dublin: Ireland

Nursing and Midwifery Board of Ireland (2014) *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives.* Dublin*:* NMBI

O' Dwyer, P. (2012) *The Future Direction of the Community Nursing Service: Moving the focus of care to health priorities and delivering outcomes in the community* Dublin: Institute of Community Health Nursing

Office of the Nursing and Midwifery Services Director (2011) *Population Health information Tool (PHIT) Changing practice to support service delivery* Dublin: Health Services Executive.

Orem, D. E. (1991) Nursing: Concepts of Practice (4th Ed) St. Louis, MO: Mosby-Year Book Inc.

Oxford English Dictionary (online https://en.oxforddictionaries.com/?utm_source=od-panel&utm_campaign=en), accessed 15th March 2018)

Phelan, A. and McCarthy, S. (2016) *Missed Care: Community Nursing in Ireland*. University College Dublin and the Irish Nurses and Midwives Organisation,

Dublin.

Population Health Interest Group (2013) Public Health nursing in Ireland: Demonstrating interventions from practice. Institute of Community Health Nursing, Dublin.

Pye, V. (2011) Caseload Management. *Nursing in the Community* **Autumn 2011** Medmedia/ Irish Nurses and Midwives Organisation, Dublin

Queens Nursing Institute English National Board for Nursing, Midwifery and Health Visiting (2014) *2020 Vision: Focusing on the future of district nursing.* London, The Queen's Nursing Institute.

Queens Nursing Institute English National Board for Nursing, Midwifery and Health Visiting (2013) *Care in local communities: A new vision and model for district nursing.* London, The Queen's Nursing Institute.

Queens Nursing Institute English National Board for Nursing, Midwifery and Health Visiting (2002) *The Invisible Workforce.* London, The Queens Nursing Institute.

Roberson, C. (2016) Caseload management methods for use within district nursing teams: a literature review. *British Journal of Community Nursing* Vol. 21 No 5 pp 248-255

Royal College of Nursing (2016) *Personal safety when working alone: guidance for members working in health and social care.* RCN: London.

Royal College of Nursing (2003) *Defining Nursing* London: RCN

Secombe, L. (1995) *Listening Exercise.* Nursing Times 95, 25, 56-58.

The Irish Longitudinal Study on Ageing (TILDA), (2016) *The Impact of Frailty on Public Health Nurse Service Utilisation.* Trinity College Dublin: Dublin.

Thomas, L., Reynolds, T., O' Brien, L. (2006) Innovation and change: shaping district nursing services to meet the needs of primary health care. *Journal of Nursing Management* **14** 447-454.

Auditor General of Wales (2017) *District Nursing Services in Wales – A Checklist for Board Members.* Wales Audit Office

Watkins, D., Edwards, J. and Gastrell, P. (2003) *Community Health Nursing-Frameworks for Practice.*2nd Edition Balliere Tindall

9.0 APPENDICES

Appendix I	Signature Sheet
Appendix II	Membership of the PPPG Development Group (Held with Master copy in ONMSD)
Appendix III	Conflict of Interest Declaration Form (Held with Master copy in ONMSD)
Appendix IV	Membership of the Approval Governance Group (Held with Master copy in ONMSD)
Appendix V	Audit Tool to Review Operation of this Procedure
Appendix VI	Preliminary Screening Flow Chart for Referrals to the PHN Service
Appendix VII	Referrals Accepted Prioritisation Document
Appendix VIII	Record of Inappropriate Referrals
Appendix IX	Letter of Outcome to Referral Received
Appendix X	Lone Worker Risk Factors (RCN)
Appendix XI	Lone Worker Risk Assessment Checklist
Appendix XII	Nursing Intervention Levels for Patient Dependency/Nursing Need within a Public Health Nursing Caseload

Appendix I: Signature Sheet

I have read, understand and agree to adhere to this Procedure: **Management of Referrals Accepted to the Public Health Nursing Service**

Print Name	Signature	Area of Work	Date

Appendix II:

Membership of the PPPG Development Group (Sub Group of PHN Metrics Working Group)

Please list all members of the development group (and title) involved in the development of the document.

