# Covid-19: Provision of Care within the Community

## Standard Operating Procedure

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<tr>
<th>Version</th>
<th>Date Finalised</th>
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Background

Information from Public Health England (2020) regarding the epidemiology of Covid 19:

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China.

On 12 January 2020 it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. This virus is referred to as SARS-CoV-2, and the associated disease as COVID-19.

Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others causing more severe disease such as Middle East respiratory syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) coronaviruses.

On the 11th March 2020 The World Health Organization declared Covid-19 was categorized as a pandemic. Please see Appendix D for the response from the joint UK nursing councils and professional bodies to assist your practice and support. The link below set’s out how providers of community services can release capacity to support the COVID19 preparedness and response. These arrangements will apply until 31 July 2020 in the first instance.

National community covid 19 guidance

Covid10 Prioritisation within Community Health Services guidance:

NHS England NHS Improvement Community SOP

Priorities for community health services

The following priorities apply during this pandemic:

1. Teams should support discharge of patients from acute and community beds today as mandated in the new guidance for Hospital Discharge Service Requirements and ensure patients cared for at home receive urgent care when they need it.

2. By default, use digital technology to provide advice and support to patients wherever possible.

3. Apply the principle of mutual aid with health and social care partners, as decided through your local resilience forum (Escalation Call) with Regular reviews of the RAG rated healthcare caseloads, to compare these with Social Services locality colleagues RAG rated social care caseloads. This will assist in reducing duplication of visits and monitoring non-urgent patients, to safety-net them so that they are not left without support.

Virtual assessment

All new patients should be virtually assessed taking into consideration clinical need to identify if:

- At the CCC point of contact all patients referred will be asked if they are happy for care and advice to be given using virtual consultation
- Carers /relatives/volunteers can provide care and support, with guidance
- A face-to-face contact is clinically necessary

Roles of Staff

**Call handlers within the Care Co-ordination Centre (CCC) or for Therapy Services who do not use the CCC:** Ascertaining on first telephone contact whether patient self-isolating and symptomatic or asymptomatic

**Clinicians within Community Care:** To continue to provide necessary care to patients in a safe and timely manner. Ensuring risk assessment and care is completed as per appendix 1 to

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protect both them and others where suspected or diagnosed cases of Covid-19 are encountered.

**Essential face-to-face care**

Essential face-to-face services and home visits should be managed through designating teams; facilities and/or premises, to segregate COVID-19 positive (including those individuals and households with symptoms) and non-COVID-19 positive services and patients to minimise the spread of infection, particularly to those most at risk.
Risk Stratification

Caseload management –

Continuity planning: Caseloads to be reviewed to determine priorities if increasing time is required with patients with Covid 19.

Use of urgency and dependency tool to be utilised on Systmone care plans to ensure patients of RED urgency always seen without delay and to aid in prioritising of care.

For partner Therapy Services not using Systmone, prioritising patients need to be agreed locally based on equivalent risk factors.

Potential support networks to be considered e.g. family/friends/support agencies that could be utilised to assist in lower level elements of care and some technical interventions.

Advice should be provided to all patients on how to keep well.

Ensure awareness within caseloads of high risk patients that may require assistance of voluntary agencies to aid with tasks such as shopping.

Rationale

Due to the current COVID 19 crisis management plan it is vital that we continually capture the urgency of our visits so that we can ensure that patients and staff are supported.

RAG Risk Stratification Guidance

1. For any new or existing patient please ensure that you capture an initial RAG rating for risk stratifying their healthcare needs.

2. There are 3 risk ratings to choose from, these are:

   - Red = Healthcare needs and frequency of face to face visits cannot be flexed and without a visit the patient will be at risk of hospitalisation or risk to life, this included shielded patients
   - Amber = Healthcare needs cannot be met without some form of virtual support or face to face intervention but frequency of contact/visits can be flexed if needed
   - Green = No immediate risk to health or safety if no nursing or therapy input is provided for a period of time. Able to make informed decisions about own health & wellbeing. Has other support networks to assist in their care needs.

N.B. For profession specific guidance see appendix A for community nursing

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For all staff that do not usually use care plans please use either the RAG referral as the indicator for COVID urgency or capture this using your clearly defined caseloads.

3. For community nursing (and anyone already using care plans) - Capture this data by opening up the care plan that you will be using and select to edit the care plan [ ]. Within the ‘Care Plan Information’ tab, in the ‘Care needed’ box add the RAG rating at the beginning of the template name.

N.B. It is extremely important you complete this in the exact format below so that your data can be pulled to support your demand and capacity planning for COVID 19 management:

**URGENT – Care plan name** (please include one space either side of the hyphen)
E.g. RED – Wound Care to Left Leg

4. Once RAG risk stratification has been added click ‘OK’
5. A prompt will appear, click ‘Yes’

6. Every time you visit or contact this patient as part of their treatment/care needs please ensure you review this risk stratification rating to ensure it meets their current needs.

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7. Standard Operating Procedure

**Key Principles**

- To ensure all staff within the community are equipped to provide safe effective care in light of the Covid-19 pandemic.
- To protect all patients that care is being provided to.
- To practice in line with evolving national advice and guidance.

