

Evolve Care Group

Social Care Nursing

Assessment of Frailty, Complexity and Needs - Streams of Complexity

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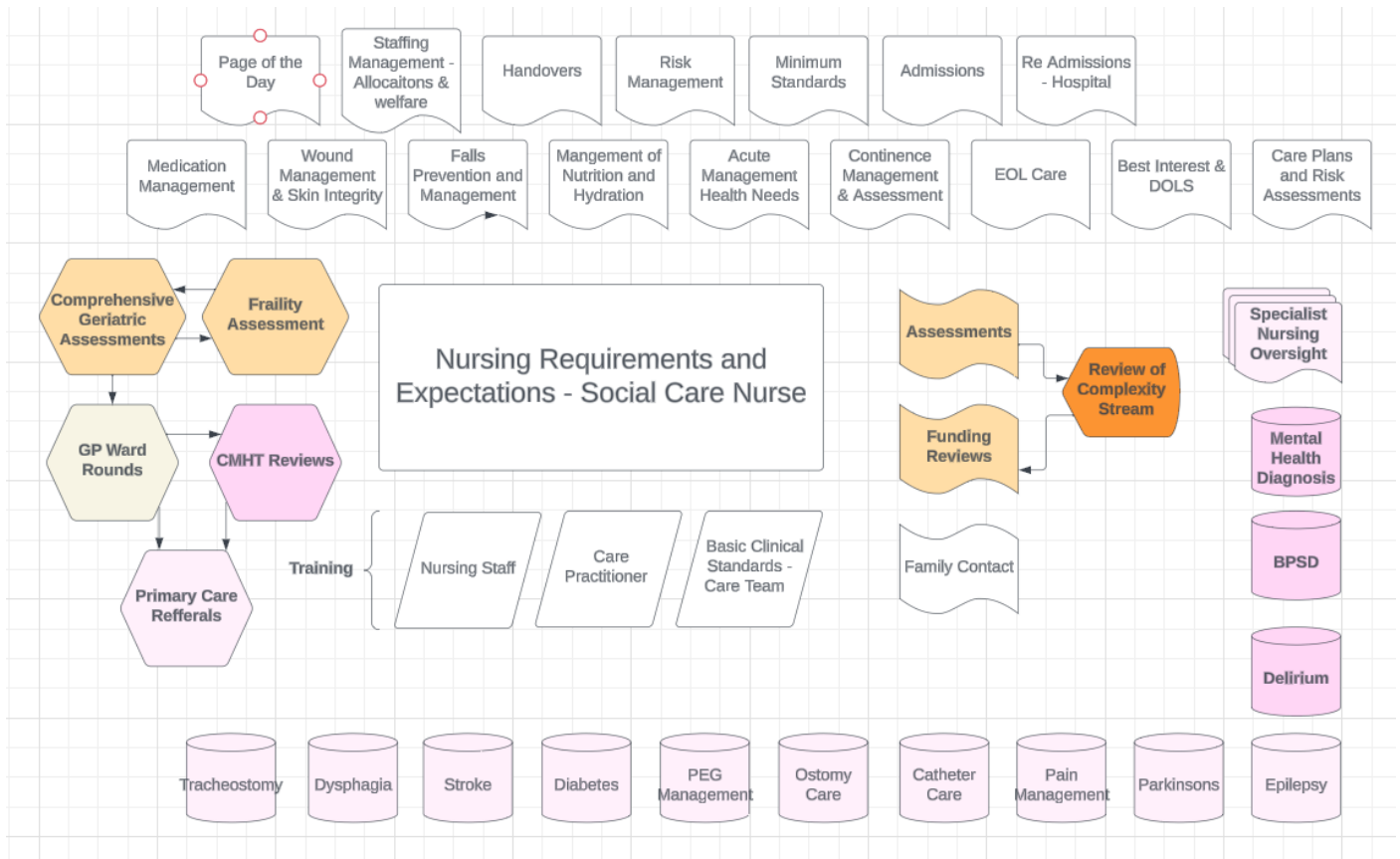
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[1] Visual Overview of Social Care Nursing Expectations and Management

There needs to be text here to put the below into context

This is about evidencing how we can use the pathways and strategies to reduce the load on primary care and acute admissions - Social Care Nursing should start from the point of prevention and the management of health conditions avoiding unnecessary acute admissions



[2] Frailty in the Geriatric Cohort

Frailty defines the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care. Older people with moderate to severe frailty are often well known to local health and social care professionals [*NHS, England*]

Frailty is the most problematic expression of population ageing. It is a state of vulnerability to poor resolution of homeostasis following a stress and is a consequence of cumulative decline in multiple physiological systems over a lifespan. This cumulative decline erodes homeostatic reserve until relatively minor stressor events trigger disproportionate changes in health status, typically a fall or delirium [Frailty in Older People, National Library of Medicine]

If someone is living with frailty, it does not mean they lack capacity or are incapable of living a full and independent life. When used properly, it describes someone's overall resilience and how this relates to their chance to recover quickly following health problems.