Virginia Pye National Lead for Public Health Nursing	Signature: _____ Date: _____
Anne Lynott DPHN	Signature: _____ Date: _____
Brenda Horgan Nursing Practice Development Co-ordinator	Signature: _____ Date: _____
Jean Whelan ADPHN	Signature: _____ Date: _____
Rosemary O Callaghan ADPHN	Signature: _____ Date: _____
Ella Ferriter ADPHN	Signature: _____ Date: _____
Anne Marie McDermott ADPHN	Signature: _____ Date: _____
Anita Roddy PHN	Signature: _____ Date: _____
Niamh Keane PDC	Signature: _____ Date: _____
Chairperson: **Catherine Whitty** National Practice Development Co-ordinator Public Health Nursing	Signature: _____ Date: _____

External Stakeholder Consultation in the Development of this PPPG;

National Directors of Nursing Acute Hospital Services

PHN Programme Co-ordinators, Higher Education Institutes

National Clinical Advisor General Practice, Clinical Strategy and Programmes, HSE

Health and Social Care Professionals Office, Human Resource Department, HSE

Safeguarding Office, HSE

Data Protection Office, HSE

Appendix III:

CONFLICT OF INTEREST DECLARATION
This must be completed by each member of the PPPG Development Group as applicable
Title of PPPG being considered:

Referral of a Patient to the Public Health Nursing Service

Please circle the statement that relates to you

1. I declare that I DO NOT have any conflicts of interest.

2. I declare that I DO have a conflict of interest.

Details of conflict (Please refer to specific PPPG)

_____
_____
_____
_____
_____

(Append additional pages to this statement if required)

Signature

Printed name

Registration number (if applicable)

Date

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that committee members act in the best interests of the committee. The information provided will not be used for any other purpose.

A person who is covered by this PPPG is required to furnish a statement, in writing, of:

(i) The interests of the person, and
(ii) The interests, of which the person has actual knowledge, of his or her spouse or civil partner or a child of the person or of his or her spouse which could materially influence the person in, or in relation to, the performance of the person's official functions by reason of the fact that such performance could so affect those interests as to confer on, or withhold from, the person, or the spouse or civil partner or child, a substantial benefit.

Appendix IV:

Membership of the Approval Governance Group

Please list all members of the relevant approval governance group (and title) who have final approval of the PPPG document.

Siobhán Mc Ardle Head of Operations: Primary Care Community Operations, Health Services Executive	Signature: _____ Date: _____
Type Name here Assistant National Director of Community Operations: Primary Care	Signature: _____ Date: _____
Type Name here Type Title here	Signature: _____ Date: _____
Type Name here Type Title here	Signature: _____ Date: _____
Chairperson: Type Name here Type Title here	Signature: _____ Date: _____

Appendix V: Audit Tool to Review Operation of this Procedure

AUDIT TOOL FOR THE MANAGEMENT OF REFERRALS ACCEPTED TO THE PHN CASELOAD

An Audit of compliance with this procedure will be carried out within 6 months of implementation using this audit tool. Please answer all questions indicating **Yes** or **No** and give a comment if applicable.

No	Question	Yes	No	Comment
1	Is the date of receipt of the referral clearly documented in accordance with agreed local procedures?			
2	Is the format (verbal/written) and the source of referral clearly documented?			
3	Is the reason for referral clearly documented in the patient's record?			
4	Is the patients consent to a nursing service clearly documented in the nursing record?			
5	Is there documented evidence that a comprehensive and holistic nursing assessment of the patient has been completed?			
6	Is there documented evidence in the nursing record that a care plan has been developed?			
7	Is there documented evidence in the nursing record that a care review date has been agreed with the patient?			
8	Is the date of acceptance to the PHN caseload noted on the caseload register?			
9	Is the agreed care review date noted in the caseload register?			
	Totals **Percentage Compliance %**	**__ /10**	**__ /10**	

