



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Discharge of a Patient from the Public Health Nursing Caseload

Policy
 Procedure
 Protocol
 Guideline

HSE National Public Health Nursing Service : Community Operations: Primary Care


Title of PPPG Development Group:		National Primary Care Metrics PHN Sub Group	
Approved by: Signature(s)			
Reference Number:		PCPHN01	
Version Number:		2	
Publication Date:		Dec 2019	
Date for revision:		Dec 2022	
Electronic Location:		National PHN Services : Primary Care www.hse.ie/phn	
Version	Date Approved	List section numbers changed	Author

Table of Contents:		Page
Part A: Outline of PPPG Recommendations.....		4
Part B: PPPG Development Cycle		10
1.0	INITIATION.....	10
1.1	Purpose.....	10
1.2	Scope	10
1.3	Objectives.....	10
1.4	Outcomes.....	10
1.5	PPPG Development Group.....	11
1.6	PPPG Governance Group.....	11
1.7	Supporting Evidence.....	11
1.8	Glossary of Terms and Definitions.....	12
2.0	DEVELOPMENT OF PPPG.....	15
2.1	Clinical Question	15
2.2	Literature search strategy.....	15
2.3	Method of appraising evidence.....	15
2.4	The process the PPPG Development Group used to formulate recommendations.....	16
2.5	Summary of the evidence from the literature	16
2.6	Resources necessary to implement the PPPG recommendations	17
2.7	Outline of PPPG steps/recommendations.....	17
3.0	GOVERNANCE AND APPROVAL.....	17
3.1	Outline formal governance arrangements.....	17
3.2	Method for assessing the PPPG in meeting the standards outlined in the HSE National Framework for developing PPPGs.....	17
3.3	Copyright/permission sought.....	18
3.4	Approved PPPG Checklist.....	18

4.0	COMMUNICATION AND DISSEMINATION.....	18
4.1	Communication and dissemination plan.....	18
5.0	IMPLEMENTATION.....	19
5.1	Implementation plan listing barriers and/or facilitators	19
5.2	Education/training required to implement the PPPG.....	19
5.3	Lead person(s) responsible for the implementation of the PPPG	20
5.4	Specific roles and responsibilities.....	20
6.0	MONITORING, AUDIT AND EVALUATION.....	22
6.1	Plan and identify lead person(s) responsible for the following processes:	
6.1.1	Monitoring.....	22
6.1.2	Audit.....	22
6.1.3	Evaluation.....	22
7.0	REVISION/UPDATE.....	22
7.1	Procedure for the update of the PPPG.....	22
7.2	Method for amending the PPPG if new evidence emerges	22
7.3	Version control update on the PPPG template cover sheet	22
8.0	REFERENCES.....	23
9.0	APPENDICES	27
	Appendix I: Signature Sheet	
	Appendix II: Membership of the PPPG Development Group	
	Appendix III: Conflict of Interest Declaration Form (held in master copy in OMNSD)	
	Appendix IV: Membership of the Approval Governance Group	
	Appendix V: Audit Tool to Review Operation of this Procedure	
	Appendix VI: GP Discharge Notification Letter	
	Appendix VII: Patient Discharge Letter	
	Appendix VIII: Types of Community Nursing Teams	

PART A: Outline of PPPG Steps

Title: Discharge of a Patient from the Public Health Nursing Caseload

2.7 The steps to be taken to achieve the discharge of a patient in receipt of a clinical nursing service all age groups from the active Public Health Nursing caseload are;

2.7.1 When to discharge a patient from the caseload:

A1.1 A patient is discharged from the nurse's caseload in the following situations:

- No further nursing intervention is required
- When no further nursing review dates are scheduled
- On the death of the patient
- On admission to a residential care unit (Long Stay Care)
- On admission to an acute hospital
- On admission to a secondary community nursing service that is part of a specialised rehabilitation/re-enablement team. (Appendix VII)
- Where an existing patient declines a nursing service
- On transfer to another public health nursing geographic area/caseload

A1.2 The patient is re-referred onto the nursing caseload when a new episode of nursing care is required.

2.7.2 Discharging a patient when no other nursing intervention is required

A2.1 Once a holistic assessment has been completed by the nurse that demonstrates no further nursing intervention is required and the goals of the nursing plan of care have been achieved, the nurse in partnership with the patient/carer discharges the patient from the caseload.

A2.2 Relevant health promotion topics pertinent to the patient's individual circumstances are addressed that include discussion on self-management goals. This discussion must be documented in the clinical nursing record (Community Nursing Record). Relevant health promotion leaflets available from <http://www.healthpromotion.ie> may be offered to the patient. The following are some of the key health topics but may include others depending on the individual patient's health status (this is a non-exhaustive list);

- Nutrition
- Physical activity
- Mental health awareness
- Self-management of chronic disease
- Medication management
- Continence management
- Falls prevention

- Winter Initiative Awareness
 - Influenza vaccination
 - Smoking cessation
 - Home safety and security

