Somerset Partnership NHS
NHS Foundation Trust

COMMUNITY HOSPITAL INPATIENT

ADMISSION, TRANSFER AND DISCHARGE POLICY

Version:	3
Ratified by:	Senior Managers Business Group
Date ratified:	June 2013
Title of originator/author:	Senior Community Hospital Matron, Bridgwater Community Hospital
Title of responsible committee/group:	Clinical Governance Group
Date issued:	**July 2013**
Review date:	**May 2016**
Relevant Staff Group/s:	All Community Hospital staff including registered nurses, Allied Health professionals, medical professionals Information only for all referrers to Community Hospitals plus partner organisations

This document is available in other formats, including easy read summary versions and other languages upon request. Should you require this please contact the Trust Equality and Diversity Lead on 01278 432000

DOCUMENT CONTROL

Reference	**Version**	**Status**	**Author**
HMJun13/ATDP	3	Final	Senior Community Hospital Matron, Bridgwater Community Hospital
Amendments	Revised policy to reflect the current position of Community Hospitals within the Somerset Health and Social Care system. Revised post NHSLA Risk Management Standards following comments relating the Handover during Transfer.		
Document objectives: This Admission, Transfer and Discharge Policy aims to ensure a smooth journey for all patients throughout their stay across the health care economy. The key factors are good communication with those involved, integrated working and effective use of time and resources.			
Intended recipients: Community Hospital staff and all referrers to Community Hospitals plus partner organisations.			
Committee/Group Consulted: Community Heads of Adult Services Group, Community Hospital Best Practice Group, Clinical Policy Review Group, Clinical Governance Group, Senior Managers Business Group,			
Monitoring arrangements and indicators: The policy includes a set of standards that will be audited across all Community Hospitals on a monthly basis.			
Training/resource implications: Local induction by Team Leaders and Service Managers			
Approving body and date	Clinical Governance Group	Date: October 2012	
Formal Impact Assessment	Impact Part 1	Date: July 2012	
Clinical Audit Standards	NO	Date: N/A	
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Review date	**May 2016**		
Contact for review	Director of Community Health Services		
Lead Director	Director of Community Health Services		

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CONTENTS

1 INTRODUCTION

1.1 Somerset Partnership NHS Foundation Trust beds are a valuable resource and it is essential that they are used efficiently to be able to provide good patient care.

1.2 The admission, transfer and discharge policy aims to ensure a smooth journey for all patients throughout their stay across the health care economy. Good communication and integrated working with those involved in the transfer, admission and discharge process is essential to ensure effective use of time and resources.

1.3 Inefficient use of beds can lead to patient and carer distress, increases in waiting lists, higher re-admission rates as well as increased workloads for staff and colleagues in the community.

2 PURPOSE AND SCOPE

2.1 All admissions, transfers and discharges involving Somerset Partnership NHS Foundation Trust community hospital inpatient beds will follow an agreed pathway that takes into account the needs of patients and carers.

2.2 Appropriate timely admission and discharge planning is fundamental to the provision of health care and this policy sets out the principles that underpin this policy and the pathway that should be followed.

2.3 It is the Trust's policy to ensure that community health staff are informed, updated and equipped to carry out assessment and management of admission, transfer and discharge in the course of their work.

2.4 This Policy should be read in conjunction with procedural documents listed in Section 16 and all documents Appended to this policy.

3 DUTIES AND RESPONSIBILITIES

3.1 **The Trust Board** has overall responsibility for procedural documents and delegate's responsibility as appropriate.

3.2 **The Lead Director** with responsibility for Admission, Transfer and Discharge within the Community Health Directorate is the Director of Community Health Services.

3.3 **The Identified Lead (Author)** is the designated community hospital Matron who will be responsible for producing written drafts of the document and for consulting with others and amending as appropriate.

3.4 **The Clinical Governance Group** is responsible for monitoring the effectiveness of this policy:

- Approving the policy inline with the requirements of the Developing and Managing Procedural Documents Policy

- Ensuring there are adequate controls to provide safe admission, transfer and discharge practice in line with national guidelines

- Advising on training requirements for individual staff groups

3.5 **The Community Hospital Best Practice Group** is responsible for monitoring performance in relation to Admission, Transfer and Discharge and will monitor compliance with the requirements outlined within this policy.

3.6 **Service Managers/Heads of Service**: responsibility for implementing this policy is devolved to Heads of Service and Service Managers.

3.7 **The Head of Governance** has responsibility for holding the central database of procedural documents including this policy and for providing review reminders. The team also have responsibility for dissemination of the final document and archiving old versions.

3.8 **Matrons/Sisters/Charge Nurses/Service Managers** are responsible for ensuring that they have a planned programme of training for staff in their team in accordance with the Trustwide Staff Mandatory Training Matrix.

3.9 **All Community Health Staff** including temporary staff are individually responsible for complying with this policy. This includes (a) attending training and updating risk assessment skills as directed by this policy, (b) reporting concerns to their line manager, (c) regularly updating risk related sections within the Patient's Healthcare Records and also completing DATIX Untoward Event report forms in line with the Trust's Untoward Event Reporting Policy accessible on the Trust Intranet.