In practice being frail means a relatively 'minor' health problem, such as a urinary tract infection, can have a severe long-term impact on someone's health and wellbeing; it can significantly impact on their ability to recover from what could be seen as a simple infection

This is why it is so important that people living with frailty have access to well-planned, joined-up care to prevent problems arising in the first place – and a rapid, specialist response should anything go wrong – the referrals into Primary Care play a central role in ensuring that people have access to the right services and the right time. The referrals are made by clinicians in the Evolve Homes alongside the person's GP

Frailty is a recognised condition that if discussed, acknowledged, and leads to a holistic review of the person can prevent serious harm and acute admissions to hospital

As part of the prevention agenda within Evolve Homes we have an independent **Comprehensive Geriatric Assessment**, this includes the use of **Frailty Scale [Rockwood]**. This tool is completed by the clinicians in the home and discussed collaboratively with the GP, CHMT and referrals made for assessments and to primary care as appropriate.

[3] Complexity Streams

The following part of this document sets out the different streams of complexity and varying needs. It is highly likely that people will move between the streams of complexity dependent on their progression within their physical and emotional journey of identified needs

Needs should not be marginalised just because they are successfully managed. Well managed needs are still needs. Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need – such that the active management of this need is reduced or no longer required [NHS Continuing Care.gov.uk]

The following streams of complexity have been identified

1. 2:1 Care and Support
2. 1:1 Care and Support
3. Line of Sight – Enhanced Care
4. High Level Nursing Needs
5. Medium Level nursing Needs
6. Low Level Nursing Needs
7. Residential – High Needs
8. Residential – Low Needs

Suggested Definitions and Examples of Complexity Streams

3.1 2:1 Care and Support

The normal model for the person would be a 1:1 – there will be times when additional support is required, this may be continuous or for planned interventions where the risks are known to require further management owing to the identified risks

2:1 Support may be required for

- Community access when the risks of absconding are identified
- Risk to members of the public
- Risks associated with travel in a car
- Acts of self-harm
- Escalated behaviors that require the positioning of staff to be a central strategy to reduce the risk of harm to the person and others within their environment
- **Where there are frequent instances of significant allegations that impact on the well-being of the person and/or those around them.**
- Preventing a person leaving or entering a setting with the home or the community
- Restricting activities where risk to self or others is higher
- Where staff burnout is identified owing to intensity of 1:1 support

There will be a Positive Behavior Support plan in place detailing the likely or known times when 2:1 support will be required

Other Areas to consider:

A CHC Checklist should be completed if not already actioned – the person may not have physical nursing needs but be an open case to the Mental Health Team

DOLS should be informed of this planned intervention

3.2 1:1 Care and Support

The most common reasons for considering regular or continuous observation of an individual in relation to reducing the risk of safeguarding adult concerns are:

- Walking with purpose and /or agitation (including high risk of leaving home or care setting)
- Physical and verbal aggression – towards other adults and risk, and staff too - very difficult to manage
- Unpredictable behaviours, including falls, self-harm – predictably unpredictable
- The use of items in the immediate environment that the person will use when physically combative which increase the risk of harm to the person and others
- Anticipated periods of time when risks are escalated and the risks to the person and/or to others are identified – this could include behavioural responses owing to cognitive impairment and/or behavioural responses in relation to a health need i.e., constipation, pain, infection, medication refusal
- Preventing incidents with others through distraction / diversion / and other planned strategies
- **High levels of impulsive behaviours and reactions**
- Safety of the person and those they encounter (including staff)
- Limiting private contact with families/significant others when risks of harm and abuse are identified
- Diagnosis of Behavioural Psychological Symptoms of Dementia [BPSD]
- Hyperactive Delirium: People often present with increased agitation and sympathetic activity. They can present with hallucinations, delusions, and occasionally combative or uncooperative behaviour – this can increase the risk of harm and escalation to 2:1 owing to the response from the Sympathetic Nervous System
- **Inappropriate sexual behaviours that place the person and others at ongoing risk of harm without this level of support**

There will be a Positive Behavior Support plan in place detailing the 1:1 support will be required – the 1:1 maybe for a planned period within a 24-hour period or assessed as required as ongoing owing to the level, intensity and frequency of risk

Other Areas to consider:

A CHC Checklist should be completed if not already actioned – the person may not have physical nursing needs but be an open case to the Mental Health Team

DOLS should be informed of this planned intervention

3.4 Line of Sight Care - Available in Homes where Complex Commissioning is in place

This model of line of sight can be appropriate when an assessment is made that demonstrates an increased level of care and observation can be shared between a small group of people; this may be referred to as enhanced care.