For new referrals via CCC or Therapy Services not using CCC: - Call Handler/service on receiving referral to ask:

1) Are you currently self-isolating due to Coronavirus?
2) Are you currently experiencing any active symptoms that may be linked to Coronavirus i.e. cough; raised temperature; loss or change in sense of taste or smell

Positive answers to be clearly documented on SystmOne or equivalent system such as ecare and TCES via a HIGH PRIORITY reminder to ensure visiting clinicians are aware on immediate receipt of referral and all relevant health professionals can access information – preset phrasing to be applied and used.

**Essential face-to-face care**

Essential face-to-face services and home visits should be managed through designating teams, facilities / premises to segregate COVID-19 positive (including those individuals and households with symptoms) and non-COVID-19 positive services and patients to minimise the spread of infection, particularly to those most at risk.

All services will need to consider, along with their CCG, the operating model that best suits their local arrangements and supports clinical decision making. The operating model will need to be tailored to each service, the current workforce capacity and numbers of patients in each of the cohorts. It may be necessary to change the established operating model for each service, depending on changes in demand and workforce capacity as the pandemic evolves. Ensure you document the rationale for any operating model changes at a local level, eg where separating a workforce is not possible and what risk mitigations have been put in place.

Community teams may need to separate their workforce to treat patients with suspected COVID-19 (based on triage) or those patients without COVID-19 symptoms needing essential care. The development of these teams may be considered in line with an escalation plan identifying the benchmark for implementation in line with community infection rates.

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For regular visits on caseloads: - To ensure safety, all clinicians to initially check whether patient is self-isolating or showing active signs of Covid 19 through means of a telephone contact. HIGH PRIORITY reminder to be set up on patients SystmOne or equivalent record clearly illustrating if self-isolating or showing active signs of Covid 19. Please refer to appendix F for timescale re high priority removal notice from systmone. For Therapy services please use your local caseload protocols to record this.

Prior to visit following telephone conversation it should be expressed that if any risk factor is recognised the CCC or service should be contacted to ensure clinicians aware and can implement correct procedure prior to next planned visit. The protocol for the community clinician/worker telephone conversation to include:

1) **anosmia** (a loss of or change in your normal sense of smell or taste)
2) **a high temperature** – “this means you feel hot to touch on your chest or back (you do not need to measure your temperature)”
3) **a new, continuous cough** – “this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual)”

If patient advises that symptoms are present refer to appendix 1 for visit protocol.

Protocol for visiting a patient:

Prior to visiting it should be ascertained if patient is self-isolating and whether they are symptomatic or asymptomatic. If a visit is deemed necessary then Appendix 1, 2, 3 and E protocols/guidance should be followed by the clinician / worker. If the telephone assessment is made by a non registered health worker and the patient is symptomatic then a conversation and local decision must be had with a registered professional to determine triage regarding essential visit status. The outcome of this risk assessment should be documented on systmone or equivalent system.

If there is an enhanced risk (out with the protocol in appendix 1, 2, 3 and E) then a formal risk assessment is required as per the trust guidelines.

If following review a face to face visit is deemed appropriate and necessary the process of ‘donning’ and ‘doffing’ of appropriate PPE must be adopted.
**Scheduling of visit if patient / client is known to be positive for Covid 19 or potential with evident symptoms:**

If a patient is known to have Covid-19 or is self-isolating with evident symptoms, where possible this patient should be scheduled to be seen last so that no further patients are seen by visiting clinicians that day.

If the care need dictates that it is not possible to schedule the patient to be seen last i.e. a morning diabetic for nursing clinicians, care should be provided using the donning and doffing technique and patients seen after should be highlighted low risk. Please consider that once a day insulin treatment could be moved to the end of the day if considers appropriate (with specialist support).

**Shielded ‘extremely clinically vulnerable’ patients – home visits**

This group of patients have been advised to practice shielding. Shielding, in this context, means remaining at home always and avoiding any face-to-face contact. The definition of this group and additional information can be found in the associated guidance on shielding.


- Those people at most clinical risk can access help here.
- Clinician and Patient FAQs for this group are available here.
- GP IT systems now have a functionality that identifies patients who are potentially at risk from COVID-19 and produces alerts within patient records. Liaise with local GP allied to CHT to review these lists.
- Review case lists and use the core screening questions and check if they have received a letter advising them to self-isolate.
- All efforts need to be taken to mitigate risk of infection including the ordering of home visits to see these people first and segregating the workforce where possible.
For guidance on residential care, supported living and home care:

NB. It is essential that the same staff member does not visit multiple homes if these visits are deemed essential. Video conferencing is the preferred route of care for residential care homes.

Please see appendix 2 for guidance on:

- how to maintain delivery of care in the event of an outbreak or widespread transmission of COVID-19
- what to do if care workers or individuals being cared for have symptoms of COVID-19

Guidance on Personal Protective equipment (PPE):

Please see appendix 3 for all PPE guidance. The links within this appendix shows you the recommended PPE to use (Please note the 2 different links for different settings).

‘Donning’ and ‘Doffing’ process to be used during required visits:

Fluid Resistant Surgical Mask (FRSM) should be applied prior to entrance of the property. All remaining PPE should be donned and doffed just inside the property entrance. If first visit with patient where donning and doffing is required telephone contact to be made with patient / relative / carer to explain the process that will be undertaken and ensure patient is aware that for safety purposes protective equipment will be being worn. Arranging access to property to also be made during telephone contact.

Following extensive review the direction below regarding visors was confirmed 12/11/20 from Sharon Basson Head of Nursing:

We have recently completed a review of Public Health England (PHE) guidance around the use of full-face visors after some of you requested permission to wear goggles instead.