4 EXPLANATION OF TERMS USED

4.1 **Out of Hours –** the time between 6.30pm and 8.00am.

4.2 **Simple Discharge Plan –** the plan for use for all patients being discharged.

4.3 **Complex Discharge Plan –** the additional plan for use for patients with complex needs being discharged with a package of care and/or multi-agency involvement.

4.4 **MAR –** Medication Administration Record.

4.5 **ICT –** Infection Control Team.

4.6 **PEG/RIG Tubes –** Percutaneous endoscopic gastrostomy tubes and Radiologically inserted gastrostomy tubes.

4.7 **NG –** Nasogastric Feeding.

4.8 **MRSA –** Methicillin-Resistant Staphylococcus Aureus.

4.9 **ESBL –** Extended-Spectrum Beta-Lactamases.

4.10 **TTAs –** Medication to take away (on discharge).

4.11 **SAP –** Single Assessment Process.

4.12 **DATIX** - the Trust's electronic risk management database used for recording the following data: PALS; Complaints; Untoward Events; Corporate and Local Risks; Medical Devices Register and CAS Alerts.

5 PRINCIPLES

5.1 Somerset Partnership NHS Foundation Trust will ensure that all staff, including clinicians, senior managers and general practitioners and all other relevant agencies, eg Acute Trusts, are fully conversant with the admission criteria and any escalation plans in accordance with capacity plans eg the winter plan.

5.2 All patients will have a management/care plan in place within 24 hours of admission.

5.3 The Trust will work with all health and social care providers to review and update this policy to reflect the changes to discharge arrangements especially in times of capacity pressures or surge in demand.

5.4 Somerset Partnership NHS Foundation Trust will monitor and review the implementation of the policy locally and undertake audits as required to review the appropriateness of admission to a community hospital.

5.5 Somerset Partnership NHS Foundation Trust will work to ensure that all staff are appropriately qualified and competent to provide the clinical care over the 24-hour period, seven days a week for those patients agreed in the admission criteria categories.

5.6 The decision to accept an admission to a community hospital bed will be made by the senior nurse on duty.

5.7 All admissions to Somerset Partnership NHS Foundation Trust will be managed by appropriate clinical teams including the medical service provider. The organisation will ensure that, as far as is reasonably practicable, equality is achieved for all service users.

5.8 Where possible patients will be admitted to the community hospital of their choice. However, this will not always be possible due to capacity and competency issues. In these circumstances patients will be admitted to the nearest possible community hospital or their community hospital of second choice. No patient should be placed in a community hospital

further than 25 miles from their place of residence or the residence of their relatives/carers.

5.9 Somerset Partnership NHS Foundation Trust will ensure that in each locality – Mendip, Taunton Deane, Somerset Coast and South Somerset at least one community hospital will be able to meet the needs of each specialist group of patients. These groups comprise:

- Nasogastric feeding
- Patients with a tracheostomy
- Patients requiring vac therapy
- Patients with PEG/RIG tubes
- Patients requiring isolation facilities
- Patients requiring specialist size equipment or beds

5.10 Patients requiring specialist stroke rehabilitation and not suitable for early supported discharge will be admitted to a dedicated community stroke rehabilitation unit. Such units are provided at:

- Shepton Mallet Community Hospital
- South Petherton Community Hospital
- Williton Community Hospital

6 ADMISSIONS

Admission Criteria for all community hospitals

6.1 All Patients admitted to the community hospital will be aged 18 years or over and will require one of the following:

- The provision of safe local observation and a suitable environment for patients who are medically stable but require further rehabilitation prior to returning safely to their home or future placement.

- The provision of intensive nursing care and treatment when required to avoid admission/transfers to an acute hospital. This would include conditions which can be safely managed in the community hospitals eg urinary tract infections, chest infections, blood transfusion.

- The provision of multidisciplinary assessment and ongoing clinical care where this cannot be delivered in the community.

- The provision of admission for observation/treatment from the minor injury unit, the patient's general practitioner, out of hours doctor, or other healthcare professional.

- The provision of end of life care where the community hospital is the patient's preferred place of death.

Admission Process

6.2 The admission process is detailed as follows:

- All admissions to Somerset Partnership community hospital beds will be arranged through Somerset Primary Link.

- Referrals will be accepted from Acute Hospitals, GPs, the Out of Hours medical service, Community Matrons, Emergency Care Practitioners and Minor Injury Units.

- Patients requiring specialist care ie NG Feeding will be admitted to community hospitals where the staff have the required competency to deliver the specialist care required – see Referral to Community Hospitals Criteria and Specialist Provision Admission Criteria for all Community Hospitals (Appendix A).

- Patients requiring in patient specialist stroke rehabilitation will be admitted to a specialist stroke rehabilitation unit.

- Staff from all referring agencies are responsible for ensuring that the admission criteria are met.