- A2.3 The patient is made aware that no further nursing interventions are clinically indicated, but the service can be initiated again by the patient by self-referral or through other referral sources (GP/hospital) if required.
- A2.4 Written contact details and information for the PHN service should be given to the patient and they are advised that they may make contact should they require a nursing service in the future.
- A2.5 The nurse ensures the patient understands all aspects of the discharge process.
- A2.6 The discharge details pertaining to the patient and all information given to the patient on discharge, both verbal and written must be clearly documented in the clinical nursing record.
- A2.7 The nurse uses her professional judgement based on the significance of the episode of care to determine whether the patient's GP needs to be notified of the patients discharge from the PHN service. If the most recent episode of care was referred to the PHN service by the patient's GP a discharge notification is issued.
- A2.8 If the nurse determines that the patients GP is to be notified of discharge, s/he will complete and sign the discharge notification form (Appendix VI). The patient is informed that a GP discharge letter will be sent. A copy of the discharge notification will be given to the patient and a copy is filed in the clinical nursing record.
- A2.9 A notification of discharge is sent to other relevant members of the inter-disciplinary team if appropriate to the episode of care delivered or where an interdisciplinary team member referred the patient to the PHN service for nursing care.
- A2.10 If nursing intervention included a referral to another health professional for assessment and further intervention and a waiting list is in operation for that service the nurse may discharge the patient from the caseload if no further nursing intervention is required. The nurse should exercise professional judgement in the context of each individual case. In this situation the service referred to is informed of the discharge of the patient from the nursing service. The patient is informed that a waiting list is in place for this service and they are given information on how to contact the relevant service if the need arises.

- A2.11 Where possible other health professionals are informed by the nurse of planned discharges from the nursing service at professional/primary care team meetings.
- A2.12 Any patient held record in the home is retrieved in a timely manner and filed in the patients nursing file at the health centre. Infection prevention and control guidelines will be followed when removing records from a household where infection control procedures have been in place.
- A2.13 The nurse should document the name of the patient and the discharge date in the nurse's/team diaries and in the caseload register.
- A2.14 The nurse must clearly document in the clinical nursing record whether the nursing care process is complete, whether the patient has gone into long term care, transferred to another area, declined the service or if the patient is deceased.
- A2.15 The caseload register is updated with the patient's date of discharge and this discharge is included in the discharge figures for the relevant monthly primary care activity metrics.
- A2.16 The records are stored in compliance with local procedures and national HSE records retention guidelines. (HSE, 2013 and HSE, 2011)
- A2.17 All nursing equipment supplied is requested for collection, recycling or disposal as most appropriate in accordance with local management operating procedures

2.7.3 Discharging a patient who is deceased

- A3.1 A note is entered into the clinical nursing record and into the caseload register that the patient has been discharged and the reason for discharge.
- A3.2 The nurse transfers the patient's record from current files into discharged patient files section for management in accordance with local procedure and the HSE records retention policy.
- A3.3 Where deemed appropriate the nurse should inform other primary care team professionals involved in the care of the patient.
- A3.4 This discharge is included in the discharge figures for the relevant monthly returns.
- A3.5 All nursing equipment supplied is requested for collection, recycling or disposal as most appropriate in accordance with local management operating procedures

2.7.4 Discharge of patient who is admitted to long-term care

- A4.1 A note is entered into the clinical nursing record and into the caseload register that the patient has been discharged and the reason for discharge.
- A4.2 The nurse transfers the patient's record from current files into discharged patient's files section for management in accordance with local procedure and the HSE records retention policy.
- A4.3 This discharge is included in the discharge figures for the relevant monthly returns.
- A4.4 All nursing equipment supplied is requested for collection, recycling or disposal as most appropriate in accordance with local management operating procedures

2.7.5 Discharge of patient who is admitted into the acute hospital/secondary community nursing service (Appendix VIII)

- A5.1 A note is entered into the clinical nursing record and into the caseload register that the patient has been discharged and the reason for discharge.
- A5.2 The nurse transfers the patient's record from current files into discharged patient's files section for management in accordance with local procedure and the HSE records retention policy.
- A5.3 This discharge is included in the discharge figures for the relevant monthly return.
- A5.4 To facilitate integrated discharge planning the nurse should liaise with the acute hospital service discharge co-ordinator, the liaison PHN, or other relevant personnel to identify issues pertinent to discharge home and prepare an appropriate plan of care where required. This may generate an indirect intervention entry onto the PC activity metrics returns.

2.7.6 Discharge of patient who has declined a nursing service

- A6.1 A new patient referred to the PHN service may choose to decline a nursing service that has been recommended by the nurse following his/her professional assessment or the patient may decline further nursing intervention during an episode of care that has already commenced. The patient's decision to decline a nursing service and the patient's autonomy is respected. (HIQA, 2016)
- A6.2 A note is entered into the clinical nursing record outlining the nurse's professional recommendations for care intervention, the discussions that took place with the patient in relation to these recommendations and the agreed outcome of this discussion is recorded.
- A6.3 If a newly referred patient declines to accept a nursing service the patient is not accepted onto the caseload. For the purpose of primary care metrics this is entered as a referral not accepted