The PHE guidance identifies full-face visors as the “gold standard” in personal protective equipment (PPE). However, we do recognise that some clinicians prefer to use goggles for specific procedures, particularly where visors significantly impair your ability to see what you are doing (e.g. for ear, nose and throat procedures, slit lamp use, ultrasound examination etc).

Your safety is our utmost priority, but in the above-mentioned instances it is acceptable for colleagues to wear goggles instead, as long as they have been obtained from the trust.
purchasing department and an appropriate risk assessment has been completed on the risk register/Datix system.

Eye protection must be worn at all times when you are within two metres of a patient and delivering care. This includes all in-patient, out-patient, and community settings.

The national guidance is under constant review and we will notify you of any change to the above arrangements.

Please note - The Covid 19 Guidance for the remobilization of services within health and care setting. Infection Prevention and control recommendations (Public Health England and NHSE August 2020 p3) includes in its key messages ‘sessional use of single use PPE items has been minimized and only applies to extended use of facemasks for health care workers’

**Equipment**

- Fluid Resistant Surgical Mask or FFP2 (FFP3 masks only required if performing aerosol generating procedures.
- Full face visor for eye protection
- Apron
- Gloves
- Clinical waste bag
- Alcohol Hand Gel and/or liquid soap, hand towel.

On arrival at property consent must be gained for entry and ensure patient aware that property has been accessed and that PPE will be being applied inside the property entrance.

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**Video link to demonstration of ‘Donning’ and ‘Doffing’:**


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**Donning (applying PPE):**

*If not wearing a sessional FRSM, apply before entering the property*

1. Enter area in home for donning – once inside apply PPE near to entrance.
2. Clinician to don PPE
   - Perform hand hygiene/hand decontamination before putting on PPE
   - PPE should be put on in the following order:
     1. Mask
     2. Plastic Apron
3. Full face visor – if visor causing safety issue for staff member, due to misting up an individual risk assessment to be undertaken with line manager and outcome documented as highlighted above

4. Disposable gloves

Within one metre of a suspected or confirmed COVID-19 patient:
1. FRSM
2. Apron
3. Full face visor
4. Disposable gloves

Suspected or confirmed COVID-19 patient requiring aerosol generating procedures:
1. FFP3 mask
2. Long sleeved disposable gown
3. Full face visor
4. Disposable gloves

Provision of care:
Necessary care to be provided with only essential contact made.
If changing of gloves is required during care, remove yourself from area close to patient, remove PPE gloves, gel/wash hands and apply clean gloves to continue care.

Doffing (removing PPE):
1. Enter area in home for doffing – near to entrance.
2. DO NOT TOUCH THE FRONT OF ANY OF THE PPE WORN DURING THIS PROCESS.
3. Remove PPE as per the PHE guidance below:

The order and procedure of removal of PPE should be;

Remove gloves and cleanse hands with alcohol gel:
- Break the apron from behind the neck and then waist. Fold the apron in on itself do not touch the outside.
Discard gloves and apron.

Remove full face visor:
- If your hands get contaminated during eye protection removal, immediately wash your hands.
Eye protection to be discarded.

Remove fluid resistant surgical mask/FFP2/FFP3:
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Surgical mask

- Lean forward slightly, reach to the back of the head with both hands to untie straps, untie the bottom tie first, then the top tie and remove by handing the ties only. For ear looped masks, unhook simultaneously.
- Let the mask fall away from your face and discard in clinical waste.

Decontaminate hands – Wash Hands / or utilise hand gel or Clinell hand wipe.

4. All used PPE equipment to be disposed of in clinical waste bag and left at property – These bags should be placed into another bag, tied securely and kept separate from other waste if possible. This should be put aside for at least 72 hours before being put in the usual household waste bin for disposal as normal. If patient already receives clinical waste collection, items can be placed in yellow bin. If no clinical waste collection already in place, to be arranged through completion of Clinical Waste Collection Form (Appendix 1).

5. Hand hygiene to be completed again on departure from house – hand gel or Clinell Hand Wipe.

Only necessary equipment should be taken into home. All equipment taken from the home must be cleaned as per infection control guidance.

Staff support:

Due to the nature and currently unknown entity of the progress and impact of Covid 19 it is advised that daily team handover remains essential to support dissemination of information to front line staff and enable both pastoral and clinical reassurance. To keep staff safe, where possible, daily handover and meetings should be virtual. Where face to face meetings of 2 or more staff are conducted (within office environments for example), 2m social distancing should still be maintained and is best practice. Offices certified as Tier 2 covid secure allows for staff to be 1-2m apart with a face mask to mitigate the risk of transmission. However there is a risk that if a positive case is identified, other staff could be contact traced.

Further information:

- National guidance regarding Covid 19 is evolving on a daily basis so it will be ensured that all updates will be disseminated to ensure most up to date advice is received and acted upon by all. Standard Operating Procedure will be updated accordingly.
- If you have any queries please contact your line manager in the first instance.
- For support out of hours the Community Manager on Call (CMOC) to be contacted initially for triage of concern and signposting where appropriate – CMOC to be contacted via 0300 130 3066

**Use of Video Consultation as part of the response to Covid-19**

**VIRTUAL MEETING GUIDANCE**

Guidance on virtual meetings has been published on the different video conferencing options that are available to Trust staff, and can be found here.

Whilst we continue to use Microsoft Teams and Visionable, the guidance reflects that other organisations may use other solutions and so Trust staff can join calls from these platforms but not initiate them. Please note that restrictions remain on some VC platforms.