- The senior nurse on duty will work closely with primary link and will accept the patient providing the referral criteria are met, staff have the appropriate competencies to care for the patient and a suitable bed is available. Where necessary, the senior nurse will discuss the admission with the community hospital medical team and a formal handover will be taken and fully documented.

- The requirements of single sex accommodation will be robustly adhered to.

- If the senior nurse on duty in the community hospital has any concerns regarding the admission of a particular patient, they must discuss their concerns with the referrer and if necessary escalate these concerns to the community hospital matron, locality manager, or on call manager.

- In accordance with the winter plan and at times of escalation, the criteria for admission can be overruled with the agreement of the community hospital matron and a member of the Community Health Services Directorate Senior Management Team. Patient Safety will, however, remain paramount.

- On admission from the community, referral and handover information provided by the referrer will be recorded by Somerset Primary Link and will be passed to the relevant community hospital.

7 TRANSFERS TO COMMUNITY HOSPITALS

7.1 Patients are transferred to the community hospitals from acute providers.

- Transfers of patients between hospitals must be undertaken with the consent and understanding of the patient.

- All transfers to Somerset Partnership community hospital beds will be arranged through Somerset Primary Link.

- Transfers should only take place between 8.00am and 6.00pm. Under exceptional circumstances at times of escalation this timescale may be extended to 9.00pm.

- The patient's clinical information and management plan must be available prior to transfer via the electronic waiting list, fax or telephone and must be reinforced by a verbal handover.

- The senior nurse on duty will complete a Patient Transfer Request form (Appendix B) for each patient for whom transfer is requested. The nurse will consider the workload, dependency of existing patients and staffing resources in the community hospital to ensure the admission request can be safely managed. Any concerns will be discussed with the referrer and if necessary escalated to the community hospital matron, the locality manager or the on call manager.

- Patients with any form of cognitive impairment will require a management plan in place prior to transfer to enable the ward staff receiving the patient to manage their mental health needs.

7.2 Patients who have specific care issues or who are at risk of harm as detailed below must be discussed with the senior nurse on duty before the transfer can be accepted. These issues and risks must be recorded as part of the handover documentation. These patients include:

- confused patients who can wander

- patients with MRSA/ESBL/Clostridium Difficile positive infections (see Section 8 Infection Prevention and Control below)

- patients requiring special size or strength equipment or bed

- patients with a tracheostomy

- patients with cognitive impairment, dementia

- patients with a learning disability

- any patient where specialised nursing or higher than usual levels of nursing is required.

7.3 When patients are transferred from a local acute hospital to a community hospital the clinician in charge of the patient's medical care must have agreed prior to the transfer that the patient is medically stable, and that a clinical management plan is available. The clinical management plan will have been reviewed within 24 hours prior to transfer and will include the following information**:**

- full summary of the patient's medical condition
- history of treatment and investigations undertaken
- clinical management plan including current Medication Administration Record and Medication Reconciliation form.
- record of any information shared with patients and family about the patient's condition and prognosis
- full summary of any complex needs for any individual with a learning disability

7.4 Discharge medicines should be sent with the patient.

7.5 Patients will be transferred from an Acute Trust to a community hospital with the following documentation:

- The **patient's medical notes**, which should contain an up to date management plan authorised by the discharging clinician within 24 hours of the planned discharge date. This must include a full summary of the patient's medical condition, history of treatment and investigations, a record of all information shared with the patient and family, and the ongoing clinical management plan.
- A full, comprehensive and legible **Medication Administration Record** (MAR) which has been reconciled within 24 hours of the planned discharge date by the Acute Trust clinician responsible for the patient's care.
- Confirmation of all outstanding **clinical investigations and outpatient appointments including transport arrangements**.
- A copy of the **Inter Healthcare Infection Control Transfer Form** (Appendix D).

7.6 Following transfer the doctor assuming medical responsibility for the patient's care should review any existing DNAR orders (in line with the Trust's Do Not Attempt Resuscitation (DNAR) Policy.

8 TRANSFERS TO ALL OTHER CARE SETTINGS

8.1 The patient's clinical information and management plan must be available prior to transfer.

8.2 The senior nurse on duty will complete the Transfer Checklist (Appendix C) which takes into account the following :

- Patient's condition summarised/reason for transfer
- Resus Status handed over
- Important medications handed over
- Oxygen requirements
- Infection Status handed over
- Equipment/Aids
- Mobility Status
- Destination confirmed
- Informed GP
- Informed Relatives
- Patient's notes or clinical summary

8.3 Patients who have specific care issues or who are at risk of harm must be discussed with the Senior nurse on duty before the transfer can be agreed.

8.4 Consideration needs to be given dependent on the patient's needs whether an escort is required to transfer the patient to the care setting. This assessment is based on an individual risk assessment.

9 INFECTION PREVENTION AND CONTROL

9.1 When transferring patients/clients to another care setting it is vital to inform the receiving ward or unit if the patient has a laboratory confirmed infection. This can be achieved using the Inter healthcare Infection Control Transfer Form (Appendix D) as advocated within the Department of Health's document Essential Steps to Safe Clean Care 2007. Staff may access this document via the staff intranet at http://intranet.sompar.nhs.uk/information/infection_prevention,_control/information.aspx. A hard copy may also be found within the locally held Somerset Partnership NHS Foundation Trust Infection Control Resource file circulated to all community hospital settings.