There may be times when 1:1 is appropriate but for the majority of the time observations within the same day space is appropriate. Risks that may be appropriately managed under this level of observation with good Positive Behavioural Support care planning and risk assessments

- Interactions and engagement are likely to need to be of high intensity to reduce the risk of harm to the person and or others occurring
- The person may be at risk of harming themselves
- The person is likely to be at high risk of entering the space of others and not being aware of the risks associated with this
- The person is likely to be reactive upon interactions with others if they feel threatened and/or not listened to
- There will be periods where the person is calm and settled – it is unlikely these periods can be planned for – they will be spontaneous and may occur at several different times throughout a period
- The person is likely to respond well to staff interaction, through the use of increased tone and pitch of voice as a strategy to preventing actual from occurring
- The use of meaningful engagement and focusing on purpose and emotional safety will be a critical part of the care planning process – the person would not be able to identify meaningful occupation and engagement independently
- Diagnosis of Behavioural Psychological Symptoms of Dementia [BPSD]
- The person may be assessed as requiring this level of care owing to the predictable unpredictability nature of their mobility
- The person may be at physical risk of harm owing to their intolerance of medical devices, catheter, PEG for example – the medical team will have assessed that the risk of removal is too high for the person to be well without this intervention
- The person may have been assessed as being dysphagic and the risks of consuming food and/or drink items outside of the instructed IDDSI levels leading to choking and/or aspiration owing to the person being mobile and being able to access food/drink items of risk – there would need to be a proven risk of this and the home will have to be able to identify the strategies that have been implemented that have resulted in the risk of harm not being within safe levels
- Ongoing positive interactions is critical to reduce the risk of emotional unregulated behaviours and expressions

There will be a Positive Behavioural Care plan in place detailing the reasons why line of sight/enhanced care is considered as a strategy to prevent harm and manage the identified risks

If this level of support and care is activated at the right time, then this can be a very successful strategy and reduce the need for 1:1 support to be in place on a continuous basis

Other Areas to consider:

A CHC Checklist should be considered – the person may not have physical nursing needs but be an open case to the Mental Health Team

DOLS should be informed of this planned intervention

3.5 High Level Nursing Care

- Catheter sites that are problematic without planned consistent nursing intervention and oversight [Prescriptions for Catheter Maintenance solutions] – this may also include the non-acceptance of the device which increase the risk of the device being removed by the person
- PEG
- Ostomy Care
- Tracheostomies
- Diabetes – Insulin Dependent and/or Complex Diabetes
- Specialist Medication Management [physical and or psychological management]
- Re occurring infections that result in an increase in physical and psychological harm
- Ongoing delirium and/or hallucinations where there is a skilled intervention that requires movement between different prescribed medications
- Grade 3/4 Pressure Sores, inc. Suspected Deep Tissue Injuries – that require review 24/48 hours
- Moisture Lesions – Severe – that require review 24/48 hours
- Diabetic Ulcers – that require review 24/48 hours
- Mixed Aetiology Ulcers – that require review 24/48 hours Bilateral swelling – severe oedema – that require review 24/48 hours
- A known active bleed or risk of bleed when falls are associated with significant harm or death occurring
- Parkinsons Disease – that requires ongoing assessment and evaluation of intervention - PRN medications prescribed
- Co Morbidities that impact on the persons respiratory system and require acute and timely intervention with PRN medications and intervention [COPD, CVD]
- Severe allergies when the person does not have capacity to understand the risk
- High Risk Swallow Difficulties when the person does not have the capacity to understand the risks of harm by consuming food/drink/items but has the physical capacity to access
- High Risk of Aspiration owing to problematic repositioning, reflux, excessive salvia production
- Complex Mental Health Conditions, i.e., personality disorders that do not require 1:1 but require skilled intervention to manage agreed nursing plans and administrations of medications
- Substance Abuse – active
- Self-Neglect where physical and or psychological harm is occurring – this is to include levels of Obesity that is resulting in harm to physical and psychological functioning when daily nursing input is required
- Unstable Diabetes where risks of DKA are identified in addition to Hypoglycemic episodes – the person would have active prescriptions in place for hyperglycemia in addition to hypoglycemia
- Terminal Care i.e., cancer [Fast Track]
- End of Life Care [Fast Track]

The fast-track pathway tool (rather than the DST) should always be used for any individual with a primary health need arising from a rapidly deteriorating condition as the condition may be entering a terminal phase.

Frailty Scale: Scores 8 – 9 Rockwood Frailty Scale

Referrals to the following Health Need Disciplines for High Level Nursing – in addition to referrals made at Medium Level Nursing Care – this list is not exhaustive

- Tissue Viability Team
- The Wet leg pathway [Wales]
- Direct Podiatry input owing to active skin integrity concerns

- Ongoing assessments to Speech and Language Therapists post initial referrals owing to level of risk
- CMHT and Psychiatry – active involvement from the Teams until agreed intervention and evidence of risk reduction – 1:1 support may be considered as a strategy at this time **or Line of Sight [we may need an additional stream of complexity for line of sight....thoughts]**
- Specialist Diabetes Team involved
- PEG team – this may be a sperate Dietetics team – post code dependent
- Urology – this may be separate to the Bladder and Bowel/Continence Community Teams
- Falls Team have confirmed no further action can be taken – this could potentially increase the likelihood of 1:1 being required at times or on an ongoing basis [until physical abilities alter and the risk is lowered]

