Isle of Man Government
Reiltys Ellan Vannin

Department of Health and Social Care

Rheynn Slaynt as Kiarail y Theay

Access to and Referral Criteria –
Adult Community Nursing Services

Adult Community Nursing Services

Adult Community Nursing is made up of a number of highly skilled teams and specialist nurses who work in partnership ensuring the best care possible for our patients. We are committed to providing a high standard of professional care to individuals within the community setting; we holistically assess and plan appropriate care/treatment in partnership with our patients. Our care is patient centred and researched and evidenced based, with the emphasis on empowering individuals to self-care to the best of their abilities. Our Vision reflects the aims of the Health Strategy (January 2011) for 2010-2020 and the Health and Social Care in the Isle of Man – the next five years (August 2015).

Adult Community Nursing works in partnership with other statutory, voluntary and independent providers to meet health care needs, offering continuing support, information and advice to patients and their carers and the island population.

Professionals working within Adult Community Nursing comprise:-

- District Nursing multi-skilled teams
- Health Visitor for Vulnerable Adults
- Continence Advisor
- Parkinson's Disease Specialist Nurse
- Long Term Conditions Co-ordinators

The District Nursing Service.

The service accepts referrals for housebound patients aged 16 and above who require nursing assessment, care planning and care delivery in support of patients who are acutely, chronically or terminally ill.

Hours of operation: The District Nursing Service operates 08.30-17.00, 365 days a year; voice mail is accessed daily until 16.30.

N.B. The Adult Community Nursing Service does not provide an emergency service. Patients are primarily housebound or have great difficulty in accessing other health care environments.

Date: Dec 2015
Review Date: Dec 18

How to make a referral to the District Nursing Service (quick guide/flowchart is shown in appendix 4a):

The District Nursing Service operates an open referral service.

Patients and carers have given their consent to a referral being made.

GPs and other members of the Multidisciplinary Team can make a written referral directly to the DN team at the surgery/office. (Appendix 1)

Patients/ Clients and Carers can make referrals to the appropriate DN base directly.

Hospital referrals are made by completing a Continuity of Care form (Appendix 2) which is then faxed to Community Nursing Administration on 642653 where this information will be disseminated to the appropriate base. Weekend referrals are as above but also need to be telephoned directly to the appropriate community nurse base to ensure the nurse has been notified. (Appendix 3)

Community Nurses can be contacted directly at their bases; answer phone messages are regularly checked throughout the day. Messages left on the community nurse answer phone should be clear and concise and it should be noted that messages left after 4.30pm may not be dealt with until the following day.

Categories of Referral

Urgent: - • Blocked catheter • Enema required • End of Life symptoms	**will be seen within 4 hours, between the hours of 8.30am – 5pm**
Non- Urgent: - • Routine Dressings • Injections, please specify if particular date or time of day is required	**will be seen 24-48 hours**
Routine Care: - • Long term partnerships with and support of patients with chronic disease, and chronic degenerative disease, carers and/or family members • Care of Hickman/PICC • Holistic nursing Assessment • Palliative and terminal care. • Wound management • Promotion of continence and assessment of incontinence • Health promotion, advice and support • Promotion of self-care through education and empowerment of individuals and their carers	**will be seen within one week**

Guidelines for referral to the District Nursing Service

Staff Safety

The protection and safety of our nursing teams are of paramount importance to us.

Health professionals working in the community are often lone workers; therefore it is vital that you share any information you might have regarding potential or actual safety issues relating to the patient or his/her carers at time of referral. Ideally in these instances a Multi-disciplinary meeting before discharge would be beneficial, if this patient is in hospital at referral.

There is a duty of care to share information where the Community worker might be subjected to violence, aggression, dangerous weapons or animals, or if there is any environmental concern.

The patient/client must have an identified nursing need that requires the intervention or advice from a registered nurse.

Does your patient have a

Nursing need? or	**Social Care need? or**	**Therapy need?**
For example: • Holistic nursing assessment • Continence care • Palliative/terminal care • Chronic illness management • Teaching self-care • Wound care management • Health promotion/education • Medication management	***For example:*** • Mealtime provisions • Day care • Domiciliary care e.g. housework • Assistance with personal hygiene • Respite care	***For example:*** • Assessment for mobility aid • Assessment for daily living activities where no nursing need
If so, refer to District Nursing.	**If so, refer to Social Care.**	**If so, refer to OT/physio**

Information we need to know from you on referral:

- **We need to know** the patient's name, address, date of birth, telephone number, contact details, GP, reason for referral/anticipated nursing need, relevant past medical history, method of entry to property, directions to the address if the property is difficult to find.