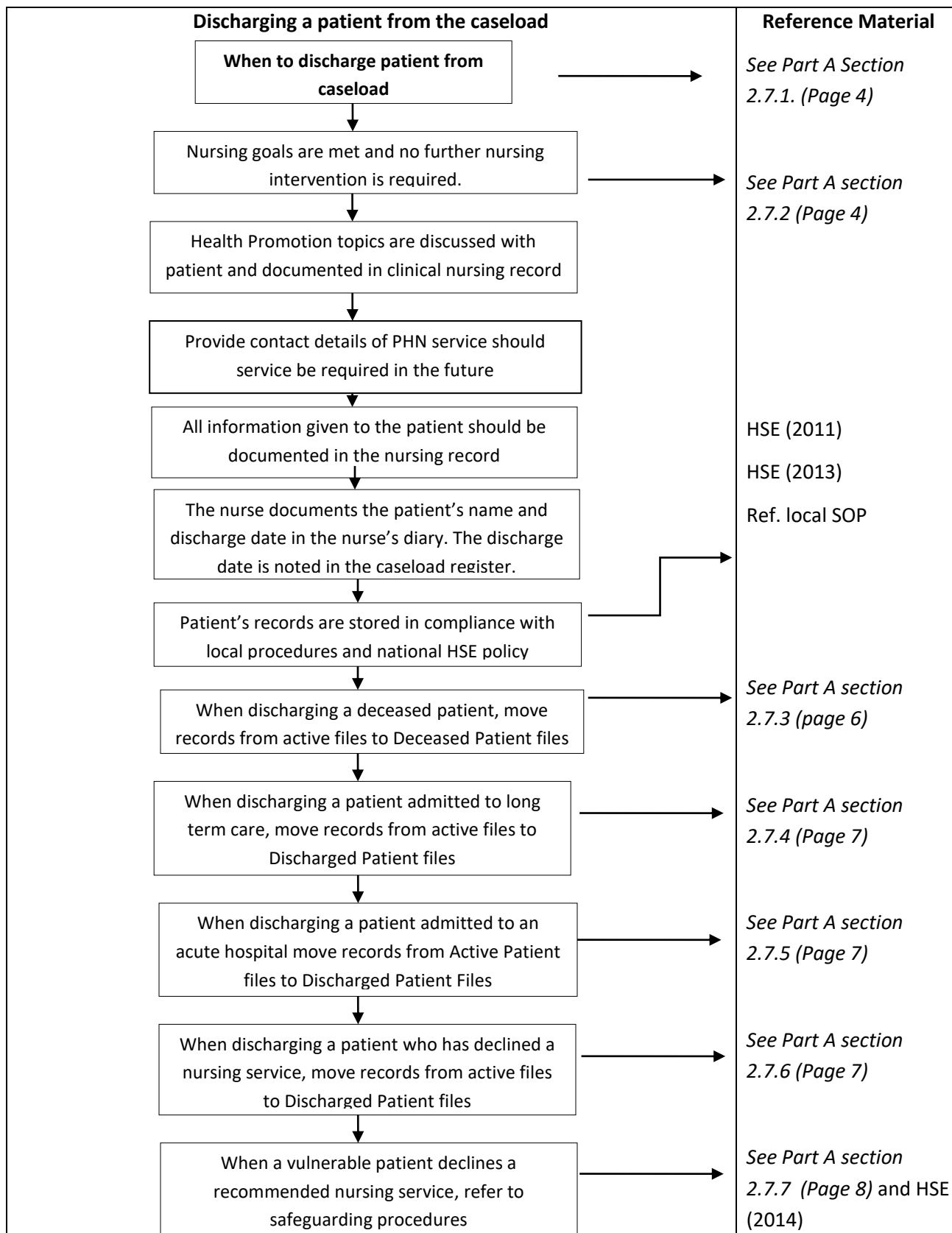
and may be entered as a face to face contact when this has been the nature of the interaction with the patient.

- A6.4 If a patient on the existing nursing caseload declines further nursing intervention, an entry is made into the clinical nursing record and into the caseload register that the patient has declined the service and is discharged from the caseload.
- A6.5 The nurse transfers the patient's record from current files into discharged patient's files section for management in accordance with local procedure and the HSE records retention policy.
- A6.6 This discharge is included in the discharge figures for the relevant monthly returns.
- A6.7 All nursing equipment supplied is requested for collection, recycling or disposal as most appropriate in accordance with local management operating procedures

2.7.7 Management of a vulnerable patient who has declined a nursing service

- A7.1 The nurse must seek a balance in respecting the patient's rights, assessing risk and protecting the patient from harm in meeting her professional responsibilities. (HSE, 2014) (HIQA, 2016)
- A7.2 If a patient declines a recommended nursing service and the nurse's professional judgement deems that this patient is vulnerable requiring safeguarding, the nurse must report her concerns in writing to the safeguarding and protection team as per HSE Safeguarding of Vulnerable Persons procedures. (HSE, 2014), (NMBI, 2015)
- A7.3 The patient is informed of this referral to the safeguarding and protection team. Other key health professionals involved in the patients care are informed as appropriate of the referral and made aware that the patient has declined a nursing service.
- A7.4 All nursing concerns in relation to the care of vulnerable persons must be discussed with the relevant line manager and a risk assessment incorporating best available evidence is completed.
- A7.5 A note is entered into the clinical nursing record outlining the nurse's professional recommendations for care intervention, the discussions that took place with the patient in relation to these recommendations and that the patient has declined the service.
- A7.6 The nurses concerns, the referral to the safeguarding team and other health professionals who have been informed are documented. A copy of the referral letter sent to the safeguarding and protection team is filed in the patient's clinical nursing record.
- A7.7 The outcome of the assessment of the safeguarding team and professional team meeting discussion with the GP and other relevant professionals will determine the future care plan to be implemented and this will guide any continued nursing intervention required. Clinical risk to the patient is monitored by the assigned key worker and risk status changes escalated as required.

