## Document Details

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<th>Title</th>
<th>Community Practitioner workload scoring guidance</th>
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<td>Use of a time allocated scores to assist in workload distribution in the community setting.</td>
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<tr>
<td>Author</td>
<td>Georgina English, Clinical lead for Community Nursing.</td>
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## Approval process

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<tr>
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<th>Clinical Policies Group</th>
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## Distribution

| Who the policy will be distributed to | Clinical Services Manager, Clinical Practice Teachers, Team leaders. |
| Method                               | Governance meetings/email/team meetings, Intranet |

## Document Links

<table>
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<th>Required by CQC</th>
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## Amendments History

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Appendix 1 – Individualised Patient Care Score Guide Error! Bookmark not defined.
1 Introduction

The number of community nurses within the Interdisciplinary teams varies across Shropshire as do caseloads and workloads. The demand for home treatment is increasing in line with the percentage of frail and complex patients in the population. The ability of practitioners within teams to respond to this demand and future practice developments requires a methodology to ensure work is allocated fairly, with patient safety and quality maintained and improved. As community Interdisciplinary teams strive to meet the increasing demand for our service the development of a common currency to allocate work is needed. To provide this currency a workload allocation timed scoring guidance has been developed.

2 Purpose

The aim of this guidance is to standardise the daily recording of time allocation to community practitioners with the aim to increase safe workloads and identify the capacity of each practitioner. Clinical services managers, Team leaders and caseload holders can look at individual practitioner’s allocation each day and redistribute work to meet variations in demand across all teams on a daily basis. All practitioners should be given sufficient time with patients to meet their individual health goals. Patient contact time should include and take into account the complexity of the patient’s needs, the complexity of the clinical intervention and the completion of required documentation. Due to the unpredictable nature of working with frail and complex patients in their home environments situations arise where the allocated time may not have been sufficient to achieve all necessary documentation. It is in these situations that additional time needs to be recorded and allocated to subsequent visits to ensure this is completed in a timely way.

3 Definitions

Community Practitioner – Community Nurses, Physiotherapists, Occupational Therapists, Case Managers, Rehab Technicians, Nursing Support Workers, Phlebotomists. This could include all healthcare workers who provide care in a domiciliary setting.

Lorenzo Caseload Management System-current electronic system to collect referral information, admission avoidance data, caseload numbers, contacts undertaken, scheduled visits / interventions and transfer of key information relating to the visit.

4 Duties

4.1 Managing Director and Deputy Directors

Directors of Services are responsible for ensuring the safe and effective delivery of services they manage; this includes securing and directing resources to support the implementation of this best practice guidance.

Must ensure that:

- All staff are to have access to this document.

4.2 Line Managers and Service Leads

Managers will ensure that a system is in place within the services they are responsible for, for the implementation of this guidance and for monitoring its effectiveness.
4.3 Clinical Services Managers and Team Leaders

Individual line managers are responsible for informing staff of this guidance and any associated policies, guidelines and documents and that the appropriate education, supervision, and mechanisms are in place to ensure safe practice. Daily escalations levels are reported daily into InPhase. It is the managers responsibility to identify team capacity and re-distribute workloads within localities to manage fluctuating demand.

4.4 Staff

This guidance applies to all community practitioners employed by Shropshire Community Health NHS Trust involved in the care and management of patients in their own homes. They must ensure they work within this guidance and associated policies and guidelines. Practitioners must inform their line manager if the time allocation score exceeds their shift time so that changes to workloads of all individuals can be made.

5 Workload Scoring / Categories

Time allocated to individual staff must be recorded daily in the allocation books 10 minutes will equate to a score of 1. There are five defined work load categories: Patient Care; Travel; Administration / Office; Team communication; Meetings / Training / Other. NB all staff who work more than 6 hours must be allocated a Dependency of 3 for a LUNCH break.

It is essential that the time allocated to each of the five workload categories is recorded and available to the coordinating practitioner. At the end of the shift the practitioner must input their activity on the computerised caseload allocation system which should include planned patient related work such as DATIX completion, Root Cause Analysis Investigation, the ordering of equipment.

Below is an example of how the work load scoring should be recorded.

<table>
<thead>
<tr>
<th>Name</th>
<th>Shift score</th>
<th>PT Care</th>
<th>Travel</th>
<th>Admin /office</th>
<th>Team Comms</th>
<th>Meetings/ Training/ other</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>8-4</td>
<td>45</td>
<td>24</td>
<td>6</td>
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5.1 Category One - Patient Care

The aim of our service is to deliver Safe Care: Harm Free to a growing Frail and Complex population in combination to ensuring the achievement of excellence in values and behaviours relating to Care, Compassion, Competence, Communication, Courage and Commitment.

To achieve these aims the Patient Care Score allocated to a patient should reflect their individual needs and circumstances and not be based on clinical tasks alone. A red amber green (RAG) Rating system should be considered to assist in identifying the status of the patients on each caseload and the most appropriate grade of practitioner to delegate the patient too. In the event of assessing and re-assessing...
complex patients in the community there is recognition that it is good practice to identify on a patient status at a glance list which patients require significant time allocation to meet their needs. These patients are often unpredictable / unstable RED and require significant time allocation and high level skill intervention. There are patients who require complex clinical procedure’s which require significant time allocation but are stable / Amber and patients whose needs can be met by support practitioners as the clinical intervention and patient are stable and predictable / Green. See full descriptors below.