- **On hospital transfers** please supply if applicable five days' worth of dressings, catheter bags, continence products etc to allow time for a prescription to be obtained.

- **Specialised Procedures/Complex Cases -** District Nursing Team members have a wide range of skills and expertise. However consideration must be given to certain specialised procedures which are not carried out frequently and which may, on occasion, require team members to undertake updates/further training.

All referrals will be assessed on (re)admission to the caseload.

The referrer should *not* give the patient information about times and frequency of visits, unless there is a specific reason as this will be decided and agreed following assessment between the patient/carer and District Nurse.

Specialised Procedures/Complex Cases

Please contact District Nurse base to arrange discharge date as equipment/training etc may need to be organised.

- IV Antibiotics (on an individual basis)
- Tracheotomy Care
- Enteral feeding
- Subcutaneous Fluids
- VAC Therapy

When specialised procedures are required it is essential that the District Nurse is contacted in advance of discharge. The District Nursing teams welcome the opportunity to discuss planned care or to attend discharge planning meetings in cases when complex health needs are identified or specialised equipment, i.e. hoists or mattresses are needed.

Nursing assessments will include the needs of carers and /or family members

Patients under the age of 16 must be routinely referred to the Children's Community Nursing Team. However under 16 year olds will occasionally be seen by the District Nurses in liaison with the Children's Community Nursing Team.

Guidelines

As the patient's condition improves, and they are mobile, they may be asked to access services in other health care settings as appropriate.

Patients referred from hospital for wound care will require a five day supply of suitable dressings to accompany them prior to prescription being obtained.

Patients on VAC wound therapy will only be accepted on the caseload via a referral from the Tissue Viability nurse.

Referrals for home care, meals on wheels, day care and assistance with personal hygiene, bathing, getting up or putting back to bed **MUST** be referred to Social Services directly or advised to contact private agency.

Community Nurses cannot move any immobile patient without the appropriate equipment: a moving and handling risk assessment will need to be made.

If a patient is discharged from secondary care appropriate equipment must be in place in the home prior to discharge and a then referral made to the Community Nursing team if any intervention required.

Referrals for Flu / Pneumovax vaccines will only be accepted if the patient/carer/relative is already on the Community Nurse caseload.

Discharge Criteria and Planning

- Health outcomes achieved
- Patient died
- Patient declines further contact
- Patient referred to another team or agency
- Patient does not fulfil referral criteria following initial assessment

Patients, families/carers and other professionals involved in the patient's care should be informed of plan of discharge and information given how to contact service should further Community Nursing needs occur.

Prevention, Self-care and Patient and carer Information

- Carers informed of support services available and how to access Carers Assessments
- Self-management plans promoted
- Patients will be issued with appropriate information leaflets pertaining to their specified needs
- All patients informed of named health professional and how to contact service on discharge to obtain further advice and support
- Comments leaflet issued to all new patients and carers

Specialist Nurses

There are also specialist nurses working within the Adult Community Nursing Teams these include:-

The Specialist Health Visitor for Vulnerable Adults

The Specialist Health Visitor for Vulnerable Adults works primarily with vulnerable adults, especially those groups of individuals who normally do not access/engage with mainstream services.

The aim of the work is to search for and identify health needs/issues in order to empower and support patients to reach optimum independence, safety and well-being.

Criteria for referral
Must have:

a) Consent/unless lacking capacity
b) Identified or suspected unmet health needs
c) Vulnerability (please explain)
d) No other nursing service already involved

Hours of operation:

This is not an emergency service. The Adult Health Visitor Service operates between 09.00am – 5pm Monday to Friday except for bank holidays and during periods of annual leave.

How to make a referral to the Adult Health Visitor service (quick guide/flowchart is shown in appendix 4b):

Referrals can be made by post, fax or telephone, it is an open referral system.

Patients and carers must have given their consent for the referral to be made

Professionals use Appendix 1 or Appendix 2 if referring from hospital.

Patients /Clients and Carers can make referrals to the Adult Health Visitor directly.

The Adult Health Visitor can be contacted directly at her base and there is an answerphone for messages.