2.7.8 Process map of procedure



PART B: PPPG Development Cycle

1.0 INITIATION

1.1 Purpose

The purpose of this procedure is;

- 1.1.1 To provide guidance to RPHN's and RGN's working in the community on the appropriate procedure for discharging patients from the active Public Health Nursing caseload that is underpinned by a person centred approach to care.

1.2 Scope

The scope of this procedure identifies what will (and will not) be covered by the procedure

- 1.2.1 Target users; this procedure applies to registered nursing staff in the Public Health Nursing service nationally. This includes Directors of Public Health Nursing, Assistant Directors of Public Health Nursing, Public Health Nurses, Registered General Nurses and locum/agency nurses working in the community.
- 1.2.2 Population to whom it applies; this procedure applies to all children receiving a clinical nursing service and all adults, including postnatal mothers on the caseload of the PHN and in receipt of a public health nursing service. It does not apply to well children who are in receipt of the National Child Health Screening and Surveillance Programme. This procedure does not apply to nurses working in specialist services or to their patient caseload. e.g. specialist palliative care; community rehabilitation, continence service; tissue viability service.

1.3 Objectives

- 1.3.1 To promote the effective management of PHN caseloads, leading to more efficient use of nursing time and resources and a more equitable service to patients in the community.
- 1.3.2 To promote an equitable and transparent discharge system nationally that is underpinned by a partnership approach to care.
- 1.3.3 To ensure that the patient and those involved in the patient's care e.g. family/carers are aware that the current episode of treatment/care has been completed.

1.4 Outcomes

- 1.4.1 The reason for discharging a patient is clear, it is directly linked to the patient's care plan and the patient's health record contains documented evidence on all aspects of the discharge process.
- 1.4.2 Standardised and accurate national nursing activity metrics will be available to facilitate HSE service planning.

1.5 PPPG Development Group

- 1.5.1 See Appendix II master copy for Membership of the PPPG Development Group.
- 1.5.2 See Appendix III master copy for PPPG Conflict of Interest Declaration Forms.

1.6 PPPG Governance Group

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

1.7 Supporting Evidence

1.7.1 Relevant PPPGs;

Department of Health and Children, (1970) Health Care Act
 Department of Health and Children, (2001) *Primary Care: A New Direction*
 Department of Health and Children, (1966) *Circular 27/66 District Nursing Service*
 Department of Health and Children (2000) *Circular 41/2000*
 Department of Health and Children (2000) Job description of the Public Health Nurse
 HSE (2018) *Primary Care Activity Metrics Workbook: PHN/CRGN Definitions 2018*
 HSE (2011) *Population Health Information Tool Changing Practice to Support Service Delivery*
 Nursing and Midwifery Board of Ireland (2015) *Recording Clinical Practice Professional Guidance.*
 Nursing and Midwifery Board of Ireland (2015) *Scope of Nursing and Midwifery Practice Framework.*
 Nursing and Midwifery Board of Ireland (2014) *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives.*

- 1.7.2 Existing local CHO procedures on discharging a patient from the PHN caseload informed the development of this procedure. This national procedure replaces any previously developed local procedures.

1.7.3 Related PPPGs;

Government of Ireland (2018) *Data Protection Act Article 7 2018*
 HIQA (2016) *Supporting Peoples Autonomy: a Guidance Document*
 HIQA (2015) *Guidance for Providers of Health and Social Care Services: Communicating in Plain English*
 HIQA (2013) *Guidance on Developing Key Performance Indicators and Minimum Data Sets to Monitor Health Care Quality Version 1.1*
 HIQA (2012) *National Standards for Safer Better Healthcare*
 HSE (2017) *Guideline for the Prioritisation of the Public Health Nursing Service in the event of Vacant Caseloads/Cross-cover DRAFT*

HSE (2017) National Consent Policy

HSE (2013) Record Retention Periods: Health Service Policy

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

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

HSE (2011) Developing and Populating a Risk Register: Best Practice Guidance

HSE (2011) Standards and Recommended Practices for Healthcare Records Management

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

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

1.8 Glossary of Terms

1.8.1 Abbreviations:

ADPHN –	Assistant Director Public Health Nursing
AHP-	Allied Health Professional
CHO –	Community Health Care Organisation
CNSp –	Clinical Nurse Specialist
DOH-	Department of Health
DPHN –	Director Public Health Nursing
GP –	General Practitioner
HIQA -	Health Information and Quality Authority
HSE-	Health Services Executive
ICT -	Information Communications Technology
NMBI-	Nursing and Midwifery Board of Ireland
NPDC-	Nursing Practice Development Co-ordinator
ONMSD-	Office of the Nursing and Midwifery Services Director
PC–	Primary Care
PPPG-	Policy Procedure Protocol Guideline
RPHN –	Registered Public Health Nurse
RGN –	Registered General Nurse working in the PHN service

1.8.2 Definitions:

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

Caseload: The number of persons / clients / patients managed by a health professional at a particular time. (NMBI, 2017) For the purpose of this procedure

the PHN caseload is defined as the number of patients admitted to the PHN service who require continuing care, have a current nursing care plan and have a date for review by the nurse within the next 12 months.