**VIRTUAL MEETINGS**

Microsoft Teams is now fully operational across the Trust, both for acute and community staff. It is a virtual meetings software which facilitates video calling and chatting to aid remote working and assist with social distancing. It is only suitable for corporate video conferencing – not virtual clinical appointments with patients.

This is safe to use for patient handovers and team meetings, but not for patient video consultations; Visionable is the tool of choice for this. Remember that MedicBleep can also be used for secure messaging if patient data is required. Please view information on Visionable and clinical conferencing here.

There is lots of good functionality in Teams, like the ability to set up ‘channels’ with lots of colleagues where you can share info and documents. If you’d like to know more about this, contact Sarah Judge for full information.

A help zone is available as a Team in Microsoft Teams; this provides top tips and advice on using Teams. Go to ‘join a Team’ and use the code s0web4t for WSH accounts, and f59eudh for NHSmail accounts.

Virtual meeting guidance link:

[https://www.wsh.nhs.uk/covid-staff-zone/Working-differently/Virtual-meetings.aspx](https://www.wsh.nhs.uk/covid-staff-zone/Working-differently/Virtual-meetings.aspx)

As part of our response to COVID-19 it is important that we do as much to protect our patients and staff as possible. As such, clinical teams must consider alternative options for delivering care to all patients. Where clinically appropriate the following should be identified:

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➢ Which patients can you switch to telephone appointments?
➢ Which patients can you deliver care to via video consultation. See the guidance at the end of this document for presentations this could include.

Every team should be working to safely switch away from face to face consultation to one of the above options where clinically appropriate as soon as possible.

**Switching to telephone appointments**

Please review your lists to ascertain which patients would be suitable for telephone consultations.

In preparation for the scenario where staff may need to isolate, but are well and will work from home, all staff without a working VPN or direct access connection should contact the NEL IT helpdesk on 0808 168 5168 to request setup immediately.

Laptops and chargers should be taken home at the end of every day.

All staff with SystmOne mobile already installed on their laptop, should ensure their passwords are current and they can access the app, please call the systmone support team for assistance with this if required on 01473 278997.

If you have any queries please contact chris.barlow@suffolkch.nhs.uk, sarah.judge@wsh.nhs.uk, or your team leads.

**Nursing guidance**

Process mapping

1. There will be two pathways for Video Consultations unplanned care and planned care

2. Within planned care this will be extended to include palliative support

3. Within the CCC an initial question will be posed to request “if appropriate and following nurse triage are you happy for your consultation to be via a videoconferencing link”

4. Unplanned Video Conferencing referrals will be referred by the COD to the “Visionable nurse”

5. Planned Video Conferencing referrals will be scheduled onto the “Visionable nurse daily schedule”

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6. It is anticipated that there will be a visionable nurse present within each team during core hours. This will be either virtually or at base. However a scoping exercise will be conducted to utilise those staff who are in isolation or shielded. The preference is for this work to be completed remotely. However it is acknowledged that there are difficulties operating the platform via VPN. We will establish which of these staff require further education or support with Tech.

7. This work will be undertaken by Band 5, 6, 7 and they will work within their professional remit.

8. CHTs to establish a rota for each CHT where “A Visionable Nurse” is available in each CHT so that a staff member is available during core hours to accept planned and unplanned VC referrals and undertake VC contact daily.

**Therapy Process Guidance**

Please do not enter care homes unless it is absolutely necessary. Explore all other possible options to deliver care.

CHT Leads to instigate telephone or teleconference triage for the care homes in your area with a regular appointment time to enable complete reduction in face to face contact.
EOL

CPR guidance in the community –

With immediate effect community staff should not be undertaking cardiopulmonary resuscitation (CPR) on any patients unless wearing full level 3 PPE. CPR is considered an aerosol generating procedure and therefore it is important that staff are fully and appropriately protected before attempting this procedure.

It is crucial for community staff to be fully aware of any advanced ‘do not attempt cardiopulmonary resuscitation’ decisions, and act accordingly if there is one in place. In the event of patient suffering a cardiac arrest who is for full resuscitation, the member of community staff must use their clinical judgement and make a decision whether resuscitation should be commenced or not. If the decision is to proceed staff should do the following:

- Call 999 as usual.
- If a defibrillator is available, apply the defibrillator pads and follow voice prompts to shock but **do not** attempt chest compressions.
- **Do not** attempt CPR unless you are wearing full level 3 PPE (as shown in the right hand side of attached diagram).
- When you are in full level 3 PPE, apply a cover to the patient’s face (covering nose and mouth) and start chest compressions.
- If you do not have access to PPE then **do not** attempt CPR.

This applies to all community and home settings, including the community hospitals. The above policy applies to all community patients (i.e. neonates, children and adults).

VOED

In response to the expected increase in demand for Verification of Expected Death (VOED) during the Covid-19 crisis, an online version of the VOED training package has been developed for registered clinical professionals working in the community in Ipswich and East Suffolk and West Suffolk. It has been developed in conjunction with St Elizabeth Hospice and hosted by University of Suffolk, and will enable us to meet a potential increased demand for verification in a timely way.
This course will take approximately 1 hour and is followed by a ‘Quiz’ which candidates are required to pass with a score of at least 80%. There is a maximum of 2 attempts to pass. In addition to the online course, candidates will be invited to attend a face to face update and reflective session with colleagues to enable continued learning from experience.