A CHC Checklist should be completed when someone is assessed internally as requiring High Level Nursing Care

Fast Track Referral to be considered as appropriate

3.6 Medium Level Nursing Care

- Catheter – non problematic
- History and or ongoing concerns re Urinary retention and/or frequency
- Monitoring vital signs as required when they have a medical diagnosis that is unpredictable in nature i.e., COPD, CVD
- Has been signed off by a Clinician as being on Scale 2 on NEWS owing to comorbidities – this increases the risk of acute deterioration due to previous presentation – risks can be reduced by timely nursing intervention
- Co morbidities that require ongoing monitoring/intervention and review, Warfarin – with complexities
- Parkinson's Disease that requires the administration of time sensitive medications but no PRN administration
- History of Pressure Damage and/or Moisture Lesions – Very high risk Waterlow Score
- The physical care of the person requires timely intervention and continue oversight to manage pressure areas and areas affected by moisture, urine and or faeces
- Multiple PRN medications that require a planned approach on each administration owing to the types of medications prescribed and the associated risks [Opioids, Analgesia that increases the risk of constipation]
- Skin Integrity concerns where multiple prescription creams are prescribed that require nursing oversight re application and pathways of use
- Grade 2 Pressure Damage – significant risk of deterioration
- RESCUE prescriptions in place, i.e. ABX or for specific diagnosis, COPD, asthma – that require immediate, timely and skilled intervention to prevent escalation
- Co morbidities that require multiple PAINAD assessments and management through PRN prescriptions across a 24 hour period
- Constipation risks that significantly impact on the psychological and/or physical well being of the person
- Hypoactive delirium is characterised by reduced motor activity, lethargy, withdrawal, drowsiness and staring into space – when the impact of this significantly increases the risk of malnutrition, skin integrity concerns – requirement for planned nursing care and Intervention to manage identified risks
- Diabetes that requires Nursing oversight owing to impact of Blood Glucose Levels on behaviours and presentation and also physical impact i.e. impact on bowels i.e. T7 bowels owing to Medications prescribed which increase the risk of Skin Integrity concerns
- Co morbidities that require ongoing monitoring/intervention and review i.e., Warfarin – that are not stable in presentation – warfarin toxicity may be a risk that requires care planning with specific signs/symptoms to be observed for with associated clinical data collection – medical history of oesophageal varices for example where risk of bleeding remain an active concern

Frailty Scale: Scores 6 – 7 on the Rockwood Frailty Scale

Comprehensive Geriatric Assessment

The completion of the Geriatric Assessment by the Nursing team and the GP at this level of Nursing Care leads to additional referrals and planned interventions but the risk of health deterioration remains an ongoing concern

Referrals to the following Health Need Disciplines may be evident in the following areas – this list is not exhaustive

- Speech and Language Therapists
- CMHT referrals open and active
- Tissue Viability/podiatry referrals
- Dietician
- Bladder and Bowel Team
- Falls Team
- Pain Management Team

3.7 Low Level Nursing Care

- Requires planned nursing assessments and evaluation to reduced the risk of acute needs developing based on their co morbidities, cogitative functioning and physical ability – this is likely to include chronic illness such as COPD,
- Modified diet and or fluids as per IDDSI framework – requires supervision for all eating and drinking owing to risks identified [holding food in the mouth, overfilling, not enough time between swallows, positioning issues]
- Diabetes where there is a risk of diabetic complications based on history or current presentation [Pressure damage, Diabetic Ulcers, Diabetic Neuropathy]
- Diabetes management that requires daily intervention from a Registered Nurse owing to unstable Blood Glucose Levels, sliding scale insulin, PRN prescriptions in place for Hypoglycemic episodes, concerns re Insulin absorption owing to injection site risks [scarring], foot health that requires nursing oversight
- High risk of falls and prescription in place for anticoagulants/antiplatelet, osteoporosis/osteopenia– requires planned and skilled preventative care to rescue the risk of hospital admissions
- Constipation that can be managed through timely and skilled intervention through PRN management written by a Registered Nurse, this may include the administration of enema so is not exclusive to oral route preparations
- Singular or Multiple fractures that require planned nursing interventions to reduce the risk of further falls; planned nursing interventions can include management of constipation, dehydration, pain
- Skin Integrity management that requires daily care and review, requires the application of various prescription creams depending on assessment and presentation. This would include the prescription for steroid based creams that increase the risk of skin integrity concerns
- Management of chronic conditions, i.e. IBS, Crohn's, Asthma, Arthritis, Dementia that will result in harm occurring if planning and evaluation is not an ongoing strategy by the Nursing Team
- PRN medications that increase the risk of sedation and associated risks of slowing down the physical responses and actions within the body [i.e, constipation, eating and drinking, altered mobility]
- Co morbidities that require ongoing monitoring/intervention and review i.e., Warfarin – that are not stable in presentation – warfarin toxicity may be a risk
- Grade 2 Pressure damage that is responding well to nursing intervention
- Active DVT risks that require Nursing Oversight, assessment and planning to reduce the risk of a DVT and/or PE occurring
- Prescribed medication for one area of assessed need that impacts on other Health Needs i.e., the use of a Medication to aid sleep but impacts on Blood Pressure
- Malnutrition concerns that impact on the physical and psychological functioning