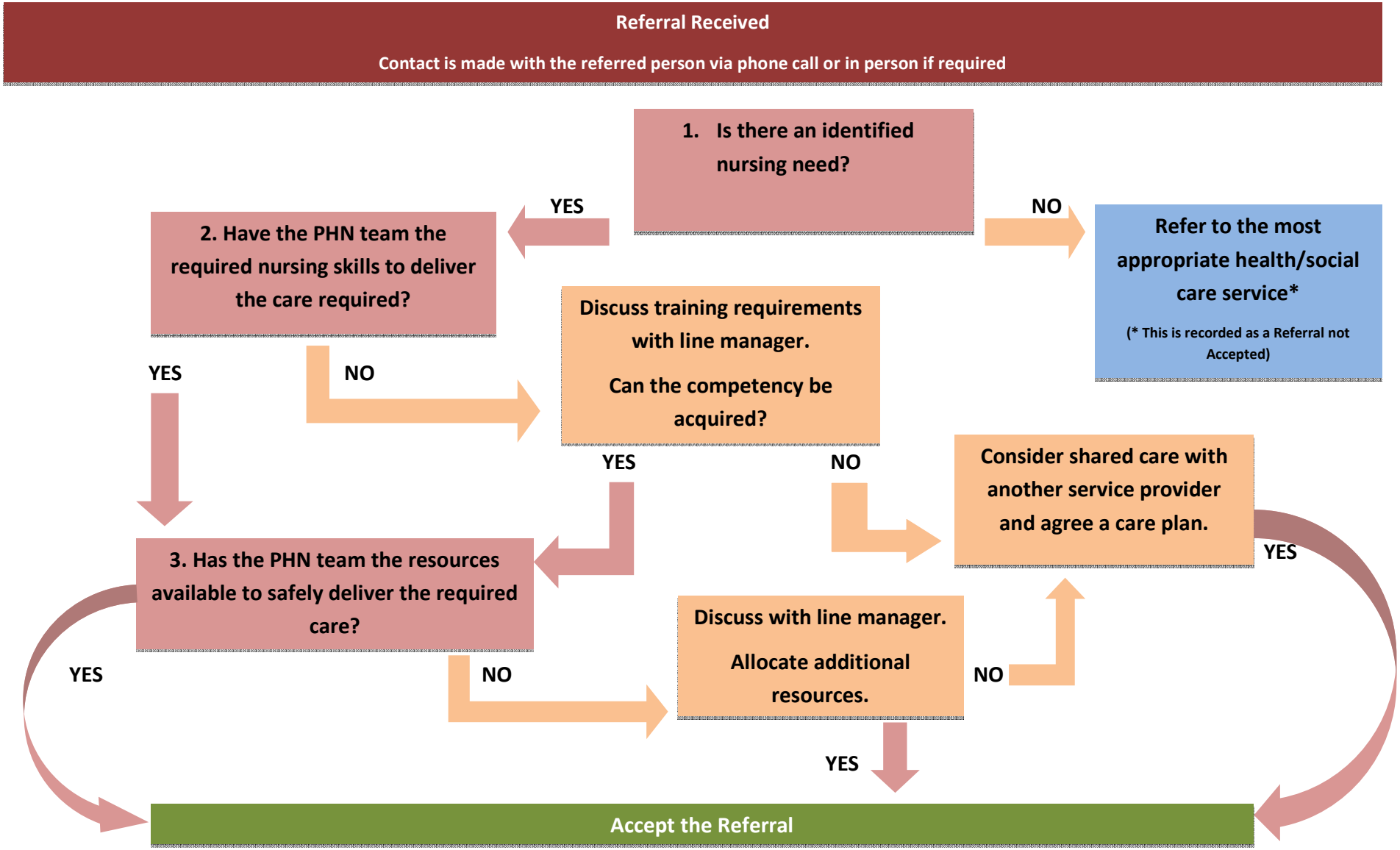
DATE: _____ **CHO:** _____ **Health Centre:**_____

Quality Improvement Plan:

_____
_____
_____
_____

AUDIT COMPLETED BY: _____ **Title:** _____

Appendix VI: Preliminary Screening Flow Chart for Referrals to the PHN Service



Appendix VII: Referrals Accepted Prioritisation Guidance Document

The following are illustrative examples for each priority level only and are based on normal staffing levels within the service. It should be noted that professional judgement on individual clinical cases may necessitate further discussion with the relevant line manager.

Priority 1 Referrals Accepted: Seen within 0-7 working days based on professional judgement

- Patient's referred requiring an essential nursing intervention; eg. medication administration, wound care, indwelling urinary catheter care etc
- patients referred for end of life care
- frail patients under care of specialist geriatric services
- patients referred deemed vulnerable requiring safeguarding
- patients referred for home supports with limited social supports in place
- patients with chronic complex medical conditions for nursing support
- children with complex medical need requiring direct nursing intervention
- high dependency patients requiring multiple nursing interventions
- patients referred for continence management impacting on skin integrity
- Direct Observational Therapy for patients with Tuberculosis not following prescribed treatment
- first visit to mothers of new born babies

Priority 2 Referrals Accepted: Seen within 8 working days and 12 weeks based on professional judgement

- patients who have had convalescence with relatives, now returned to own home
- patients referred for routine primary preventative care and health promotion activity
- patients referred for CSAR, Home Care Package assessment with social supports in place
- patients with chronic stable medical conditions
- patients referred for general continence management support
- children with complex medical need requiring parental support
- routine referrals to avail of day care, respite services and other support services

Appendix VIII: Record of Inappropriate Referrals to the PHN Service

Name of patient **Address** **Date of Birth**	
Name of referrer **Contact details**	
Reason for referral	
Reason for declining referral	