**RED** unpredictable / unstable
A person’s responses to internal or external triggers cannot be anticipated with any certainty / a fluctuating disease process resulting in an altering health status.

**AMBER** Predictable
A person’s response to internal and or external triggers can be anticipated with some certainty through established interventions.

**GREEN** Stable
Health or disease processes are in a steady state and likely to remain so, providing correct care regimes continue.

These categories must be clearly identified on the computerised caseload management systems in order to assist in appropriate delegation and review as identified in the Standard Operating Procedure for managing Demand and Capacity. Appendix 1A provides an indication of the time it may take to undertake clinical interventions relating to community nursing and therapy practice but can be adapted for other community disciplines. The time allocated to meet patients’ needs must be individualised to incorporate the complexity of the patient, clinical intervention, circumstances and goals to be achieved at each visit.

### 5.2 Category Two - Travelling

It is difficult to accurately predict travelling time due to traffic congestion and other factors affecting the speed of travel. Consideration needs to be given to the distance that the practitioner is expected to travel, the amount of visits planned, their location (e.g. if the majority of the visits are in a care home) and the number of timed visits. A score should be allocated taking these factors into consideration. The average travel time on audit for an 8 hour shift ranged between 1 Hour and 2 Hours (2012). In the Community Nursing Safer Staffing Report (Nov 2015) the average was 48 minutes.

### 5.3 Category Three - Administration Duties in Office

Where ever possible it is good practice to complete the patients client held records within their home environment, although this may not be possible at all times. Practitioners should be allocated an administration Score to complete Lorenzo / emails / EMIS which should be undertaken daily. The average time for a Band Five 8 hour shift being 1 Hour (2012).

### 5.4 Category Four - Team Communication

Team Communication and handover of information requires a score, this may vary depending on team size and working practices with an average of half an hour (2012).

### 5.5 Category Five - Meetings / Training / Other

Practitioners need to have a score allocated so that they can undertake, clinical supervision, training, mentorship of students and attend link nurse meetings and undertake their required Continuing Professional Development.
6 Consultation
This best practice guidance was distributed to the following groups for consultation and comment:

- Clinical Services Manager: Sam Townsend
- Community Practice Teachers: Lucy Shier, Claire Wheeler, Anita Sharrad
- Team Leaders: Annie Cuthbert, Vicky Hinks, Jane Sullivan, Tracey Fisher, Lynda Randle, Mary Henshaw, Sandra Parkes

7 Dissemination and Implementation
Dissemination and implementation of these guidelines will be via service leads. Interdisciplinary Team Leaders will be supported to implement this guidance by their community practice teachers and clinical services managers.

8 Monitoring Compliance
Feedback will be collected via team leaders and band six nurses on the use of this guidance in practice. Team leaders will be able to demonstrate their use in practice when communicating there teams capacity to clinical services managers.

9 References
Dependency Scoring Audit Report (NOV 2012) Shropshire community NHS Trust
Community Nursing Safer Staffing Report (Nov 2015)
## Appendix A

### Score | Clinical Intervention
--- | ---
1-3 | Insulin administration  
Administration of medicines by injection.  
post-operative eye care,  
venepuncture  
Simple dressings  
Simple equipment check  
Routine follow up appointment or equipment review  
Telephone review

3-6 | Issuing commode for sudden deterioration in mobility  
Palliative Care support visits.  
Hospital discharge without correct equipment to support patient at home ie mobility equipment, commode, toileting equipment  
Issuing commode for sudden deterioration in mobility  
Bowel Care, catheterization,  
Gastrostomy procedures  
Tracheostomy care.  
Single leg compression therapy. Complex dressing including VAC.  
Ongoing therapeutic intervention  
Ear Syringing, continence re-assessments, diabetic checks

6-12 | Falls assessment,  
Routine one off face to face assessment where no treatment plans have been generated.  
Reassessment of acutely ill patients.  
New assessment for patient identified as potential hospital admission. Requiring urgent assessment and potential issue of several pieces of equipment.  
Or palliative patient with sudden deterioration in condition.  
Bi lateral compression therapy and ulcer evaluation.  
Continuing Health Care Assessment,  
Continence assessment.  
IV administration  
Doppler assessments  
health promotion.  
Complex assessment i.e seating assessment  
Home assessment visit to assess patient in own home who is currently in respite
| 12 and over | New patient assessments with complex interventions / treatment plans.  
          | Patients with Palliative care needs. Acutely ill patients. Terminal care. IV initiation.  
          | New assessment for patient identified as at risk of hospital admission. Requiring liaison with other agencies to either provide urgent social care or emergency respite admission, hospice at home, night sitters etc  
          | Multiple treatment plan interventions,  
          | Complex holistic re-assessment of need and treatment plan writing.  
          | Multidisciplinary case conference to discuss with patient and/or family plan for future placement or care. |