Frailty Scale: Scores 4 – 7 on the Rockwood Frailty Scale

Comprehensive Geriatric Assessment

The completion of the Geriatric Assessment by the Nursing team and the GP at this level of Nursing Care is able to stabilise and improve outcome for the person, physically and psychologically

Referrals to the following Health Need Disciplines may be evident – [this list is not exhaustive](#)

- Speech and Language Therapists
- Diabetic Screening Clinic
- Audiology
- Memory Clinic

- Dietician
- Bladder and Bowel Team
- CMHT – if appropriate – awareness of current presentation with the acknowledgement that risks have the potential to escalate
- Falls Team
- Pharmacy team to ensure polypharmacy is a managed risk

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3.8 Residential – High Needs

- Requires the full support to manage their prescribed medications safely, this may include the application of eye drops
- PRN prescriptions that don't carry additional risks upon administration
- Grade 1 Pressure Damage – responsive to intervention and planned assessments by the DN team to reduce the risk of deterioration
- Co Morbidities that have the potential to require Nursing Oversight but at the time of assessment ongoing, assessment and planned intervention are not required
- Diabetes that requires no ongoing actions and oversight of a Registered Nurse – Diabetes Non-Insulin dependent, managed with Medication and/or Diet
- Fragile skin that responds well to planned and PRN intervention with emollients/barrier products
- Co morbidities that require ongoing monitoring/intervention and review i.e., Warfarin – that are stable in presentation
- **A diagnosis of Dementia or a Cognitive Condition with the presence of expressive behaviours that impact on the well being of the individual or others. *(Based on the SRC banding in Somerset)***
- **A PRN prescription that requires an assessment of a Registered Nurse re administration owing to risks post administration, falls, constipation, increase in confusion, change in clinical observations**
- **A hospital admission that results in a change of primary health care needs – this will be picked up by the assessment of the hospital and the review on return to the care home**

The District Nurses are to be made aware of the potential risks to enable them to produce a care plan for the areas of risk to reduce the risk of deterioration and harm – **see FNC eligibility referral process**

Frailty Scale: Scores 4 -5 on the Rockwood Frailty Scale

Referrals to the following Health Need Disciplines may be evident – this list is not exhaustive

- Speech and Language Therapists
- Diabetic Screening Clinic
- Audiology
- Mental Health Team
- Memory Clinic
- Dietician
- Bladder and Bowel Team
- Urology
- CMHT
- Falls Team
- GP
- District Nursing Team

3.9 Residential – Low Needs

- Support with personal care i.e., washing and dressing
- Self-Administers Medication
- Diabetes – Stable
- No Health Needs identified that impact on daily living activities
- Diagnosis that have no impact and no likely impact in the near future

Frailty Scale: Scores 1 – 3 on the Rockwood Frailty Scale

Health Disciplines Involved may include – this list is not exhaustive

- GP
- District Nursing Team if required
- Chiropody
- Diabetes Community Teams

[4] Considerations and Actions for Complex Care Management

2:1, 1:1 and Line of Sight Management

Consider the root cause of the behaviour you are looking to protect the person or others from when agreeing appropriate strategies

Close monitoring and support aim to minimise risk of harm to the person / others however, such close observation is a restriction on the person's freedom and can lead to escalation of the behaviour in some circumstances; it also requires increased staffing and funding which may not be sustainable in the longer term. It is essential that the MDT for the person understand the value of the 1:1 support

Comprehensive Geriatric Assessment – has one been completed?

Care Notes and Incident records that explore possible reasons as to why behaviours are being displayed covering all domains that we know can result in risks escalating quickly, looking for patterns and trends – in NHS language ABC (Antecedent – Behaviour – Consequence) charts

Evaluation of care notes and the A&I system - these may identify specific triggers for the person which may prompt more focused care planning or external referral for additional support.

Positive Behavioural Support (PBS) is increasingly used as well as trauma informed approaches – understanding the behaviour as a form of communication or need that cannot be expressed in other ways. Understanding what the person with an impairment may be experiencing differently – e.g. perception / auditory or visual hallucinations. Where PBS plans are in place, ensure they are understood and being followed.

Use and review of **medication** – are there interactions happening if a person is on a lot of different meds, are the dosages right (e.g. too much medication for high blood pressure can cause more falls)? Is the person refusing medication on a regular basis, is PRN being offered appropriately? Are staff confident in managing more complex regimes and PRN doses of medication such as sedatives?