9.2 If a patient/client being transferred is suspected or confirmed as being infectious the senior nurse on duty must contact Somerset Partnership NHS Foundation Trust Infection Prevention and Control Team (Tel: 01278 432132) within normal working hours prior to the transfer being carried out and **BEFORE** transport is arranged.

9.3 If advice is required Out of Hours, the On Call Manager should be contacted, who can take advice via the On Call Consultant Microbiologist based at Musgrove Park Hospital.

9.4 The Inter Healthcare Infection Control Transfer Form (Appendix D) must be completed by the transferring facility and supplied to the receiving healthcare establishment. It is important to complete the form in full whether a patient/client presents an infection risk or not.

9.5 This form should be used for all inter-healthcare facility admissions, transfers and discharges, including:

- all patients/clients admitted to hospital from a shared-living environment (eg a care home)

- all ward-to-ward inter-hospital transfers, community hospital to community hospital transfers or discharges and all discharges where healthcare may be involved

9.6 In the event of escalation, due to a lack of bed capacity across the Somerset Healthcare system, Somerset Partnership NHS Foundation Trust managed community hospitals may be requested to directly admit patients diagnosed with gastro-intestinal symptoms. These patients would only be admitted if medically appropriate and if sufficient isolation facilities are available. Advice must be sought from the infection prevention and control team prior to the acceptance of such patients. Out of hours, the on Call Manager must be contacted.

10 DISCHARGE

10.1 Timely discharge plays a key role in patients return to the community setting and should be planned from an early stage with full involvement of the patient and their carer. The process outlined below is applicable to each discharge, regardless of when discharge takes place (including Out of Hours).

10.2 Somerset Partnership NHS Foundation Trust will plan all discharges in accordance with the Somerset Health and Social Care Community Principles of Discharge.

10.3 Key points for achieving timely discharge include:

- A predicted date of discharge should be identified within 48 hours of admission by the multi-disciplinary team, and the patient and family/carer informed

- Patients should be provided with the ‘Planning to go Home’ Leaflet (Appendix E)

- The predicted date of discharge will be pro-actively managed against the discharge plan on a daily basis and formally reviewed at each ward round and multi-disciplinary meeting ensuring that all changes are communicated to the patient

- Appropriate written discharge care plans including follow up arrangements will be provided to patients

- Inpatient discharges should be **planned** to occur before 12 noon, on any day of the week, including weekends in order to safeguard vulnerable patients against the associated risks of late/out of hours discharges

- The discharge nurse will refer to the Simple Discharge Checklist (Appendix F) and the Complex Discharge Planning Form (Appendix G) if required, to ensure completion of the various components of discharge, eg TTA's, transport, referral to appropriate specialist professionals, provision of information and documentation to the Patient, GP and other key professionals

- Ward discharge summaries to be forwarded to GP/relevant health agencies and copy given to the patient at the time of discharge. A record of this will be recorded in the Simple Discharge Checklist (Appendix F)

- A full summary of the admission will be provided to the patients GP within 24 hours of patients discharge, with a copy given to the patient. A record of this will be recorded in the Simple Discharge Checklist (Appendix F).

11 PATIENTS WITH COMPLEX DISCHARGE NEEDS AND 'RELUCTANT DISCHARGES'

11.1 All patients requiring a Nursing or Residential Home placement will receive a letter from the ward sister/nurse in charge outlining the hospital's expectations regarding discharge, regardless of funding arrangements.

11.2 Every attempt must be made to ensure that patients are discharged in line with their predicted discharge date. Proactive and regular communication with the patient and their family must be promoted where it is judged that a timely discharge is at risk of not happening.

11.3 The multi-disciplinary team will identify potential reluctant discharges and discuss these with the ward sister/charge nurse and community hospital matron in the first instance.

11.4 Where the patient or carer appears to be reluctant to discharge the nurse in charge will refer to the Somerset Health and Social Care Community Principles of Discharge – Good Practice in Handling Difficult of Reluctant Discharges from Hospital Care and issue the appropriate letter.

12 TRAINING REQUIREMENTS

12.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix (training needs

analysis). All training documents including the Learning Development and Mandatory Training Policy and the Training Prospectus is accessible to staff within the Learning and Development Section of the Trust Intranet.

12.2 The ward sister/charge nurse is responsible for training staff in the management of patient admission / transfer and discharge. This should be part of local induction training and the relevant competency framework.

12.3 Service managers and team leaders are responsible for training referring staff in the criteria and process for admission.

13 EQUALITY IMPACT ASSESSMENT

13.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Document Lead (author) who will then actively respond to the enquiry.