Adult Health Visiting Service
Third Floor, Markwell House,
Douglas, Isle of Man, IM1 2RZ
Tel: 01624 665941 Fax: 01624 662593
Email: mandy.davies@gov.im Web site: www.gov.im/health

Referrals will only be accepted if the patient meets the case holder's criteria.
All patients/clients will be contacted within 5 working days of receipt of the referral.

Please note this service is not covered during holidays and sickness

Continence Nurse Advisor

The Continence Advisor provides confidential advice on all continence related matters to sufferers and their carers, both informal and professional. The main aim of the service is to help people maintain or regain normal bladder and bowel control. Where this proves to not be possible the service can arrange the supply of suitable products to manage incontinence.

Hours of operation:

The Continence Advisor operates 08.30-4.30pm Monday to Friday except bank holidays. Appointments can be made outside these times by negotiation.

How to make a referral (quick guide/flowchart is shown in appendix 4c):

Referrals can be made by post, fax or email to Karen Trowbridge, Continence Advisor, Independent Living Centre, Central Community Health Centre, Westmoreland Road, Douglas,IM1 4QA Tel: 693551, Fax:617235 or email Karen.trowbridge2@gov.im

Phone messages are collected each weekday morning.

Clinics are held at:

Nobles Hospital, Braddan in the Women's and Children's Outpatient Department each Monday 2-4pm

RDCH Out Patient Department on the 2nd and last Wednesday each month
2pm -4pm.

Clinics are also arranged in Central Community Health Clinic, Westmoreland Road, Douglas, Thie Rosien, Port Erin and Peel Day Centre.

Home visits can be arranged if patient unable to attend clinic.

Information we need to know from you on referral:

- **We need to know** the patient's name, address, date of birth, telephone number, contact details, GP, reason for referral/anticipated health
  need, relevant past medical history, whether the patient is able to attend clinic or needs a home visit.

  NB The patient must have consented to referral

Categories of referral

All referrals are classed as Non Urgent – will be assessed within 2 – 3 weeks of receipt of referral.

Please note this service is not covered during holidays or sickness

Parkinson's Disease Specialist Nurse

The Parkinson's Disease Specialist Nurse will assess patients with Parkinson's disease or Parkinsonism, identifying problems and planning care, monitoring of medication and its side effects and ensuring effective co-ordination and collaboration with the Multi Disciplinary Teams both in Primary and Secondary Care. The Parkinson's Disease Specialist Nurse provides on going education and support for patients and families/carers from diagnosis and throughout the course of the disease**.**

Hours of operation:

The Parkinson Disease Specialist Nurse is available 30 hours per week over four days, answerphone is available for non-urgent messages.

How to make a referral (quick guide/flowchart is shown in appendix 4d):

Patient's must be in full agreement of a referral and must be aware of their diagnosis.

The Parkinson's Disease Specialist Nurse, Sue Lawley, can be contacted by post at Crookall House, Demesne Road, Douglas, Tel: 642676 or email susan.lawley@gov.im.

Information we need to know from you on referral:

- **We need to know** the patient's name, address, date of birth, telephone number, contact details, GP, reason for referral/anticipated health need, relevant past medical history, method of entry to property, directions to the address if the property is difficult to find.

Categories of referral

Patients will usually be contacted within two weeks of the referral being made however this may be longer during periods of annual leave. During periods of leave any urgent problems/difficulties should be directed to either the patients own GP or Parkinson's disease Consultant.

Long Term Conditions Co-ordinators (LTCC)

This is not an emergency service

Service delivery:-

The LTCC work alongside GP surgeries identifying patients who have complex co-morbidities or complex needs who would benefit from case management in order to empower them to be experts in their own conditions and to self-manage.

How to make a referral (quick guide/flowchart is shown in appendix 4e):

LTCC work 8.30-5 pm Monday to Friday except for Bank Holidays

Initially referrals will be from G.P.s only

Please use Community Nursing Referral Form (Appendix 1) FAX: 642659 (On EMIS)

Southern Group Practice/Ballasalla/ Castletown/Loch Prom/Finch Hill, Snaefell:
Bev Marsh 831864

Palatine/Hailwood Kensington Group Practice/Onchan:
Sue Wilson 665942

Ramsey Group Practice/Peel/Laxey:
John Davison 811822

Patients must have given consent / agree with referral and be willing to engage with the service.