The caseload includes individuals within all categories and care groups: over 65 years, under 65 years, patients with disability, children from birth to 4 years and 11 months with clinical needs. It includes all patients in receipt of home help support/home care package who may have no direct nursing needs but require a regular nursing review in line with national and local policies, those in receipt of continence products and postnatal mothers and children receiving clinical care. For the purposes of this procedure it does not include children from birth to 4 years 11 months in receipt of the National Child Health Developmental Screening and Surveillance Programme. The area PHN has overall accountability for the caseload but works collaboratively with the RGN to actively manage the caseload.

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

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

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

Discharge Case: is a patient discharged from the caseload who following assessment requires no further nursing intervention or review dates, the episode of care is complete, nursing goals have been met and the care plan is closed. A patient case is deemed to be discharged when there is:

- Admission to acute hospital services
- Admission to long stay residential care facilities
- A refusal or decline of service offered
- Death

Evidence Based Practice: The conscious consideration and application of the best available evidence together with the nurse or midwife’s expertise and a person’s values and preferences in making health care decisions. (NMBI, 2017)

Health Care Record: All information collected, processed and held in either manual and / or electronic formats pertaining to a person under the care of a registered midwife or nurse or health care team, including personal care plans, clinical data, images, unique identification, investigation, samples, correspondence and communications relating to the person and his / her care. (NMBI, 2017) For the purposes of this procedure the health care record will be referred to as the clinical nursing record. As HSE national ICT systems develop the clinical nursing record may become part of a shared interdisciplinary clinical electronic patient record.

Must: Commands the action a nurse or midwife is obliged to take from which no deviation whatsoever is allowed. (NMBI, 2017)

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

Person: A person means an individual who uses health and social care services. In some instances, the terms 'client', 'individual', 'patient', 'people', 'resident', 'service user', 'mother', or 'baby', 'child', 'young person' are used in place of the term person depending on the health or social care setting. (NMBI, 2017) For the purposes of this procedure the term patient will be used throughout.

Professional Judgement: A nurses professional judgement is based on the principles of responsibility, accountability and autonomy as outlined within her professional scope of practice. (NMBI, 2015)

Should: Indicates a strong recommendation to perform a particular action from which deviation in particular circumstances must be justified (NMBI, 2017)

2.0 DEVELOPMENT OF PPPG

2.1 List the questions (clinical/non-clinical)

Will the implementation of a standardised process to discharge patients from the PHN caseload promote a safer, more efficient and person centred community nursing service?

- What does a national PHN caseload constitute?
- What is the national definition of a *discharged case* from the PHN caseload?
- When is the appropriate time to discharge a patient from the caseload?
- What constitutes safe and effective clinical practice in the discharge of a patient from the PHN caseload?
- How to ensure a person centred approach is evident during the discharge process?
- How to ensure the patient is prepared for self-care upon discharge?
- Who needs to be aware that the discharge has occurred?

2.2 Describe the literature search strategy

Current local procedural documentation/guidelines on caseload management and patient discharge from the PHN caseload were requested from DPHNs nationally. Five guidelines were returned from four CHO areas. These were reviewed and relevant references within these local documents were sought and reviewed. (See Section 8.0) The following websites were accessed between June and September 2017 to identify publications and guidelines that related to the subject area; Nursing Midwifery Board of Ireland, Health Information Quality Authority and Health Service Executive. These documents were reviewed.

A search was performed on the CINAHL database using the following search terms on “community nursing” AND “discharge” and “caseload management” AND “community nursing” for articles of relevance. Only English language publications and articles published after 2010 were included. A number of articles specific to acute hospital inpatients discharge planning identified in the search process were excluded for the purpose of this procedure. All relevant articles were reviewed.

Evidence gathered as part of the development of National Quality Care Metrics for the PHN service on discharge processes was accessed from the National Quality Care Metrics Project team and reviewed.

2.3 Describe the method of appraising evidence

This procedure draws on previous evidence appraisal, recommendations and PPPG revision work of the following;

- National Quality Care Metrics Project ONMSD
- Local PPPG Development Committee’s at CHO level

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

This is a management operational procedure for the PHN service nationally and

therefore existing CHO local procedures supported by statutory guideline publications predominantly informed the development of the first draft of recommendations. This first draft was circulated to all DPHNs nationally for consultation and feedback in June 2017. This feedback allowed an assessment to be made on the ability of the service to operationalise any new recommendations and incorporate into the final procedure prepared.

2.5 Provide a summary of the evidence from the literature

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

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

The Nursing and Midwifery Board of Ireland provides guiding principles to all nurses on responsibility, accountability and autonomy in relation to patient care. These outline expectations in meeting the standards of care of the profession and include sound professional judgement, nursing actions and omissions of care. (NMBI, 2015 & 2014). Within nursing best practice champions are frequently utilised to promote evidence based practice through guideline implementation and quality improvement initiatives. They play an important role in creating and promoting positive change. (Ploeg et al, 2010)

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

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

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

2.6 Detail resources necessary to implement the PPPG recommendations

Standardised systems need to be agreed to support the filing of discharged cases in the designated site and for the retrieval of re-activated case notes.

Measures will be taken to develop an electronic caseload register system that is capable of producing key statistical information as required on caseload activity.

2.7 Outline of PPPG Steps/Recommendations

An outline of the procedural steps and recommendations to be followed are in Part A Pages 4 – 9.