- Health Needs that increase the risk of harm to the person and/or others
- Falls – Altered ranges of Blood Pressure for example
- Infections – common infections but also underlying infections that can result in a person experiencing an ongoing delirium with known and unpredictable risk periods
- Constipation – impact on physical reactions to others and their environment

Use of medication very clearly has limitations, especially when considering sedation – it is not only potentially restrictive, but also we must consider impact on mobility and cognition in itself.

Assistive technology – are there sensors, monitors or other technology options which could help to support the need?

Suitability of environment / setting – is the person living in the right place, with the right support for them?

Anecdotally there can be a drive towards admission to hospital under the Mental Health Act where there are complex behavioural needs; but this is likely only to help where there is a therapeutic need - moving the person may simply move the unmet need if the underlying cause is not identified.

Use of the Understanding Me Octopus Analogy to review the multiple factors that influence and result in actions and reactions

[5] Coded Traffic Light System

5.1 Ladder of Referrals

The route of referrals have been coded as a traffic light system

Visual Representation of the Ladder of Referral – this is split into 2 pathways

[1] Residential Streams and [2] Complexity Streams Nursing

ECG 2023 - Coded Traffic Light System of Referrals

Residential Streams

PURPLE – Multiple Areas of Clinical Oversight Required Ongoing – **FNC Referral to be made and/or to include referral to CMHT** *[may include 1:1 support]*

RED – acute change in need - Active Clinical Oversight Required Ongoing – **FNC Referral to be made and/or to include referral to CMHT**

AMBER – change in need – District Nursing Review required

AMBER – change in need – CPN Review required

GREEN – new admission Residential – Health Input required to reduce risks



Complexity Streams – Nursing

PURPLE – 2:1 Support required – **CHC Checklist to be completed**

RED – 1:1 Support to manage risk and/or High-Level Nursing Needs – **CHC Checklist to be completed**

AMBER – Increase in oversight – possible line of sight and/or Medium Level Nursing Needs – *increase in nursing needs & time*

GREEN – Routine Oversight and Low-Level Nursing Needs

5.2 Complexity Streams Coded Traffic Light System – owing to Identified Risks [Physical and Mental Health]

Green - Routine oversight [inc Low Level Nursing]

Routine checks through 24hr period to monitor well-being, safety and meet unplanned needs as required. Recorded in daily records. Checks through the night are completed according to individual preference and need.

It is likely that all people in our care, 24 hour care will meet this criteria.

Amber - Intermittent supervision / monitoring (where possible ‘In line of sight’) [inc Medium Level Nursing]

Staff are allocated to monitor a person’s whereabouts at regular intervals following a specific plan of care detailing the reason(s) for support, frequency of supervision and risk factors. Care plan should also include detail of personalised interventions and interactions to minimise these risks, which must be recorded to evidence actual support given during the relevant period.

An appropriate review period should be set to evaluate the effectiveness and impact of the care plan, with contingency in the event of a change of need for oversight.

Red - Continuous 1:1 supervision [inc High Level nursing]

A member or members of staff are allocated to support one adult directly for a specified period of time. They are not expected to provide care to any other person during that time, with appropriate contingency for breaks and handovers agreed.

Best practice would be that staff undertaking observations are rotated every 2 hrs to other activities to avoid burn out / complacency / tired. They must have access to and follow a specific plan of care detailing the reason(s) for support and risk factors. Care plan should also include detail of personalised interventions, activities and interactions to minimise these risks, which must be recorded to evidence actual support given during the relevant period.

Records should be completed at least hourly depending on the overall length of the continuous supervision period. This will also support identification of any particular patterns or triggers to observed behaviour and potentially prompt a change to the required level of support on review.

The member of staff must be able to see the person at all times and possibly be close enough to intervene if there is an incident, whilst respecting privacy and dignity where possible.

The member of staff will provide positive interaction in conjunction with therapeutic interventions and activities.

DOLS will need to be considered at this level and application to the Supervisory Body detailing the 1:1 Support provided

Purple – 2:1 Support and Supervision

Periods of 2:1 Care will be provided – this may be at time of planned intervention, this may range from personal care through to extended periods of time. i.e., community access

It may be responsive to the presentation of the person and activated owing to escalated risk of harm to the person and/or others within the environment. This may be driven by the cognitive impact and presentation of the person owing their dementia and/or an acute health need

DOLS will need to be considered at this level and application to the Supervisory Body detailing the 1:1 Support provided

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5.3 FNC Management and Referrals - Coded Traffic Light Referral System

Identifying when a person *may* have eligible nursing needs

There are 3 key steps in supporting a person who is funded for Residential Care

Step 1 On Admission **Green**

1. **Communication Template/referral form** – outlining the known risks on admission
2. This is sent to the DN team for Health Leadership
3. This is shared at the first GP ward round post admission