14 MONITORING COMPLIANCE AND EFFECTIVENESS

14.1 The following measures will be used to review the impact of the Admission, Transfer and Discharge Policy and will be formally reported to the Community Hospital Best Practice Group and the Senior Managers Business Meeting on a monthly basis:

- patient readmission rates
- delayed discharge rate
- average length of stay

14.2 In addition the following metrics will be monitored as part of the community hospital performance scorecard which will be monitored by the Community Hospital Best Practice Group and Senior Managers Business Meeting on a monthly basis:

- Numbers of admissions discharges and transfers
- Performance against the following standards:
    - Direct admission from Primary Care – patient admitted within four hours of referral
    - Acute Hospital transfers – patients transferred within 48 hours of being assessed as “ready to go”

14.3 The following will be used to monitor the quality of admissions, transfers and discharges:

- documentation audits – undertaken annually as part of the organisational annual audit plan

- patient satisfaction survey – undertaken for all discharges and reported to the Clinical Governance Group on a bi-monthly basis

- patient safety incidents reports (including inappropriate admissions) – reviewed at the Clinical Governance Group meeting and the Community Health Services Clinical Assurance Group meeting on a monthly basis

- complaints - reviewed at the Clinical Governance Group meeting and the Community Health Services Clinical Assurance Group meeting on a monthly basis and the Patient and Public Involvement Group meeting

14.4 The responsibility for developing action plans as a result of the above monitoring and the sharing of lessons learnt will sit with the Community Hospital Best Practice Group which is chaired by the Head of Adult Community Services.

15 COUNTER FRAUD

14.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

16 RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

16.1 The standards and outcomes which inform this procedural document are as follows:

Section	Outcome	
Information and involvement	1	Respecting and involving people who use services
Personalised care, treatment and support	4	Care and welfare of people who use services
	6	Cooperating with other providers
Safeguarding and safety	7	Safeguarding people who use services from abuse
Quality and management	12	Records

16.2 Relevant National Guidance

- Guidance on Continuing Care HSG (955)

- NHSLA Risk Management Standards 2012-2013 for NHS Trust providing Acute, Community, MH & LD and Non-NHS Providers of NHS Care Standards

- Department of Health's document Essential Steps to Safe Clean Care 2007

- Department of Health (2004) Achieving *Timely 'Simple' Discharge from Hospital.* Department of Health, London.

17 REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

17.1 References

- Department of Health's document Essential Steps to Safe Clean Care 2007

- Department of Health (2004) Achieving *Timely 'Simple' Discharge from Hospital.* Department of Health, London.

- Department of Health (2004) The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process. Department of Health, London.

- Disability Discrimination Act 1995 (HMSO)

- Human Rights Act 19998 (HMSO)

- Parliamentary and Health Service Ombudsman (2008-2009) Six Lives: the provision of public services to people with learning disabilities. HC203

- The Protocol for the Management of Community Hospital Multi Disciplinary Meetings and Implementation of the Single Assessment Process 2004

- Somerset Health and Social Care Community Winter Plan 2010/11

17.2 Cross reference to other procedural documents

The following procedure documents relate to this policy:

- Being Open and Saying Sorry When Things Go Wrong
- Clinical Supervision and Coaching Policy
- Consent to Examination and Treatment Policy
- Data Protection & Confidentiality Policy
- Do Not Attempt Resuscitation (DNAR) Policy
- Escorting Patients Between Care Settings
- Handover Policy for Inpatient Wards

- Learning Development and Mandatory Training Policy
- Mandatory Training Matrix (Training Needs Analysis)
- Medicines Policy
- Privacy, Dignity and Respect Policy
- Professional Interpreting and Translation Service Policy
- Records Keeping and Records Management Policy
- Resuscitation Policy
- Risk Management Policy and Procedure
- Risk Management Strategy
- Safeguarding Children's Policy
- Safeguarding Vulnerable Adults Policy
- Serious Incidents Requiring Investigation (SIRI) Policy
- Training Prospectus
- Untoward Event Reporting Policy and Guidance

All current policies and procedures are accessible to all staff on the Trust intranet (on the home page, click on 'Policies and Procedures'. Trust Guidance is accessible to staff on the Trust Intranet (on the home page, click on Information, then Local Guidance).

18 APPENDICES

Appendix A	Referral to Community Hospitals Criteria and Specialist Provision Admission Criteria for all Community Hospitals
Appendix B	Patient Transfer Form
Appendix C	Transfer Checklist
Appendix D	Inter-healthcare Infection Control Transfer Form
Appendix E	Planning to go Home Leaflet
Appendix F	Discharge Plan - Simple Discharge Checklist (Adults)
Appendix G	Complex Discharge Planning Form
Appendix H	Out of Hours Transfer Guidance

APPENDIX A

REFERRAL TO COMMUNITY HOSPITALS CRITERIA AND SPECIALIST PROVISION ADMISSION CRITERIA FOR ALL COMMUNITY HOSPITALS

All Patients admitted to the Community Hospital will be aged 18 years require one of the following:

- The provision of safe local observation and a suitable environment for patients who are medically stable but require further rehabilitation prior to returning safely to their home or future placement.