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Community Nursing Referral

To: Adult Health Visitor / District Nurse / Child Health Visitor / School Nurse
(delete as appropriate)

Patient Name: .....

Address: .....

D.O.B.: ..... Tel No: .....

GP: ..... NHS no: .....

Next of kin: ..... Relationship: .....

Address: ..... Tel No: .....

Lives alone: Yes/No

Date visit required (DN only) _____

Reason for referral, please identify health need:

Patient aware of this referral: Yes/No (delete as appropriate)

Brief medical history:

Relevant medication. (GP please include medication summary print off from EMIS):

Services involved (please circle appropriate)

District Nurse	Health Visitor	Social Services	Mental Health	Other (please specify)

Referred by: ..... **Date: .....**

Signature: ..... **Designation: .....**

Health outcome/Action taken:

Signature:..... Designation:..... Date:.....

Print Name .....

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Department of Health and Social Care
Rheynn Slaynt as Kiarail y Theay

Department of Health
Request for Continuity of Care /District Nursing/Health Visiting

Please print names

Patients Surname:	Forenames:	Mr/Mrs/Miss/Ms
NHS no.	Date of Birth	
Telephone no.	Mobile no.	

Home Address	Discharge Address
Patient Lives: Alone/Relative/Other Is patient a carer: Yes/No	Key Pad No.: Yes/No Code

Lone Worker Concerns:	Yes/No	State:
Environment Hazards:	Yes/No	State:

Next of Kin:	Relationship:
Address:	
Telephone No.:	Mobile No.:
Name of GP:	Practice:
Consultant	Date of Admission
Date of Operation	Follow-up Appointment Yes/No
Complications Yes/No	
Date of Discharge	Allergies

Diagnosis

Diagnosis Explained to Patient Yes/No

Patients understanding of illness

Referral for: District Nurse/Health Visitor

Identified Nursing Need/Health Need:

Date Visit Required:	Dressings Provided: Yes/No
Equipment Given Prior Discharge: Yes/No	State:

Isle of Man Department of Health
Request For Continuity of Care District Nurse/Health Visiting

Patients Surname	Forenames
NHS No	
Care needs on discharge	Home Care/Private, please state

Pressure Areas

Waterlow Score	Date Assessed
Wound Classification grading (EPUAP)	
Date dressing last changed	Treatment

Mental State			
Mobility on Discharge		Aids Used	
Height		Weight	
Bowels Continent	Yes/No	Bladder Continent	Yes/No
Catheter Yes/No		Indwelling Urethral	Yes/No
Suprapubic Yes/No	Date Inserted	Size of Catheter	
Continence Supplies Used		Delivered	Yes/No

Medication (Please list ALL Medication):

Medication Provided	Yes/NO	Medidose used	Yes/No	Medidose arranged	Yes/NO

Other Health Professionals informed of Discharge (Please list)

Day Hospital Yes/No	Planned Respite Care Yes/no	Date:

Signature	Print	Faxed Yes/NO

Status	Hospital	Ward	Date

Isle of Man Department of Health

Request For Continuity of Care Form/District Nurse/Health Visiting

Additional Information Sheet

Hospital Number

Patients Surname Forenames

Appendix 3

Attachment List – Adult Team

District Nurse Base/Address	Tel/Fax No.	GPs covered
Base: Ramsey Dalmeny House Cumberland Road Ramsey IM8 3RH	Tel: 811833 Tel: 811834 (answerphone) Fax: 656096	Ramsey
Base: Peel Medical Centre Albany Road Peel IM5 1HU	Tel: 686966 (answerphone) Fax: 686967	Peel
Base: Southern Group Practice Thie Rosien Castletown Road Port Erin IM9 6BD	Tel: 836284 (answerphone) Fax: 835572	Ballasalla Southern Group Practice Castletown
Base: Central Community Health Centre Westmoreland Road Douglas IM1 4QA	Tel: 612332 Tel: 616757 (answerphone) Tel: 660218 Fax: 685100	Kensington Palatine
Base: Onchan Surgery Village Walk Health Centre Village Walk Onchan IM3 4EA	Tel: 656032 Tel: 628462 Tel: 656033 (answerphone) Fax: 656034	Onchan Laxey Finch Hill Hailwood Loch Promenade Snaefell
Central Community Health Centre Treatment Room Westmoreland Road Douglas IM1 4QA	Tel: 642696 (answerphone) Fax: 685100	