3.0 GOVERNANCE AND APPROVAL

3.1. Outline Formal Governance Arrangements

This national procedure was sponsored by the Office of Nursing and Midwifery Services Director and the Community Operations: Primary Care Office (formerly National Primary Care Division). Final approval of the procedure was issued from the sponsors and follow up reviews will be initiated by the Community Operations: Primary Care Office. Refer to Appendix IV for Membership of the Approval Governance Group. This national document will be submitted to the National Central Repository Office for referencing when this office is established.

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

National review of the draft procedure was undertaken with key stakeholders to identify any issues in presentation, clinical processes recommended within, recommendations for implementation and any further suggestions. These stakeholders included the following; frontline professionals in the PHN service, PHN service managers, HSE ONMSD, Higher Education Institutes, GP representative, HSE Nursing Midwifery Planning and Development Unit, HSE Quality Improvement Division and HSE Primary Care Division. All feedback received from the consultative process was

considered by the PHN Discharge Procedure Working Group convened specifically for this purpose. (Appendix II). This working group consisted of members of the National PHN Working Group for HSE Primary Care Metrics. Consensus was reached by the group on whether to accept or reject suggested amendments from feedback. Subsequent changes were recorded and all feedback received is available with the master copy of the procedure. The PPPG Checklist (Section 3.4) was reviewed in conjunction with the final revised procedure to ensure compliance with the standards as outlined in the HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (2016). This completed checklist and the final draft of the procedure was submitted to the National Community Operations; Primary Care Office and to the Office of the Nursing and Midwifery Services Director to confirm that all stages in the revision of the procedure had been completed and met the NCEC National Standards for Clinical Practice Guidance (NCEC, 2015). The procedure was approved for national implementation. A signed and dated master copy will be retained within the Office of the Nursing and Midwifery Services Director (National PHN Service), Dr Stevens Hospital.

3.3 Attach any copyright/permission sought

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

3.4 Insert approved PPPG Checklist

Available with master copy of PPPG in the ONMSD- National PHN Service.

4.0 COMMUNICATION AND DISSEMINATION

4.1. Describe communication and dissemination plans

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

A working group consisting of members of the National PHN Primary Care Metrics Sub Group was convened in November 2017 to review all feedback received and a final draft of the procedure was prepared.

The final draft was submitted to the Office of the Nursing and Midwifery Services Director (ONMSD) for professional review and recommendation and to Community Operations: Primary Care for final approval.

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

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

5.0 IMPLEMENTATION

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

As part of the exploring and preparing stage of implementation existing procedures in place in local CHO's were reviewed prior to preparing the first draft of this national procedure. The draft copy of the procedure was circulated to all DPHN's for review and feedback in June 2017. This evidence assisted in assessing the ability of the service to implement the recommendations made.

On planning and resourcing, metrics champions were identified from ADPHNs and frontline nurses to train and support nursing staff on the initial implementation of primary care metrics. Discharge of patients from the PHN caseload is a key clinical activity metric and this procedure will support the collection and monitoring of this specific metric. A data collection sheet and definitions workbook was designed that included specific detail to assist the accurate collection of discharge data.

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

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

5.2 Describe education/training plans required to implement the PPPG

Discharging patients from the PHN caseload was included as part of the training workshops delivered during the roll out of the national primary care activity PHN service metrics between June and August 2017. Communication with the Higher Education Institutes responsible for student PHN education commencing in September 2017 occurred to ensure this procedure formed a component of the education module on caseload management. Local induction programmes for new nurses commencing employment will include briefing on all PPPGs approved for use within the PHN service. Metrics champions within local services will be available to provide additional support in relation to discharge criteria queries.

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

At national level the National Lead for Public Health Nursing and the National Practice Development Co-ordinator for PHN service will lead on the implementation of this procedure and address issues arising nationally with implementation. An evaluation of the roll out of metrics occurred in November 2017 and this offered nurses an opportunity to provide feedback in relation to discharge activity on caseloads. Post this evaluation follow up national briefing sessions were delivered in early 2018 to ADPHNs and metrics champions.

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

5.4 Outline specific roles and responsibilities

National Primary Care Metrics Sub Group PHN: The development of this specific PPPG is under the governance of this Group. On approval of this PPPG by the National Community Operations Division, the Group will ensure the final approved copies are circulated to all DPHNs nationally. The Group will initiate an earlier review date for this procedure in the event of amendments to legislation, HSE policy or other related PPPGs.

National Governance Group for Quality Improvement in the Public Health Nursing Services: The National Governance Group established early in 2018 will be responsible for prioritising, developing, reviewing and recommending national PHN service PPPGs for use in the service and submitting these PPPGs to the Community Operations Division for approval. The Group will review this PPPG as stated on the front page of the document. The Group will initiate an earlier review date in the event of amendments to legislation, HSE policy or other related PPPGs once the National Primary Care Metrics Sub Group is disbanded.

Director Public Health Nursing: The DPHN is responsible for resourcing, implementing and managing and auditing this procedure within her area of responsibility. The DPHN will identify and support ongoing related educational opportunities to further enhance knowledge and skills. The DPHN will ensure that all discharge activity metrics for her

department are returned in a timely manner to the designated person within the CHO.