Step 2 Change in a Health Need **Amber**

1. This does not need to be an acute event but an event that without timely review and planning will lead to an increase in risk and deterioration in potentially multiple health areas. For example a change in risk MUST/Waterlow/Mobility/continence/ increase in falls/ UTI/ diabetic event / new diagnosis / discharge from hospital/increase in PRN medications
2. **The Communication Template** is shared with the District Nursing Team
3. A request for care plans and risk assessments based on change in presenting need is made via the Communication Template

Step 3 Referral Processes for FNC Eligibility Assessment – Acute Event and/or Rapid Change In Needs **Red OR Purple**

1. Care home and or Governance Team alert that a person has moved into Residential High Needs and assessed as RED or PURPLE
2. Alert DN team if the primary needs as physical nursing needs using the **Communication Template**
3. A request to the DN team to come in assess and write care plans and a risk assessments for the identified change in Health Care Needs
4. Referral to CMHT/Mental Health Team if primary nursing needs are mental health through the GP – request made for Behavioural Support plan and risk assessments from CMHT/ Mental Health Team

Steps 1- 4 are completed on the same day – owing to the identified risk of harm if clinical oversight is not implemented

5. Nursing team and Governance Team outline Nursing needs [physical and or Mental health] within Care Notes
6. If there are specialist physical disciplines that are required to provided clinical oversight and support the referral will be made by the GP/Care home as appropriate – the DN team will be informed by email on the Communication Template
7. A care plan review is completed by the Governance Team and shared with the home – *7 day time period of review and completion*

Draft Communication Template for the above District Nursing referrals is on page 20 & 21

5.4 EVOLVE Care Group District Nursing Referral Form - Coded System – Communication
Template [2pages] ---- DRAFT VERSION ----

Name of the Person	
DOB	
Gender	
DOA	
NHS Number	
GP – Name and Address	
Name and Address of Nursing Home [inc. telephone number, email address]	

Referrals made or involvement from other services – shade as appropriate and date							
GP	Tissue Viability	Lower Limb [inc podiatry]	Wet Leg Team	SALT	Falls Team	Dietician	Bladder & Bowel
Urology	Memory Clinic	Mental Health	Diabetes	Parkinsons Team	Any other specialist services:		

Referrer Check List – Add YES and DATE to appropriate referral pathway	
New Admission to Nursing Home Residential Funded – GREEN ALERT <i>Complete on residential admissions – no active District Nursing input identified</i>	
Change in Physical Presentation – AMBER Alert <i>Change in risk identified – advice and guidance request</i>	
Change in Mental Health Presentation – AMBER Alert <i>Change in risk identified – advice and guidance request</i>	
Dual Change [Physical and Mental Health] - AMBER Alert <i>Change in risk identified – advice and guidance request</i>	
Active Clinical Oversight Required Ongoing – RED Alert – <i>Urgent review</i> <i>District Nursing visit required and leadership of active health issues identified</i>	
Multiple Areas of Clinical Oversight Required Ongoing – PURPLE Alert <i>Urgent review</i> <i>Multiple areas of nursing needs identified. CHC / FNC application required and change of contract required by the Provider.</i>	

Medical History:	
-	
Medication Prescribed: [inc. PRN prescriptions]	
-	
Amy medication requested by the GP:	Last Acute Admission:

Reasons for Referral							
For Green Referrals Detail Potential Risk that require Health Input into the Social Care plan – shade as appropriate							
MUST		Waterlow		Falls		Diabetes	
COPD							
Other Risks:							
For Amber, Red or Purple Referrals complete the following [shade as appropriate]							
Catheter in place	Ostomy in place	PEG in place	MUST Score >	Waterlow Score >	Falls Risk >	PRN Medication that requires Clinical Oversight owing to increase in risk [add detail below]	
Pressure Damage G1	Pressure Damage G2	Pressure Damage G3	Pressure Damage G4 +	SDTI	Skin Tears/Lacerations/Hematoma	Leg Ulcers	Constipation Concerns
DVT Risk – Active	Blood Pressure Concerns – that require active oversight	Bilateral leg oedema	Diabetes – unstable and/or complex	COPD that requires active nursing oversight	Epilepsy	Any other areas where Nursing Oversight is required:	
Any other detail/reason for referral/explanation of the above [Amber, Red or Purple Referrals]							
Care Plans/Risk Assessments required to be written by a District Nurse Amber, Red or Purple Referrals : [detail below]							
Baseline Information							
NEWS Score [add detail]			Scale 2 Sign Off [range and date]			Baseline PAINAD [add detail]	
MUST Score	=	BMI Score	=	Waterlow Score	=		
DNACPR in place			Yes			No	
For Hospital Admission [as per TEP or ACP]			Yes			Maybe for symptom control	
						No	

Does the person have capacity?	
If yes, are they aware the referral has been made?	
Date the GP last contacted	
NOK Details	
Referrer [Full name]	
Designation	
Date Referral sent to the DN Team	

[6] Considering Referrals and Change in Needs to Nursing and/or CHC

Intensity – Complexity – Unpredictability

Possible eligible nursing needs can be identified by considering the person's needs in the context of their;

- a. Intensity;
- b. Complexity; and
- c. Unpredictability.