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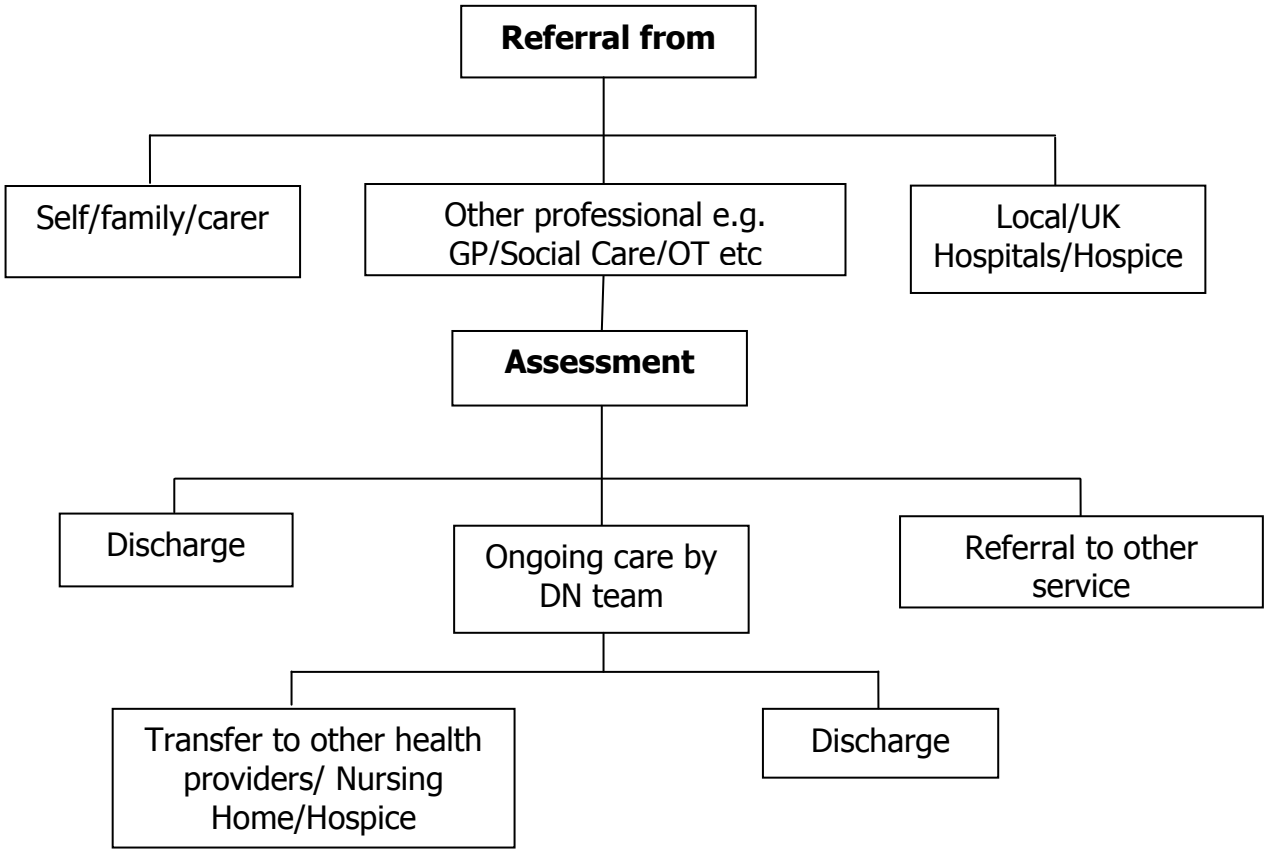
Adult Community Nursing Team Pathway