The course is for registered clinical professionals working in Ipswich and East Suffolk and West Suffolk, and is suitable for

- RNs working in the community
- Nurse practitioners in primary care
- Paramedics working in primary care
- Any trained and competent qualified health care professional which could include therapists

For information, on the advice of the Suffolk Coroner, this training is not currently being offered to RNs working in nursing homes.

Preparing for the training

At least 24 hours before you plan to take the training you need to request a login. To do that, please

- Click on the link below to register using Google Chrome or Microsoft Edge (you may have to copy and paste the link) as Internet Explorer is not supported by University of Suffolk.
- Registration form link https://libguides.uos.ac.uk/voed/register
- Fill in the form and submit
- Your login will be emailed to you (up to 24 hours later). Note: Requests are processed by University of Suffolk once per day, Monday to Friday.

On the day you plan to take the training

- You should allocate approx. 1 hour to do this training. Work through the slides by reading and listening to the audio AND by reading the workbook
- There is no time limit to complete the course, but you should do this in a single session.
- Take the Quiz – you will need to get at least 80% to pass and you are given a maximum of 2 attempts.
- Once you have successfully completed the test, the certificate will become available for you to download.

Follow-up reflective session
After 12 months you will be invited to attend a face to face update/ reflective session with colleagues to update and continue to learn from experience.

Questions or issues?

Please contact Gillian Mountague, Redesign Project Manager at Ipswich and East Suffolk CCG

gillian.mountague@ipswichandeastsuffolkccg.nhs.uk
## Appendix 1 – WSFT Clinical Waste Collection form

### Clinical Waste Collection Request

For a collection of Clinical Waste from Patients Homes – suspected Covid-19

(Send To)  
FacilitiesServices@suffolkch.nhs.uk  
(Search 'Facilities' in global address book)

### Requisition Details

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Covid 19 WSFT Version 1.14 community
Date Contractor contacted |
Appendix 2 - Visit protocol incorporating .Gov guidance for Social and Health Care Workers


Appendix 3 – Recommendations for PPE

Secondary care inpatient clinical setting
The recommended PPE for healthcare workers by secondary care inpatient clinical setting, NHS and independent sector (acute hospital inpatient and emergency departments)

https://associationofbreastsurgery.org.uk/media/252021/t1_poster_recommended_ppe_for_healthcare_workers_by_secondary_care_clinical_context.pdf

Primary, outpatient and community care setting
The recommended PPE for primary, outpatient and community care by setting, NHS and independent sector

file:///C:/Users/kevin.mcginness/Downloads/Recommended_PPE_for_primary_outpatient_and_community_care_by_setting_poster.pdf
Appendix A

To be used as part of flow chart for prioritising community nursing visits. Inform patient you will be wearing PPE as this may be alarming for them.

Prioritisation of urgent visits in to RED AMBER GREEN categories – Caseload holder to indicate these on system 1 within caseload from NOW.

**RED**

Diabetic treatment- insulin administration

End of life symptom control and syringe driver meds

Anticoagulant injections- Tinzaparin etc.

Blocked catheters not bypassing

IV medications via PICC and flush

Essential dressings- those where daily exudate management is required or risk of sepsis is very high

Drains to relive symptoms (Plurex/rocket)

**AMBER**

Compression- please review all compression to consider if fitted stockings would allow a non-registered member of staff to support these patients and or family/carer to help manage these wounds

Pressure ulcer dressings

Vac pumps- consider removing if needed and use conservative dressings

Urgent or planned venepuncture

Bypassing catheters

Removal of sutures/clips

**GREEN**

Routine catheter changes

Wound management- on a case by case assessed basis

Dopplers

Covid 19 WSFT Version 1.14 community
B12’s

Non urgent phlebotomy

Consider stop ear syringing
Appendix c

Patient Information Leaflet:

Wound Care at home

Preparing to dress your wound:

You will need:

- Dressing pack: which includes gauze, gloves, tray, apron and waste bag.
- Wound dressings: provided by nursing staff
- Scissors cleaned prior to use
- Creams / barrier creams for surrounding skin
- Tape if required
- Running tap water is used to clean surrounding skin

Procedure:

- Wash hands thoroughly especially between fingers and palms of hands.
- Dry hands with a clean towel / kitchen roll.
- Open dressing pack, apply apron provided.
- Remove waste bag for dirty dressings.
- Open new wound dressings and drop into clean opened dressing pack.
- Remove dressing without touching the inside of the dirty dressing or the wound bed, you might have to wet dressing with tap water if dressing is stuck to wound, do not pull if stuck as this will damage the healing wound.
- Place dirty dressing into the bag provided.
- Wash hands again.
- Apply clean gloves from sterile pack.
- Clean surrounding skin with tap water and gauze from dressing pack.
• Ensure skin surrounding wound is dry using gauze from the dressing pack.
• Apply new dressings as directed by the nurse who provided dressings.
• Place used dressing pack, waste and packaging in the waste bag and dispose of in domestic waste bin.

Please monitor for signs of infection

Look for:

• Redness to skin surrounding the wound.
• Skin surrounding the wound is warmer than normal.
• Wound has become painful.
• Swelling around the edge of the wound.
• Increased leakage of fluid from the wound.
• Offensive smell.
• Yellow or green pus.
• If wound deteriorates / gets larger or deeper.

