Taken From National Clinical Guidance for Adult Nursing and AHP Community Health Staff during COVID-19 Update

Prioritisation of Care in the Community – District Nursing Services

Workforce

It is important to ensure that key aspects of service delivery continue to operate appropriately; however, it is reasonable to expect that staff will be required to work flexibly and modifications made to working practices that may include redeployment into different roles. In doing so, it is essential that local risk assessments are utilised underpinning local decision-making and that service adaptations necessary are for the shortest period of time possible.

Strategic Framework Levels Key	
	Level 4 **Very high or rapidly increasing incidence, and widespread community transmission which may pose a threat to the NHS to cope**
	Levels 2 and 3 **Increased incidence of the virus, with multiple clusters and increased community transmission**
	Levels 0 and 1 **Low incidence of the virus with isolated clusters, and low community transmission**

Prioritisation Key	
	Stop
	Adapt based on professional judgement
	Continue normal service provision
	Start COVID-19 specific measures

#	Service	Location	Plan during pandemic	Details
Stop – it is important to ensure systems are in place to ensure early identification, monitoring and escalation of any deterioration of a patient's conditions				
1.	Stop all non-essential face-to-face visits.		The decision-making skills of the district nurse in assessing what is essential and requires a face-to-face consultation. Where possible supporting self-management and the use of telehealth.	Decisions re: essential care should be undertaken by the district nurse as part of caseload management. Consider appropriate delegation. *Aberdeen City agreement to stop: routine continence reviews, ear irrigation, routine annual chronic disease reviews, routine Doppler reviews, ECGs* *Priority given to end of life care, essential medication administration & interventions that will prevent deterioration that could lead to hospital admissions, subject to adaptation where appropriate (see below)*
Adapt based on professional judgement – it is important to ensure systems are in place to ensure early identification, monitoring and escalation of any deterioration in a patient's condition.				
1.	Routine visits		Clinically prioritise urgent care needs and ensure dynamic caseload management to free nursing capacity for more complex care needs. Defer visits where clinically appropriate to do so where a patient is self-isolating because they have suspected COVID-19 or they are living with someone who has confirmed or suspected COVID-19. Encourage self-management where appropriate and the use of telemedicine (Near Me or alternative) where appropriate to do so.	Consider appropriate distribution of work and which professional is best placed to undertake this work. For example AHPs, a HCSW, a carer (paid / unpaid). Ensure systems in place to monitor care that has been deployed across the MDT, or deferred. Actively coach patients / carers to self-care and self-administer where appropriate to do so. Consider how the wider MDT can provide professional-to-professional

				support *(eg injected medications, wound care, bowel care, catheter care)* Provide support to care home teams and their residents regarding infection prevention and control (IPC), education and training and clinical care. Approaches should include the use of technology where appropriate to including access to NHS Near Me technology. Co-ordinate care to reduce duplication and footfall.
2.	Ongoing holistic assessment of needs of patients on case load and other referrals to service to ensure high levels of person centred care		Holistic assessments should include assessment of full needs of the patient, e.g. food fluid and nutrition, continence and bowel care, frailty score, supports at home, skin integrity, long term condition management and Dalhousie vulnerability score.	Consider Dietetic, Occupational Therapy or Social Work input if required using Near Me or other technology. Care should be prioritised as appropriate according to professional judgement. Early referral to DN to help timely assessment to reduce risk of deterioration. Ensure all patients have up to date anticipatory care plans and clear plans re choices around end of life care where appropriate.
3.	Non-complex wound care		Support patient self-management of non-complex wounds. These plans should be person centred and individual. Education and training of carers in the management of non-complex wounds.	Ensure systems are in place for ongoing assessment and evaluation by the community nursing team. This could include the use of medical photography and remote technology.
4.	Lymphoedema Management		Continue to support where bandaging is required; promote self-management where appropriate.	