Date: Dec 2015
Review date: Dec 2018

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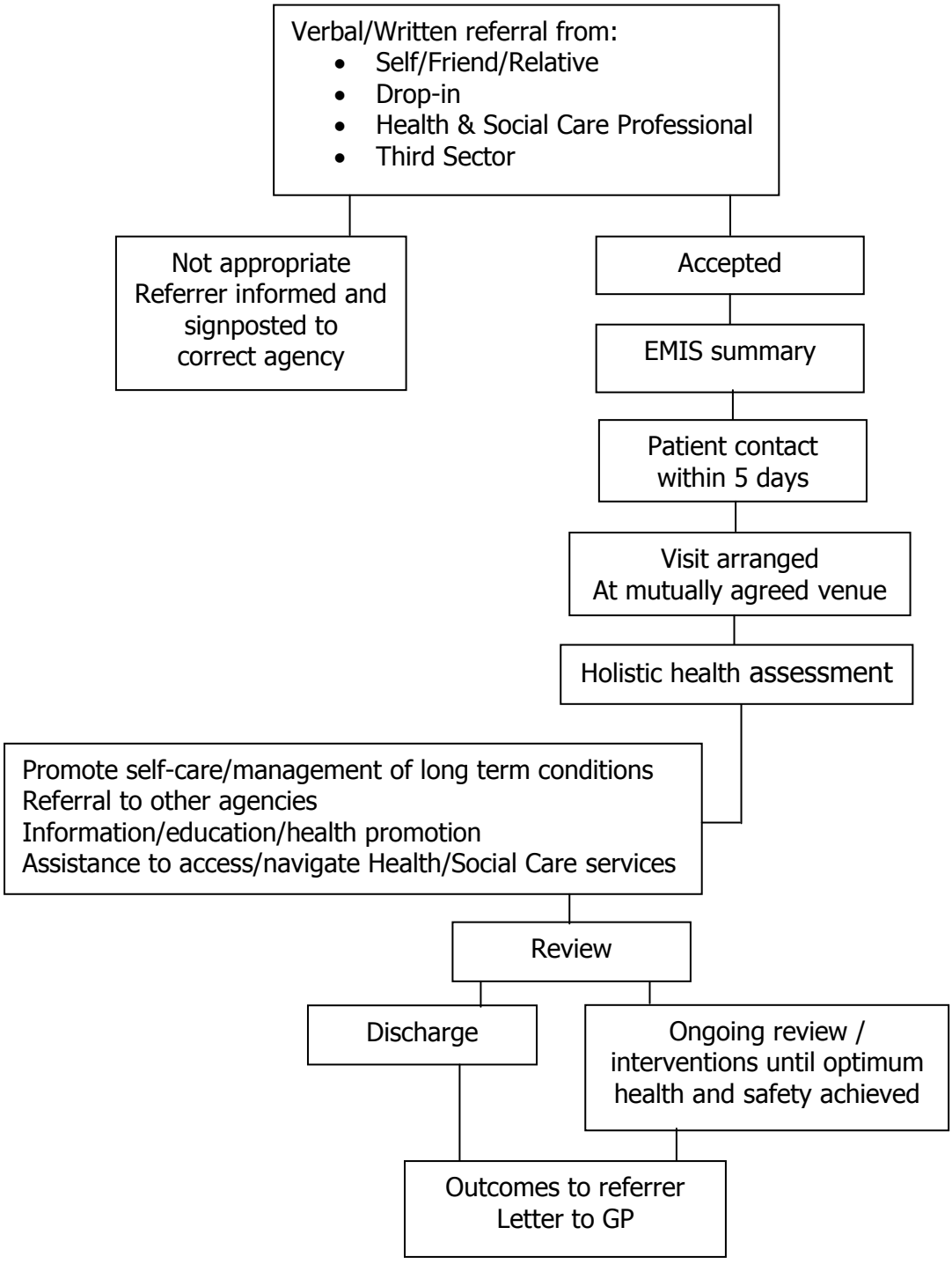
Referral Pathway – Health Visitor for Vulnerable Adults