If the infection spreads further, the redness will keep spreading to more areas of the skin which will need to be assessed by a Nurse

If you suspect a wound infection please contact:

Care Coordination Centre CCC

0300 123 2425
Appendix D

12 March 2020

Dear colleagues,

Supporting Nurses and Midwives across the UK and Nursing Associates (England only) in the event of a COVID-19 epidemic in the UK

Let me start by thanking you, we know that you and your colleagues have been working exceptionally hard, and you should know that the work you are doing is having a real impact.

If COVID-19 becomes an established significant epidemic in the UK, NHS services across the health and care sectors will be put under extreme pressure. This pressure will inevitably be exacerbated by staff shortages due to sickness or caring responsibilities. It will be a challenge, but we are confident that nursing and midwifery professionals will respond rapidly and professionally. We want to assure colleagues that we recognise this will require temporary changes to practice, and that regulators and others will take this into account.

A significant epidemic will require health and care professionals to be flexible in what they do. It may entail working in unfamiliar circumstances or surroundings or working in clinical areas outside of their usual practice for the benefit of patients, individuals and the population as a whole. This can be stressful, and we recognise that you may have concerns about both the professional practicalities and implications of working in such circumstances.

We need to stick to the core principles of nursing and midwifery practice. As registered professionals you are expected to practice in line with the NMC code and use judgement in applying the principles to situations that you may face. However, these also take account of the realities of a very abnormal emergency situation. We want nursing and midwifery professionals in partnership with patients and those individuals that we care for, to use their professional judgement to assess risk and to make sure people receive safe care, informed by the values and principles set out in their professional standards. A rational approach to varying practice in an emergency is part of that professional response.

It is the responsibility of the organisations in which you work to ensure that you are supported to do this. They must bear in mind that clinicians may need to depart, possibly significantly, from established procedures in order to care for patients in the unique and highly challenging but time-bound circumstances of the peak of an epidemic.
We expect employers, educationalists, professional bodies and national NHS organisations to be flexible in terms of their approach and the expectations of routine requirements. Health and care professional regulators, including the NMC have already committed to take into account factors relevant to the environment in which the professional is working.

Due consideration should and will be given to health and care professionals and other staff who are using their skills under difficult circumstances due to lack of personnel and overwhelming demand in a major epidemic. This may include working outside their usual scope of practice. The health and care regulators have already released a joint statement to explain this: [https://www.nmc.org.uk/news/news-and-updates/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus/](https://www.nmc.org.uk/news/news-and-updates/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus/)

We are now working with the NMC to enable people to come back to work and to invite our final year student nurses and midwives to come into clinical practice to support us over the next few months.

Finally, we would like to thank you all for all the efforts you are already making. Many nursing and midwifery professionals across the NHS, public health and care services have already made major contributions to the response to COVID-19. We are very proud of the response of the professions in all areas of practice in their response to this challenge. It has been exemplary. We are confident of the commitment, dedication and hard work that nursing and midwifery professionals have and will continue to have in the very testing event of a significant epidemic in the UK.

Your professionalism and work has never been more vital or more valued.

Yours sincerely

Ruth May  
Chief Nursing Officer, England

Fiona McQueen  
Chief Nursing Officer, Scotland

Charlotte McArdfie  
Chief Nursing Officer, Northern Ireland

Jean White  
Chief Nursing Officer, Wales

Dame Donna Kinnair  
CEO, RCN

Andrea Sutcliffe  
Chief Executive and Registrar, NMC

Professor Brian Webster-Henderson  
Chair, Council of Deans of Health

Gill Walton  
Chief Executive, RCM
Appendix E

Community wound care ANTT Practice Framework.
Appendix F

Stay at Home guidance for households: current guidelines illustrated

Criteria and guidance applied as known on 17/03/2020:
* Incubation period = maximum 14 days
* Symptomatic individuals stay in self isolation for 7 days from becoming ill (having symptoms). Day 1 is first day of symptoms
* Household members who remain well stay in self isolation for 14 days due to maximum incubation period, calculated from day 1 of first symptomatic person
* Household members do not need to restart the clock if other members become symptomatic during the 14 days self-isolation

| Days | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| A    | X |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| B    |   | X |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| C    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| D    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

**Example 1**

| Days | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| A    | X |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| B    |   | X |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| C    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| D    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

**Example 2**

| Days | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| A    | X |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| B    |   | X |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| C    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| D    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

Key: **X** = ill/having symptoms
**✓** = allowed to go out again

Covid 19 WSFT Version 1.14 community
Appendix G – Lymphoedema SOP

COVID-19 West Suffolk Lymphoedema Service - Action Plan

Standard Operating Procedure

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<th>Date approved</th>
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<td>Guidance on how to integrate clinics post COVID</td>
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Please see Covid-19: Provision of Care within the community SOP for background guidance, the Lymphoedema service will work to the community SOP with this SOP being more service specific.

Staff involved and roles

Jess Pearce (up to 14th April) – Team lead of Lymphoedema service. To support with staff redeployment, staff and service management and escalation, patient escalation and telephone clinics.

Kate Laybourne – Lymphoedema Specialist Nurse. To provide continuity and essential assessment to patients via telephone consultations and home visits where urgent cases require preventing patient deterioration.

Rosie Hunkin – Service administrator. To book and manage all telephone consultations and home visits. Ascertaining on first telephone contact whether patient self-isolating and symptomatic or asymptomatic prior to home visit completion. To manage all service administration.