- The provision of intensive nursing care and treatment when required to avoid admission/transfers to an acute hospital. This would include conditions which can be safely managed in the community hospitals eg urinary tract infections, chest infections, blood transfusion.

- The provision of multidisciplinary assessment and ongoing clinical care where this cannot be delivered in the community.

- The provision of admission for observation/treatment from the minor injury unit, the patient's general practitioner, out of hours doctor, or other healthcare professional

- The provision of end of life care where the community hospital is the patient's preferred place of death.

All Community Hospitals will accept the following

- Confused patients who do not wander
- Patients needing IV antibiotics
- Patients fed via PEG/RIG tubes
- Patients needing blood transfusions
- Patients receiving IV fluids
- Patients needing sub-cut therapy
- Patients needing vac therapy
- Patients requiring active rehabilitation
- Patients with dysphagia
- Patients needing palliative care
- Patients requiring specialist rehab equipment (eg Encore hoist, pulpit frame, stand aid hoist)
- Amputees
- Patients at risk of falling
- Patients who need regular blood monitoring (eg INR)
- Patients needing oxygen

Admissions will be accepted between the hours of 08.00am and 6.00pm.

Prior Acceptance Discussion

The following issued must be discussed with the senior nurse on duty before an admission can be accepted:

- Confused patients who can wander
- Patients with MRSA positive infection
- Patients requiring special size or strength equipment or specialist hire beds
- Patients with a tracheostomy
- Patients with a diagnosis of dementia

The ability to accept the patient will depend on the specific needs of the patient, the patient environment, the available staff competencies and the case mix within the hospital at any one time.

Specialist provision available at specific community hospitals

	Criteria **Y = Yes, can accept these patients** **N = No, unable to accept these patients**	**Bridgwater**	**Burnham**	**Chard**	**Crewkerne**	**Dene Barton**	**Frome**	**Minehead**	**Shepton Mallet**	**Wellington**	**Williton**	**West Mendip**	**Wincanton**	**South Petherton**
	Patients requiring NG feeds	N	N	N	N	N	N	N	Y	Y	Y	N	N	Y
	Patients for stroke rehabilitation	N	N	N	N	N	N	N	Y	N	Y	N	N	Y

APPENDIX B

SOMERSET PARTNERSHIP NHS TRUST
PATIENT TRANSFER FORM
FOR PATIENTS TRANSFERRING TO COMMUNITY HOSPITALS

1. Form to be completed by Community Hospital staff/In-Reach Nurses for all patients **prior** to patient transferring in from another hospital/ establishment. Please telephone the transferring hospital to obtain this information.

2. Please keep form stapled to the front of the patient's notes until patient admitted and checked in, then file in notes.

3. Entries refer to current date only, and any monitoring records need to be kept separately.

Patient Name:	**Patient DOB:**
Referring Nurse:	**Receiving Nurse (DB)**
Referring Establishment:	**Date:**

Discussions	**Discussed?**		**Comments**
	Yes	**No**	
Mobility Pre-admission			
Present mobility			
Falls Risk?			
Continence Bowels			
Bristol Stool Chart			
Bladder			
Catheter			
Infection Control ESBL			
MRSA			
C.Diff etc			
History of loose stools in previous 72 hours			
Wounds and Care Plan Pressure area risk score			
VAC Therapy			
Nutrition and Fluids MUST score			
SALT			

Discussions	Discussed?		Comments
	Yes	No	
Mental State			
Dementia Capacity Issues			
CPN			
Special Requirements Medications, bloods, warfarin, insulin, VTE prevention, PICC or Hickman line etc			
Rehab Current mobility Weight bearing status ADL Equipment requirements Any specific treatment needs			
Patient Discharge Goal			

Name of Staff Member completing form: ……

Print Name: ……

Designation: ……

Contact Number: ……

APPENDIX C

TRANSFER CHECK LIST

DATE	
TIME	
Destination HOSPITAL	**Is this from or to? Perhaps needs both**
STAFF NAME	
SIGNATURE	**Do you want sign out and receiving signature too?**

Affix
Patient Address Label
Here

	YES	**NO**	**N/A**	**COMMENTS**
Patient's condition summarised/reason for transfer				
Resus Status handed over				
Important medications handed over				
Oxygen requirements				
Infection Status handed over				
Equipment/Aids				
Mobility Status				
Destination confirmed				
Informed GP				

Informed relatives				
Patient's Notes or Clinical Summary				

APPENDIX D

Inter-healthcare infection control transfer form

Patient/client details (insert label if available) Name: Address: NHS number: Date of Birth:	**Consultant:** **GP:** **Current patient/client location:** **Transferring facility – hospital, ward, care home, other:** **Contact no:** Is the ICT aware of transfer? Yes/No
Receiving facility- hospital, ward, care home, district nurse **Contact no:** Is the ICT/ambulance service Aware of transfer? Yes/No	Is this patient/client an infection risk? ***Please tick the most appropriate box and give confirmed or suspected organism*** I Confirmed risk Organism: ❑ Confirmed risk Organism: I Suspected risk Organism: I Suspected risk Organism: Patient/client exposed to others with infection e.g. D&V Yes/No