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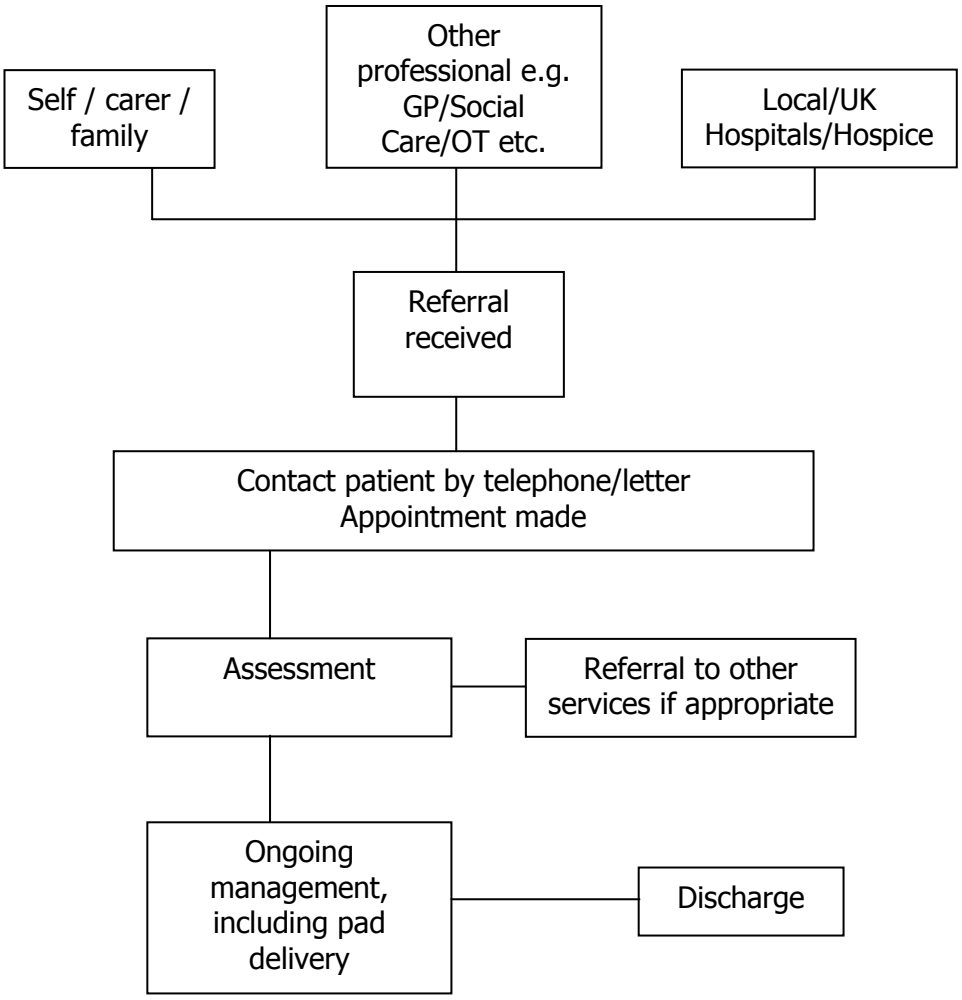
Referral Pathway – Continence Advisor



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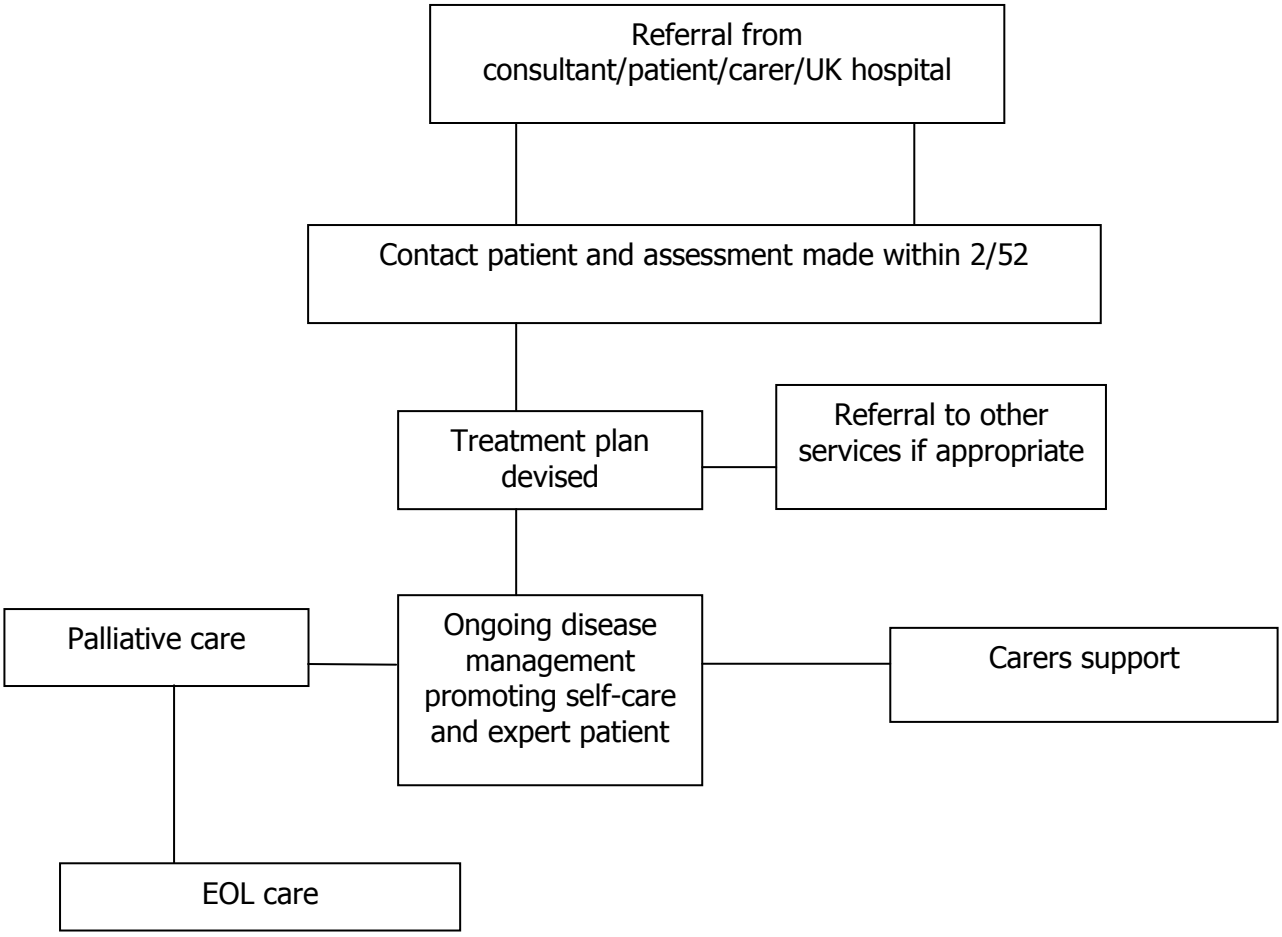
Referral Pathway –
Parkinsons Nurse Specialist