RPHN/RGN/LPHN/LN/Locum Name: _____

(write in block print)

Signed: _____ Date: _____

Health Centre _____

Appendix IX: Letter of Outcome of Referral Received

Addressee Referring Service:

_____

_____

Regarding referral received from on: _____

Patient name: _____

Address: _____

DOB: _____

Dear _____

- I acknowledge receipt of referral and confirm the patient has been accepted to the service. ☐
- I have completed a preliminary screening of the referral / the patient and find that there is no public health nursing care need at this time. ☐

  Should the patient's nursing need change in the future a re-referral to the Public Health Nursing service can be made.
- I have completed a preliminary screening of the referral / the patient, offered a nursing service but the patient has declined this service. ☐

_____ (signature)

_____ (grade)

_____ (health centre)

_____ (contact number)

Appendix X: Lone Working Risk Factors

Patient:

- History of abuse or aggression from previous incident (patient or other co-habitant)
- Unpredictable behaviour
- Substance abuse

Interaction:

- Breaking bad news
- Withholding treatment
- Changes to levels of care or support provided
- Discussion about behaviours
- Safeguarding procedure
- Sanctions

Working environment:

- Patients home
- Outreach work in street
- Unfamiliar environment
- Working alone in a health care building
- Working alone in a non-health care building
- Working in a geographical area with high crime levels (including carjacking)
- Mode of transport Eg. Public transport, cycling, taxis
- Carrying equipment such as drugs or computers
- Restricted access to buildings ie. apartment blocks

Working patterns:

- Out of hours Eg. Late evening, night, weekend work
- Closing or opening buildings alone

Staff member:

- Inexperienced
- Newly assigned to caseload
- Medical condition/disability
- Returning after a long spell of absence
- Expectant mother

Royal College of Nursing (2016)

Appendix XI: Lone Worker Risk Assessment Checklist

Patient Name:			**Date:**
Check	**Yes**	**No**	**Comment**
Have you obtained information regarding the patient/family?			
Have you clarified this information?			
Have you contacted the patient/family to arrange a visit, obtain directions and enquire regarding dogs?			
Have you requested that animals are securely restrained during your visit?			
Is the patient or other person likely to become agitated, angry or violent as a result of your visit?			
Have you arranged the visit for early in the day?			
Do you need to carry out a joint visit?			
Do you need to activate your buddy system?			
Is your mobile phone charged?			
Have you sufficient fuel in your car?			
Have you got your ID card to hand?			
Are you dressed appropriately as per H & S recommendations?			
Have you documented patients name and address in your desk diary?			
<u>Nurses signature</u>			

The completed risk assessment should be filed in patient's record.

Appendix XII\; Nursing Intervention Levels for Patient Dependency/Nursing Need within a Public Health Nursing Caseload

Nursing Intervention 1 (Low Dependency (Code Green)

• Assessed and has no direct clinical nursing needs, has a care plan in place that may include the following;
• Need for health promotion/ risk reduction (pendant alarm), and may be referred to primary care team; day care, chiropody, community welfare services etc;
• Home help / Health Care Assistant providing personal care e.g shower requiring no other direct nursing intervention;
• Aids/Appliances organised requiring no other direct nursing intervention
• Clients receiving incontinence wear requiring no other intervention

Nursing Intervention 2 (Medium Dependency (Code Blue)

• Estimated length of care will be up to 12 weeks short term nursing care; direct and /or indirect nursing care in the clinic/home setting following hospital discharge, referral from GP etc. Examples include: Administration of injections/medication management/wound care/stoma care / community rehabilitation interventions /any nursing intervention that can be provided in a clinic/home situation ≤ 12 weeks
• Any other nursing care/intervention required beyond 12 weeks is re-assessed and re-ranked as intervention 1, 3 or 4 with the exception of any medication required on a three monthly basis. E.g. Neo- Cytamen Injection

Nursing Intervention 3 (High Dependency (Code Yellow)

• Continuing need for direct nursing care but this client is stable.
• May include the nursing management of clients with chronic stable conditions.
• Clients with a palliative care condition requiring psychosocial care/nursing intervention

Nursing Intervention 4 Maximum Dependency (Code Red)

• Continuing nursing need for client with complex needs who requires high dependency care, case management, co-ordination, advocacy etc in a constantly changing environment.
• Clients requiring end stage palliative care

Adopted from Population Health Information Tool (PHIT)
HSE/Office of the Nursing & Midwifery Services
Director (2011)