If patient/client has diarrhoeal illness, please indicate bowel history for last week:
(based on Bristol stool form scale)

Is the diarrhoea thought to be of an infectious nature **Yes/No**

Relevant specimen results (including admission screens- MRSA, glycopeptides-resistant enterococcus SPP, C. *difficilie*, multi-resistant *Acinetobacter* SPP) and treatment information, including antimicrobial therapy:

Specimen:				
Date:				
Result:				

Treatment information:

Other information:

Is the patient/client aware of their diagnosis/risk of infection? Yes/No

Does the patient/client require isolation? Yes/No

Should the patient/client require isolation, please phone the receiving unit in advance

Name of staff member completing form:.....

Print name:

Contact number:

For further advice, please contact your infection control team/advisor

If your preferred option is not immediately available, it will be necessary for you to move to a short-term placement.

Information about this will be provided by your Social Worker.

Other support to help with any concerns is available for patients and carers from:

Age Concern	Tel: 01823 326212
Care Direct	Tel: 0845 3459133

The day of your discharge

A final check will take place to ensure that everything is in place for your discharge. You may be seen by a nurse instead of a doctor immediately before your discharge.

On your day of discharge you will need to be ready to leave the ward by **11 am at the latest.**

If applicable, you will need to check that you have your SAP document and your discharge letter with you on the day of discharge.

A supply of your current medication may be given to you or your family/carers. If you have any questions or concerns about your medication, please speak to the nurse in charge.

Useful Contacts

(Staff to highlight those relevant to patient)

Ward:

……

Social Worker:

Occupational Therapist:

Physiotherapist:

District Nurse:

Somerset Partnership NHS
NHS Foundation Trust

PLANNING TO GO HOME
(Adult patients)

Patient:

Admission Date:

Planned Discharge Date:

Our commitment to you

We appreciate that a hospital stay can be a stressful and worrying time. We will offer support and advice to you and your family or carers throughout your hospital stay. We will discuss with you the continuing support you may need when you leave hospital. This will help to make the transition as easy as possible.

If you have any queries regarding the information contained in this leaflet please raise them with any member of the team caring for you.

Planning for your discharge or transfer from hospital

This hospital is the right place to be when you are in need of specific care and/or rehabilitation. However, when this has been completed it is important that you leave hospital as soon as possible so that another patient can be admitted to receive treatment

We will start planning for your discharge as soon as you are admitted. This means that we will begin to:

- assess what your needs are likely to be when you are ready to leave hospital
- involve any relevant staff who can help in meeting those needs, e.g. Occupational Therapist, Physiotherapist, GP, Speech Therapist, Community Nurse, Social Worker, etc.
- organise equipment or services that you may need when you leave hospital

Working together

All staff will work with you and your family/carers to plan an effective discharge or transfer.

There may be concerns such as your future safety, your ability to move around, or to manage your personal care and domestic arrangements. If so, please have no hesitation in raising these with staff at the earliest opportunity.

As soon as we know when your treatment will be completed, you will be given an expected discharge or transfer date. It is important that you are aware of this so that necessary arrangements can be made.

These may include:

- transport home – patients are normally expected to arrange their own transport
- suitable clothing and footwear, if you are not already using them in hospital
- access to a key to your property
- adequate basic food supplies at home
- adequate heating in your home
- delivery of any equipment needed to provide continuing care in your home

Further support

If there are difficulties in returning to your home, a number of options can be considered. A Social Worker is available to discuss these with you and your family/carers. Options might include:

- an emergency call system
- home care
- adaptations in your own home
- moving to sheltered housing
- moving to extra care housing where there is 24 hour support and care
- short stays in a residential or nursing home
- longer term accommodation in a residential or nursing home

APPENDIX F

SOMERSET PARTNERSHIP NHS FOUNDATION TRUST
COMMUNITY HOSPITAL SIMPLE DISCHARGE CHECKLIST

PLANNED DATE/ TIME OF DISCHARGE:

Initial Date:	Change Date: Reason:	Change Date: Reason:

Planned Discharge Destination:
Home ☐ Nursing Home ☐ Residential Home ☐ Other (please specify)

Care Package ☐ Community Support Team ☐

	Comments Yes / No	**Date**	**Signature**
Multidisciplinary Team agreement for discharge			
All equipment arrangements made Please state:			
Social Work agreement to discharge date			
Care package in place – Date and start time:			
Patient aware of proposed discharge date			
Relatives aware of proposed discharge date			
Call required on discharge			
Community Services informed **OR** Community Support Team arranged			
Telephone contact with District Nurse Team			
Person to receive patient arranged			
House keys available			
Heating on			
Food available			
Relatives able to transport patient home			

Patient is able to transfer into a car?			
Hospital transport booked (please circle) Car / Ambulance / Sitting / Stretcher			
Discharge Medication ☐ Ordered ☐ Received ☐ **Consider Compliance Aid**			
GP Surgery informed			
Out-patient appointment made / to follow by post			
Referral to Specialist Psychiatric Liaison team / Memory Service, or GP for specialist diagnosis (dementia)			