Key principles

- To ensure safe working of Lymphoedema staff and effective care throughout COVID-19 pandemic.
- To practice in line with recommended national and local guidance
- To provide appropriate essential care to patients with Lymphoedema in the West of Suffolk.
• **Actions**

**New referrals –**

New referrals will continue as normal to be emailed through the West Suffolk Lymphoedema generic email address and E-care. When a referral is received we will triage appropriately as per normal process, but complete an initial telephone consultation to discuss urgency of visit. We will follow the prioritisation route as below after this telephone consultation. We expect an increase in breaches throughout this time, but also a reduction in referrals.

**Prioritisation –**

**Red- offer home visit**

Patient has repeat infections/cellulitis – or at risk.

End of life symptom management

Lower limb oedema increasing falls risk

Community nursing support with complex patients – supporting community nursing caseload.

Oedema become unmanageable leading to papillomatosis, lymphorrhea and vast lymphatic changes.

**Amber – offer routine phone call**

Patient struggling with donn and doff of compression

Being well managed by community nurses/leg ulcer clinic despite increased oedema

Patient psychologically not managing lymphoedema

Patient struggling with self-management whilst in self-isolation

**Green – offer a routine appointment when service is running to normal capacity.**

Patients self-managing safely

Patients requiring MLD or DLT.
**Routine appointments**

Routine appointments will be completed as appropriate via telephone consultation, which will then be triaged as above if concerns. The aim of this is to manage our current patients to reduce the risks of patients deteriorating and leading to further complications, alongside managing the potential for long waiting lists in future months.

- To order repeat prescription if patient managing in current garment, to maintain safety of oedema and reduce risk of deterioration
- To discuss self-management over the phone and encourage
- To guide to resources to support self-management
- Dopplers to not be completed at present

**Home visits**

To only be completed for patients who are class as a red priority. On the day of home visit clinician to telephone patient and discuss the below questions –

- Are you currently self-isolating due to Coronavirus?
- Are you currently experiencing any active symptoms that may be linked to Coronavirus i.e. cough, raised temperature, (please explain a high temperature) —“this means you feel hot to touch on your chest or back (you do not need to measure your temperature)” (A new, continuous cough) — “this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual)”
- Is there anyone else in the property that has been exposed to COVID-19?
- We ask that any other members of the household are in another room for the purpose of the visit unless necessary to support and assist the patient
- Clinician to explain to patient infection control measures being taken on visit.
- To ask patient if they have hand washing facilities available with hand soap and a clean towel to dry hands
- To gain consent to visit patient once above completed document verbal consent gained in E-care documentation.
- If home visit deemed not appropriate to visit to be clearly documented in E-care documentation.

Positive answers to be clearly documented on eCare to ensure visiting clinicians are aware on immediate receipt of referral and all relevant health professionals can access information. To then contact any other health and social services involved in patient care through CCC to inform them of positive answers. In this instance Lymphoedema clinician to triage if remains appropriate to visit or if visit can wait until 14days isolation completed and safe to visit.

**Self-isolating patients** - To ensure safety, all clinicians to initially check whether patient is self-isolating safely in line with government restrictions or self-isolating due to symptoms of COVID-19.

Prior to visit following telephone conversation it should be expressed that if any risk factor is recognised the CCC or service should be contacted to ensure clinicians aware and can implement correct procedure.
prior to next planned visit. To follow the above guidelines prior to visit. Clinician to also follow guidelines outlined by West Suffolk Foundation Trust community SOP.

**Infection control on visit**

**To follow trust guidelines and community SOP**

Clinician to wash hands on arrival of visit with soap and water and clean hand towel. If unable to be provided by patient, clinician to provide resources for visit.

If patient is demonstrating no symptoms of COVID-19 then normal infection control measures to be implemented as per trust guidelines.

Please follow community SOP for advice on PPE.

**In-reach to hospital**

Referrals to be triaged for in reach patients as per current Lymphoedema procedures.

Patients classed under ‘red’ prioritisation only to be seen as in-reach to hospital. If patient has suspected or confirmed COVID-19, to triage if patient is appropriate to wait to be seen when 14 day isolation period completed. If Patient has no suspected COVID-19 then to complete assessment on ward as per normal process.

**Staff support and well-being**

Staff to contact each other when logging in remotely from home, lunch break and logging off remotely at the end of the day.

Staff to remain in good contact throughout the day through means of medic bleep, email and phone.

Staff should be encouraged to maintain a staff meeting once a week to discuss how current service process is working and if any changes can be utilised to increase efficiency.

Staff to raise any occupational health, service, or concerns appropriately to the team.

**Re-integration of clinics post COVID-19 pandemic**

We will expect to see an increase in our breaches, which will have an impact to our follow up appointments. At present on the 6.4.2020 we have 44 new patients yet to be seen, which has potential to increase if we get referrals prior to clinics starting.

**New assessments**

To ensure that we prioritise the new assessments we will allow for more new patient slots in the clinic scheduling for the first 3 months. However, prior to completing the new patient assessments we will
complete an initial phone call, which will then be re-triaged dependent on clinical need and appointment booked following this.

**Follow up patients**

As we continue to complete our clinics via telephone and potentially video clinics the team are completing post clinic summaries as per normal policies. Therefore, Lymphoedema administrators to book follow up appointments as per guidance from this.

**Intensive treatment – Decongestive Lymphatic therapy/Manual Lymphatic therapy**

Decongestive Lymphatic Therapy or Multi-Layer Limb Bandaging to be completed only if patient is at risk of deteriorating whilst service establish reducing the new patient breaches that have formed.