Consideration	Context and Detail
Intensity	This relates both to the extent ('quantity') and severity ('degree') of the needs and to the support required to meet them, including the need for sustained/ongoing care ('continuity').
Complexity	This is concerned with how the needs present and interact to increase the skill required to monitor the symptoms, treat the condition(s) and/or manage the care. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction between two or more conditions. It may also include situations where a person's response to their own condition has an impact on their overall needs, such as where a physical health need results in the person developing a mental health need.
Unpredictability	This describes the degree to which needs fluctuate and thereby create challenges in managing them. It also relates to the level of risk to the person's health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

[7] Rockwood Frailty Scale

https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2022/02/rockwood-frailty-scale_.pdf

This features in the Evolve Comprehensive Geriatric Assessment

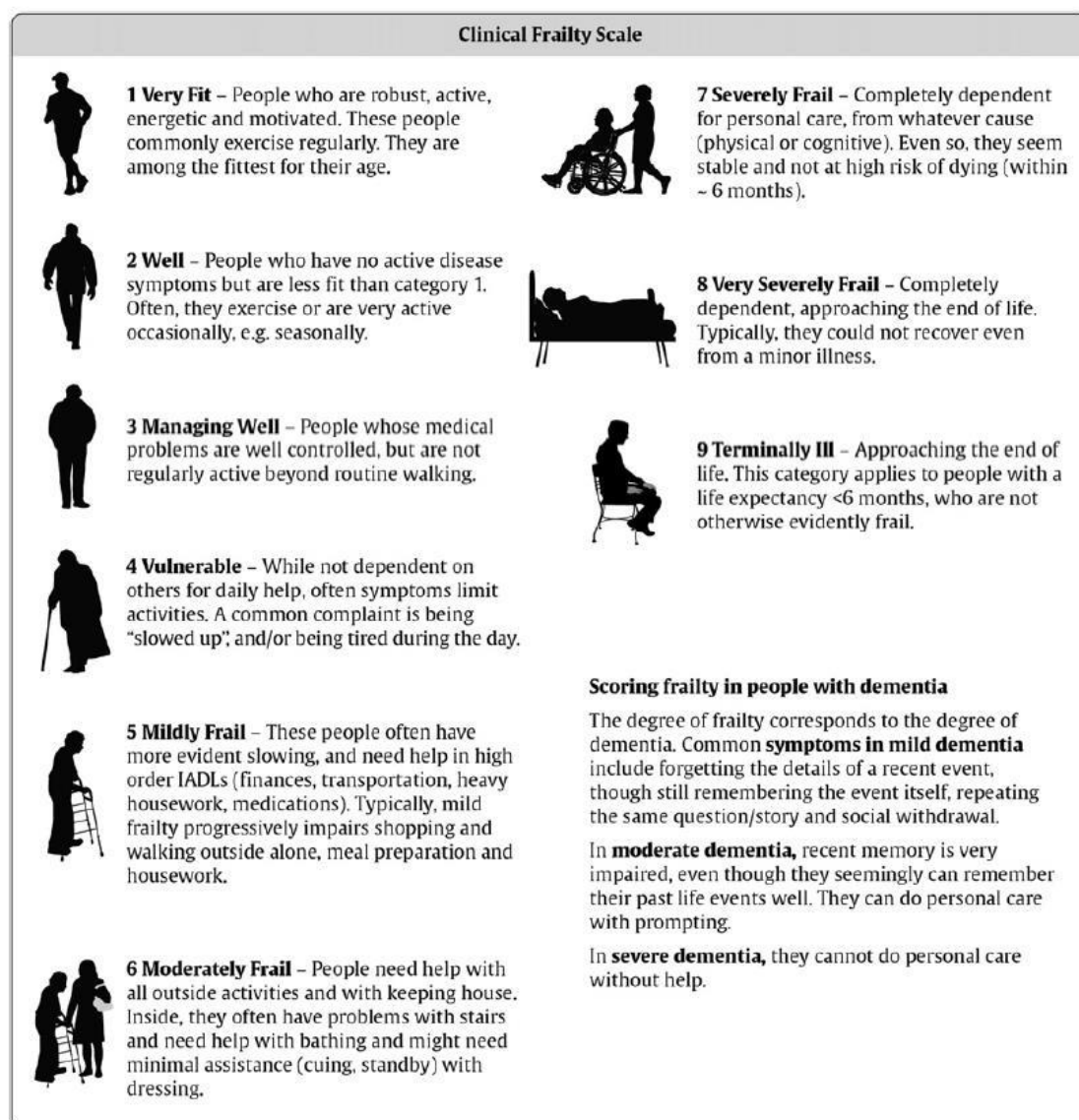


Figure 1. Clinical frailty scale. Adapted with permission from Moorhouse P, Rockwood K. Frailty and its quantitative clinical evaluation R Coll Physicians Edinb. 2012;42:333-340.