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

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

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

6.0 MONITORING, AUDIT AND EVALUATION

- 6.1.** Describe the plan and identify lead person(s) responsible for the following processes:
- 6.1.1. Monitoring** of this procedure will occur by the ADPHN through professional supervision, caseload annual audit and monthly primary care activity returned.
- 6.1.2. Audit** of the operation of this procedure will be initiated by the DPHN in consultation with the local CHO audit lead. Good governance arrangements and an identified lead person are required to ensure systematic monitoring (HIQA, 2012). Audit will be carried out retrospectively by the designated person appointed by the DPHN. This designated person may be the area nurse, a nursing peer, the ADPHN or other. This procedure will be the standard for audit using the attached audit tool (Appendix V). The objectives of the audit will be to provide evidence of compliance to the national procedure, ensure standardisation of application of the procedure, identify areas for improvement, make recommendations and prioritise actions. Frequency of audit, sampling processes and timescales for completion will be determined at local level following the first initial audit.
- 6.1.3. Evaluation** will be initiated by the DPHN/ADPHN and will occur through feedback at professional team meetings, direct patient feedback and through structured review surveys on the PHN service. Feedback from Your Service Your Say and through local formal complaints processes will be considered in any revision of the procedure.

7.0 REVISION/UPDATE

- 7.1 Describe procedure for the update of the PPPG**
This procedure will be revised every three years on the date specified on the front page of the document. This review will be triggered by the National Community Operations: Primary Care office and the National Quality Improvement Governance Group/PHN Services.
- 7.2 Identify method for amending PPPG if new evidence emerges**
Practitioners will assist in the revision of the procedure and also request an earlier review of this procedure where required if new evidence based practice is recommended.
- 7.3 Complete version control update on PPPG Template cover sheet**
This is the first national version of a procedure for the discharge of patients from the PHN caseload.

8.0 REFERENCES

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

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

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

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

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

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

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

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

Greenhalgh, T., Robert, G., Bate, P., MacFarlane, F. & Kyriakidou, O. (2005) *Diffusion of Innovations in health service organisations: A systematic literature review*. Malden, MA:Blackwell.

Government of Ireland (2018) *Data Protection Act Number 7 2018*
<http://www.irishstatutebook.ie/eli/2018/act/7/enacted/en/html>
 accessed 12th July 2018

https://ec.europa.eu/info/files/regulation-eu-2016-679-protection-natural-persons-regard-processing-personal-data-and-free-movement-such-data_en
 accessed 12th July 2018

Hanafin, S. (1997a) The role of the Irish Public Health Nurse: manager, clinician and health

promoter *Health Visitor Vol. 70 No. 8*

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

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

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

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

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

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

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

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

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

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

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

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

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

Health Services Executive (2014) *Safeguarding Vulnerable Persons at Risk of Abuse: National Policies & Procedures*. Dublin, HSE.

Health Services Executive (2014 a) *Discharge of Adult Patients from the Public Health Nursing*

Service. Public Health Nursing Services North Dublin

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

HSE (2013a) *Guideline: Management of Discharge of Patients from an Active PHN Caseload.*
Public Health Nursing Service Longford & Westmeath/Laoise Offaly

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

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

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

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

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

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

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

Health Service Executive (2009) *Guideline for Nurse/Midwife Facilitated Discharge Planning,*
Dublin: Office of Nursing and Midwifery Services Director (ONMSD).

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

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

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

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

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

- Kane, K. (2016) Caseload analysis in district nursing: the impact on practice. *British Journal of Community Nursing* Vol. 13, No 12 pp 567 – 573
- McDonald, A., Frazer, K. and Cowley, S. (2013) Caseload management: an approach to making community needs visible. *British Journal of Community Nursing*, Vol. 18, No. 3, pp. 140-47
- National Directors of Public Health Nursing in partnership with Shannon, M. (2014) *Quality Integration and Collaboration: A Strategy for Community Nursing. Consultation Document* Dublin: Office of the Nursing and Midwifery Services Director, Health services Directive.
- Naylor M. Aiken L. Kurtzman E. Olds D. Hirschman K. (2011) The importance of transitional care in achieving health reform. *Health Affairs* 30, 745-754.
- Naylor M. Keating S. (2008) Transitional care. *J Soc Work Educ* 44, Supplement 65-73.
- Newbury, J. & Hatherell C.A. (2004) Audit on discharging patients from community specialist palliative care nursing services, *International Journal of Palliative Nursing*, 10(1), 24-31.
- Nursing and Midwifery Board of Ireland (2017) Standards & Guidance: Glossary of nursing and midwifery terms. <https://www.nmbi.ie/Standards-Guidance/Glossary> accessed 30th November 17
- Nursing and Midwifery Board of Ireland (2015) *Recording Clinical Practice Professional Guidance*. Dublin: NMBI
- Nursing and Midwifery Board of Ireland (2015a) *Scope of Nursing and Midwifery Practice Framework*. Dublin: NMBI
- Nursing and Midwifery Board of Ireland (2015b) *Public Health Nursing Education Programme Standards and Requirements* Dublin: Ireland
- Nursing and Midwifery Board of Ireland (2014) *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives*. Dublin: NMBI
- O' Dwyer, P. (2012) *The Future Direction of the Community Nursing Service: Moving the focus of care to health priorities and delivering outcomes in the community*. Dublin: Institute of Community Health Nursing.
- Office of the Nursing and Midwifery Services Director (2011) *Population Health information Tool (PHIT). Changing practice to support service delivery*. Dublin: Health service Executive.
- Orem, D. E. (1991) *Nursing: Concepts of Practice* (4th Ed.) St. Louis, MO: Mosby-Year Book Inc.