Once the new assessment waiting list has reduced to a safer level, to commence intensive treatment above as per normal guidelines prioritizing patients by clinical need.

**Outreach clinics**

To begin outreach clinics as soon as guidance provided by trust safe to do so.

**Staffing**

Redeployed staff to return to the service when agreed safe from the Trust.

Stefan Currington (band 4 Lymphoedema Assistant Practitioner- to join full time whilst service lead on maternity leave. To be supervised and appraisal completed by Kate Laybourne

Bank Band 4 – Lymphoedema Assistant Practitioner Tracy Nunn – to join team every Friday and be based at WSH. To be supervised by Laura Beaumont.

Bank Band 6 – Lymphoedema Specialist Nurse – Tess Henry – To join team twice a month on a Wednesday – to be based at WSH. To request supervision from Gylda Nunn when required. Tess will require induction to team.
Appendix H – Nutrition and Dietetics RAG guidance

Dietetics

New Patients
- All referrals are triaged upon receipt and RAG rated either, Red, Amber, or Green.

Red
- Need for dietetic input and frequency of face to face visits cannot be flexed.
- High risk of deterioration from presenting condition.
- Without an urgent assessment the patient will be at risk of hospitalisation or risk to life.

Amber
- Need for dietetic input cannot be met without some form of virtual support but frequency of contact/visits can be flexed if needed.
- Low risk of acute deterioration from presenting condition.
- Intervention unlikely to prevent admission to hospital.

P3/Green
- Low risk of deterioration from presenting condition.
- No immediate risk to health or safety if no dietetic input is provided for a period of time.

Current caseloads

Clinic Patients: All clinic patients are allocated a Red, Amber, Green risk rating based on the above.
- Red - patients are contacted within or before their original scheduled appointment.
- Amber - patients are contacted before or within a month after original scheduled appointment.
- Green - patients are contacted within 3 months of their original scheduled appointment for a review or assessment.

Group: All groups are cancelled

Patients requiring a Home visit: All patients have been RAG rated and are reviewed in order of priority. A letter has been sent to patients to inform them that their consultation will take place via telephone and providing contact details.

Oral nutrition advice: letters have been sent to GPs to extend prescriptions of Oral Nutritional Supplements for a period of 6 months unless advised.

Home Enteral Feeding patients: All patients have been RAG rated and are reviewed in order of priority. A letter will be sent to inform patients of contact details for troubleshooting and out of hours support.
Nursing Homes: All patients have been RAG rated and reviewed according to priority. A letter has been sent to all Nursing Homes to advise that consultations will take place via telephone with a link to a MUST referral form.

NUTRITION NURSE SERVICE

New referrals and follow up visits
- All new referrals are triaged and RAG rated; Red, Amber, or Green.

Red
- High risk of deterioration from presenting condition
- Would benefit from urgent Nutrition Nurse ax
- Reduce risk of admission to hospital

Amber
- Low risk of acute deterioration from presenting condition.
- Would benefit from Nutrition Nurse intervention
- Intervention unlikely to prevent admission to hospital

Green
- Low risk of deterioration
- Low need of Nutrition Nurse
- No benefit from prevention of admission to hospital

All referrals received will be been seen in order of priority and advice will be provided via telephone, except in the following instances:

- Infection of the stoma site (patients that are unable to send a picture)
- Routine or emergency tube change
- Tube training for new or existing patients/carers
- Pump training
- Troubleshooting unable to resolve of the telephone

All patients are contacted by telephone on the day of the visit as per community protocol and the appropriate equipment is used according to the assessment carried out.

Equipment: Any equipment required is delivered to patient’s doors without any patient contact.

Out of hours: Patients have been provided with contact details of the Care Coordinator Centre for emergency displaced tubes which will be managed by the Early Intervention Team.
Appendix J –PERIPHERAL STORE DETAILS FOR COMMUNITY EQUIPMENT - UPDATED

Access to the Disability Resource Centre (DRC) 4 Bunting Road, Bury St Edmunds, Suffolk, IP32 6BX

There is usually someone in the building from 8:00 am to 16:30 pm weekdays but not always.

If you don’t have your own keys there is a key safe on the right-hand side of the building, the code is 1346 pull the black tag downwards, this should allow you to get the key.

On entering

If you are the first person to enter the building you should obtain the key from the key safe on the right-hand side of the building, the code is 1346 pull the black tag downwards, this should allow you to get the key.

Please open the doors with the rounded key, the key with the white dot should be used to turn the lock to the left of the doors this should mean that the doors open automatically.

Once inside the building the alarm can be disabled by entering 8844 then press ent, please lock the double doors behind you.

On leaving

If you are the last person to exit the building you must make sure that no one else is still in the building before you alarm it. A sweep of the building by checking upstairs and checking doors and calling out should be done. Please ensure that all fire doors are closed and turn off any lights still on, the fire door downstairs in the main corridor to the side of the building which leads out to the bin area may also need locking. It is the reverse of a normal lock and is twisted (no keys).

To alarm the building, you should press 8844 then press A, then lock the doors behind you. The keys will need to be put back in the key safe ready for the next person to use.

Other considerations

There is a green button at the top of the door panel on the left-hand side and this will release the doors from the inside.

A master set of keys on a purple Papworth Trust lanyard will be on the front desk this will open the doors to the admin room if required.