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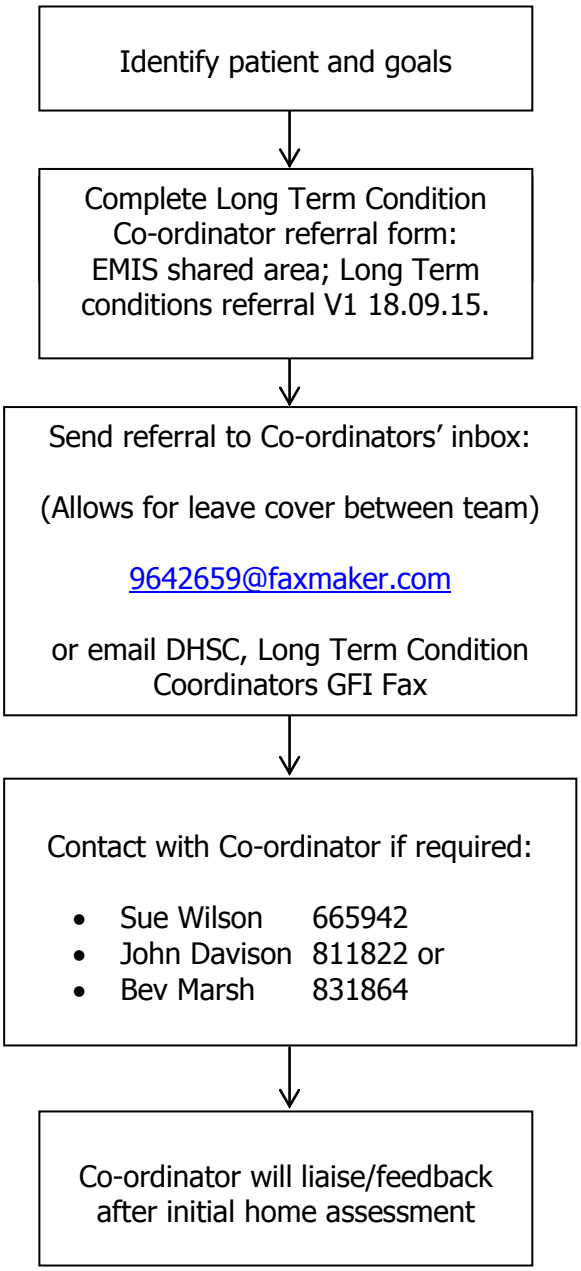
Referral Process to Long Term Conditions Co-ordinators



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