			Reduce number of bandaging changes on an individual risk assessment basis.	
5.	Routine Intramuscular (IM) and Subcutaneous injections – including insulin and non - molecular weight heparin injections		Prioritise what must continue and consider alternative options for administration including oral that could be adapted. Vitamin B12 - if cannot be switched to oral, then consider ceasing administration of Vitamin B12 until post pandemic. If patients report neurological symptoms to GP / team, then consider administration.	Where appropriate to do so consider self-administration and support required to progress this, should the patient wish this to be the case.
6.	Medication Prompts		Utilise appropriate staff to administer medications where necessary, using the HCSW (Healthcare Support Worker) Framework for Administration of Medications and Medicines Administration Resources Carers and HCSWs (8th December 2021).	Where appropriate to do so use technology or delegate to family / friends or carers
7.	Support Care at Home Services		Where packages of care are unable to be filled, deploy appropriate staff, including HCSWs, to provide fundamental care and support to keep people safe and well at home, preventing admission and promoting early supported discharge from hospital.	
Continue normal service provision – It is important that systems are in place to ensure early identification, monitoring and escalation of deterioration in a patient's condition				
1.	All essential visits – based on holistic person centred planning as above		Continue but clinically prioritise urgent needs and ensure dynamic caseload management. Reduce regular review work through appropriate risk assessment**.** All patients with long-term conditions who feel they would benefit from an Anticipatory Care Plan (ACP) should have this discussed and	Identify caseload workload to ensure that appropriate deployment of staff with the right skills and knowledge to enable care to be provided safely.

			agreed with them and their families where appropriate. In addition discussion and recording on the Electronic Key Information Summary (eKIS) of the ACP along with personal care choices on the level and place of care should their condition deteriorate. Where appropriate DNACPR (Do not attempt cardiopulmonary resuscitation) should be completed and reviewed.	*Essential visits include phlebotomy for patients on DMARDs, DOACs & Warfarin, as well as with acute clinical presentation; Doppler & continence assessment where there is clinical evidence that not doing so would compromise skin inegrity*
2.	Monitor rising risk of deferred work		Monitor rising risk of deferred work if disruption continues.	Telehealth and telecare should be used to monitor all deferred appointments. Patients should have a single point of contact if they have had a deterioration in their conditions so an assessment can be undertaken prior to a face-to-face visit. Care should where appropriate should be co-ordinated with other community specialists
3.	Palliative and end of life care		Continue to support those in last days of life or high complexity palliative care at home or in a residential setting – syringe drivers and symptom management and any other identified clinical need. Respond to increased needs for palliative care for people with complex co-morbidity. Ensure sufficient numbers of registrants are competent to confirm death in the community. Plan for increased need for end of life care within the community.	Co-ordinate care with other community specialist palliative care nurses and other speciality nurses whom the patient may know where possible to reduce contact and maximise continuity. Ensure end of life ‘just in case’ medication and syringe driver availability to meet demand. Ensure access to sufficient equipment including ‘medication pumps’,

			Support for end of life care must be considered on 24/7 basis.	subcutaneous fluids and oxygen if required. Increases in demand should be factored into NHS Board and Health & Social Care Partnership (H&SCP) resilience plans.
4.	Early supported discharge from hospital		Prioritise early supported discharge from acute hospitals who will have ongoing nursing care needs.	Work with AHP teams and HCSW/social care workers to support early discharge from hospital. Work with third and independent sectors.
5.	Planned care		Ensure use of ACP to help with holistic assessment and planning of care needs. Planned care should be informed by professional judgment following a holistic assessment of need.	
5.	Urgent Care and 24/7 cover		Prioritise Rapid Response teams response to rapidly deteriorating patients to support more urgent care, maximising the skills and knowledge of the district nursing teams in the community where appropriate to do so. Plan for increased demand including deployment of staff with the right skills and competencies to meet the changing needs of patients in the community including care homes. Support for urgent care should be considered 24/7 to meet demand and ensure people and communities receive the right level of compassionate care to meet the needs of the individual and their families / carers.	Work with primary, Scottish Ambulance Services, palliative and secondary care teams to support more urgent care in the community where possible, maximising the skills of the community nursing team in clinical assessment and prescribing where appropriate to do so. Increased demand should be factored into NHS Board and H&SCP resilience plans
6.	Complex Wound Management		Complex wound care should continue.	Care when necessary to do so should be co-ordinated with other specialists.

			Wound care where there are immediate concerns regarding the patient's condition e.g. infected wounds, heavily exuding wounds and compression bandaging that has been in situ for more than 7 days.	
7.	Diabetic Foot Care		Needs continued.	Maximising shared care between podiatry and other specialist professionals.
8.	Urgent Catheter Care / Bowel Care		Needs continued - should be reviewed on a patient-by-patient basis, with some blended self-management where appropriate.	Maximise shared care between other specialist professionals.
9.	Roll out of COVID -19 vaccination		Support the delivery of the COVID-19 vaccination roll out in particular to people who are house bound. Utilise skill mix as appropriate, including HCSWs, the new COVID-19 HCSW Job Description, the National Protocols and Education Frameworks for HCSW administration of the COVID-19 vaccination.	