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

Ploeg, J., Skelly, J., Rowan, M., Edwards, N., Davies, B., Grinspun, D., Bajnok, I. and Downey, A. (2010) *Worldviews on Evidence-Based Nursing* Fourth Quarter Pg 238-251

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

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

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

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

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

9.0 APPENDICES

Appendix I	Signature Sheet
Appendix II	Membership of the PPPG Development Group Template
Appendix III	Conflict of Interest Declaration Form Template (with Master copy)
Appendix IV	Membership of Approval Governance Group Template
Appendix V	Audit Tool to review operation of this procedure
Appendix VI	GP Discharge Notification Letter
Appendix VII	Patient Discharge Letter
Appendix VIII	Types of Community Nursing Teams

Appendix II:

Membership of the PPPG Development Group (Working Group from National PHN Primary Care Metrics Sub Group)

Signatures in the master copy of this procedure held in the ONMSD: National PHN Service.

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

Appendix IV:

Membership of the Approval Governance Group

Signatures in the master copy of this procedure held in the ONMSD: National PHN Service.

<p>Siobhan McArdle Head of Operations Primary Care/Community Operations</p>	<p>Signature: Date:</p>
---	-----------------------------

Appendix V: Audit Tool to Review Operation of this Procedure

AUDIT TOOL FOR THE MANAGEMENT OF THE DISCHARGE OF A PATIENT FROM A PHN CASELOAD

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

No	Question?	Yes	No	Comment
1	Is the date of discharge recorded in the patient's record?			
2	Is the reason for discharge clearly indicated in the patient's record?			
3	Is there evidence that a holistic assessment has been completed to support the discharge?			
4	Is it noted that the patient/carer has been informed of their discharge from the caseload?			
5	Is it noted that the patient/carer has been informed how to contact the service if required in the future?			
6	Is it noted in the patients file that written details were given on how to contact the service in the future if required?			
7	Has health information given to the patient/family been documented in the patient's record?			
8	Has a GP discharge notification been completed and a copy filed in the patient's record where this has been indicated in the care plan?			
9	Has the date of discharge been noted in the caseload register?			
10	Have any clinical intervention file notes held in the home been retrieved and filed in the patient's file?			
	Totals	__ /10	__ /10	
	Percentage Compliance	__ %	__ %	

DATE: _____ CHO: _____

Health Centre: _____

Quality Improvement Plan:

AUDIT COMPLETED BY: _____

Title: _____

Appendix VI: GP Discharge Notification Letter

Discharge Notification from Public Health Nursing Service

Area: _____

Patient's Name: _____ **Date of Birth:**

Address:

G.P. Name: _____

Address: _____

I wish to inform you that the above named patient who was referred by; _____ has completed their episode of care and has been discharged from the Public Health Nursing Service. The patient has been advised that if they have any further concerns or their health care needs change they may contact their local primary care centre. I have left contact details with the patient and /or carer.

Additional Information:

Patient is aware of this notification letter. Yes/No (please circle)

Signed: _____

Print Name: _____

Title:

Date: _____

Local Primary Care Centre: _____

Tel. Number: _____

Appendix VII: Patient Discharge Letter

PHN SERVICE COMMUNICATION CONTACT SHEET

Date: _____

To whom it may concern;

If you require the public health nursing service in the future please contact as below;

Name:

Health centre:

Phone no.:

Name:

Health centre:

Phone no.:

Additional Information:

Nurses Signature; _____ **Grade:** _____

Appendix VII: Types of Community Nursing Teams

Community Rehabilitation Team (CRT): is a community based multidisciplinary rehabilitation team providing assessment and rehabilitation short-term (6 to 8 weeks) to clients over 18 years of age, requiring the services of two or more of the disciplines on the team, living in Dublin North Central Area of CHO 9. The ethos of the team embraces both the client's needs and those of their families/carers.

Community Re-ablement Homecare Service (CRHS): is a community based multidisciplinary service providing assessment and support services to clients over 65 years of age, living in Dublin North Central Area of CHO 9. The ethos of the service embraces both the client's needs and those of their families/carers. Re-ablement provides planned short term support at home with a focus on restoring the persons independent functioning.

CHO 9 Dublin North Central 2017

Community Intervention Team (CIT)

A Community Intervention Team is a specialist nurse led health professional team which provides a rapid and integrated response to a patient with an acute episode of illness who requires enhanced services/acute intervention for a defined short period of time. This may be provided at home, in a residential setting or in the community as deemed appropriate, thereby avoiding acute hospital attendance or admission, or facilitating early discharge. CIT personnel have a strong **liaison** role with hospital and community clinicians and provide services in the patient's home, primary care centres and in both public and private nursing homes.

The CIT, through its fast-tracked provision of services enhances the overall primary care system, providing access to nursing and home care support, usually from 8am to 10pm, seven days per week.

The CIT provide a range of services including administration of home IV antibiotics (Out-patient Parenteral Anti-microbial Therapy -OPAT); acute anticoagulation care; acute wound care and dressings; enhanced nurse monitoring following fractures, falls or surgery; care of a patient with a central venous catheter; urinary related care; care of the patient with a respiratory illness; bowel care including ostomy care; short term older person support and care and other medication management/administration as part of patient's acute intervention package.

CIT/ OPAT Programme, Dr Steeven's Hospital 2016