Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
COMMUNITY SERVICES ASSESSMENT AND DOCUMENTATION

Document Reference	SOP22-007
Version Number	1.1
Author/Lead **Job Title**	Katie Barraball – Therapy Lead Carol Wilson – Locality matron
Instigated by: **Date Instigated:**	Kerry Brown – Clinical lead Jan 2022
Date Last Reviewed:	15 June 2023
Date of Next Review:	June 2026
Consultation:	Community Services Clinical Network Group
Ratified and Quality Checked by: **Date Ratified:**	Community Services Clinical Network Group 15 June 2023
Name of Trust Strategy / Policy / Guidelines this SOP refers to:	Consent Policy (N-052)

VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*May 2022*	*New SOP. Approved at Community Services Clinical Network Group (5 May 2022).*
1.1	*June 2023*	*Reviewed with minor amendments re: specialist services. Approved at Community Services Clinical Network Group (15 June 2023).*

Contents

1. INTRODUCTION

The provision of Community Services to people in our locality will inevitably require a flexible and personalised approach which recognises: -

- The need to undertake robust and standardised assessment approach which will ensure consistent safe and effective planning of care for each individual patient.

- The need for good communication and coordination

This standard operating procedure is designed to guide staff in how and when to undertake the assessment and care planning for patients and guide the decisions regarding the continuity and coordination of care.

2. SCOPE AND PURPOSE

This SOP will be used across all community services teams within Humber Teaching NHS Foundation Trust. It includes both registered and unregistered community staff who are permanent, temporary, bank or agency staff. It is to be used to guide staff in appropriate documentations to be completed when documenting clinical care.

3. DUTIES AND RESPONSIBILITIES

Service Managers, Locality Matrons, Therapy leads and appropriate clinical and professional leads will ensure dissemination and implementation of the SOP within the sphere of their responsibility. They should also ensure staff are supported in attending relevant training and that time is dedicated to the provision and uptake of training and sign off competencies.

Clinical Leads /Team Leaders will disseminate and implement the agreed SOP. They will maintain an overview of associated training needs for their respective teams. The Clinical Lead /Team Leader will ensure mechanisms and systems are in place to facilitate staff to attend relevant training as part of their appraisal process in order to undertake training and sign off competencies.

All clinical staff employed by the Trust will familiarise themselves and follow the agreed SOP and associated guidance and competency documents. They will use approved documentation and complete relevant paperwork as per Standard Operating Procedures as relevant to each clinical activity. They will make their line managers aware of barriers to implementation and completion.

4. PROCEDURES

Clinicians should always use clinical judgement to determine the appropriate level of assessment. This guidance is the ***MINIMUM*** standard required but variance from this standard may be applied with a clear rationale in evidence and recorded in the patient record.

4.1. Principles

- All patient under the care of community services will have an assessment completed at first patient contact. (other than one off contacts, e.g. blood tests)

- Professional judgement should be exercised when determining the information obtained during the first visit however rationale must be given if the core assessments and observations are not completed during the first visit.

- Review any existing records on SystmOne for information regarding previous intervention / treatment.

- Obtain past medical history from an appropriate source. If these are paper documents they must be scanned to the patient record.

- Discuss consent of sharing records with patient and supply them with the information governance information sharing leaflet https://intranet.humber.nhs.uk/directorates/ig-leaflets.htm and record the consent given/not given on SystmOne.

- By the end of the first week of care, it is expected that any outstanding documentation from the initial visit (as detailed in section 4.2) will be completed including any additional assessments deemed necessary and relevant care plans in place for individual care delivery.

- All documentation to be completed in line with timescales set out in professional standards (within a maximum of 24 hours post contact with the patient).

- Where it has not been possible to complete any of the assessment process within the set timeframes, reasons for this must be documented and a plan put in place for its completion in the patient record. This should also be escalated to a senior clinician / clinical lead / team lead.

- Develop personalised plans for the identified care needs and obtain consent from the patient or work under best interest if deemed appropriate. Care planning and prioritising of care needs should be made in conjunction with the patient and where appropriate, family/carer.

- Commence discharge planning at initial contact with the patient and document.

- Determine appropriately skilled staff to visit for ongoing care if required and delegate as appropriate.

- Care Plans are updated by the Case Load holder (or delegated other) to reflect any change in patient care and treatment and made in conjunction with the patient and where appropriate, family/carer.

- Information and contact details regarding the provision of community services is provided to the patient and family/ carer on the first visit.

- For those admitted into permanent residential/nursing care whilst on a caseload ensure a transfer of care information which include assessment and care plan is disseminated to the appropriate care home team as soon as practicable.

- For patients on caseload for a prolonged period of time it is expected that the patient will be re assessed if there is a change in clinical presentation or yearly as a minimum.

4.2. SystmOne Documentation Templates

The following comprises the expected minimum documentation to be completed for each patient assessed by community services

Template / Questionnaire	**Core Nursing**	**Community Therapist / Urgent community response / intermediate care**	**Specialist Services – more detail provided in individual service documents**	
Holistic assessment	*	*		
Next of Kin (record relationship)	*	*	*	
Multifactorial Falls risk assessment	* if indicated following screening	* if indicated following screening		
Lone Working risk assessment	*	*	*	
Walsall	*			
Adapted Walsall		If indicated		
MUST	*	If indicated		
Problem List / Treatment Plan		*		
Care plans	*	if care element provided by UCR / intermediate care		
Consent to share	*	*	*	
Rockwood Frailty Score	*	*	*	

4.2.1. Profession specific templates

Following completion of the core assessments for the patient, specific professional assessments may also be completed specific to each service area – these are detailed in individual service SOP's. These should be completed on S1 and are agreed by each specialist service and locality matron / therapy lead.

5. REFERENCES

Consent Policy.pdf (humber.nhs.uk)

Community - Delegation of Care to Non Registrants SOP21-027.pdf (humber.nhs.uk)

Information Governance Policy N-008.pdf (humber.nhs.uk)

Standards of conduct, performance and ethics | (hcpc-uk.org)

Standards of proficiency for registered nurses - The Nursing and Midwifery Council (nmc.org.uk)