SIMPLE DISCHARGE CHECKLIST
(Continued)

Day of Discharge Inter-healthcare infection control transfer form to be completed on all relevant discharges	**Tick**	**Discharging Nurse** (Print Name)
GP letter given to patient or sent to GP		
District Nurse referral completed and given to patient		
Discharge medication given and explained to patient		
For all patients receiving anticoagulant therapy, fax INR and medication record to their GP on the day of discharge and update the patients yellow card		
Pad/dressing checked if appropriate		
Pads/ dressings/catheters/stoma supplies given to patient if appropriate		
Check that ALL cannulae have been removed		
Property returned to patient including from the safe e.g dentures, glasses, hearing aid, etc		
Relatives/ carers/ relevant destination informed	**Yes/ No**	
In the event of death, checklist completed	**Yes/ No**	

In the event of a discharge or patient death, form completed and documented in records
Yes / No

Print Name:.....

Signature:.....

Date:.....

Print Name: ..... Designation: .....

Signature: ..... Date / Time: .....

Contact Number: .....

APPENDIX G

COMPLEX DISCHARGE PLANNING FORM

Patient at risk because (tick relevant box)

☐ ↑ Requires Specialist assessments
☐↑ Already received community services
☐ ↑ Requires complex package of care
☐↑ Family / Carers / Staff have concerns
☐ ↑ Dementia
☐ ↑ Learning Disability

Addressograph

Discharge Leaflet given on Admission: YES / NO
Is SAP required: YES / NO

Referral to / request for assessment to	Type of referral Verbal/written Dated completed	Referrer	Name and contact details for assessor	Outcome of referral
Occupational Therapist				
Physiotherapist				
Social Worker				
Specialist Learning Disability Service				
Community Psychiatric Nurse				
District Nurse				
Community Matron or Case manager				
Care Home Matron				
Red Cross 'Home from Hospital'				
Other (eg Dietitian, Independent Mental Capacity Advocate				

Use nursing continuation sheet for more detailed comments, ID labelled and attached to this form

Difficult/Reluctant Discharge Policy (refer to policy)

Action	By Whom	Date Issued
Letter 1 issued		
Letter 2 issued		
Letter 3 issued		

APPENDIX H

Somerset Partnership NHS
NHS Foundation Trust

GUIDELINES FOR CLERKING PATIENTS TRANSFERRED FROM AN ACUTE HOSPITAL TO A COMMUNITY HOSPITAL BED

Following an episode of acute care, patients who have an ongoing need for clinical care (medical, nursing or rehabilitation) can be transferred to a Community Hospital if their health care needs cannot be met at home.

The Somerset Partnership NHS Foundation Trust county wide Community Hospital admission criteria requires patients to have been assessed as medically stable and fit for transfer prior to transfer to a Community Hospital .

Acute Trust Discharge Documents

It is expected that patients will be transferred from an Acute Trust to a Community Hospital with the following documents

- The patient's medical notes, which should contain an up to date management plan authorised by the discharging clinician within 24 hours of the planned discharge date. This must include a full summary of the patients medical condition, history of treatment and investigations, a record of all information shared with the patients and family, and the ongoing clinical management plan.

- A full, comprehensive and legible Medication Administration Record (MAR) which has been reconciled within 24 hours of the planned discharge date by the Acute Trust clinician responsible for the patients care.

- Confirmation of all outstanding clinical investigations and outpatient appointments including transport arrangements.

- A copy of the Inter Healthcare Infection Control Transfer Form (Appendix D)

Community Hospital Admission of Acute Trust Transfers

All acute trust transfers to a Community Hospital will be admitted with prior agreement of the nurse in charge who will be responsible for ensuring that the medical practitioner is informed of the patient's admission.

Wherever possible, patients should be transferred between the hours of 08.00am and 6.00pm, and anticipated transfers after this time should always be in discussion with the nursing shift leader.

In-hours it is expected that all admissions (including Acute Trust transfers) will be clerked by the Community Hospital Medical Practitioner in line with the Somerset Partnership NHS Foundation Trust clerking checklist.

During the periods 6.30pm and 8.00am Monday to Friday and 24 hours on Saturday, Sunday and Bank Holidays, medical cover is provided by the Out of Hours Medical Service.

In most instances the clerking of Out of Hours Acute Trust transfers will be completed **on the next working day** ie by the Community Hospital Doctor**.**

Exceptions to this will include the following:

- If there is not an up to date and clear management plan in place on admission
- If the MAR chart is not clear, legible or authorised as accurate before discharge from the Acute Trust
- If the patient's medical condition changes or deteriorates at any time following transfer from the Acute Trust, and the patient requires a clinical review.

If any of the above should happen, the nurse in charge of the Community Hospital ward will require an out of hours doctor to attend the ward to complete full clerking of the patient, to include completion of a Somerset Partnership NHS Foundation Trust MAR chart.

In the case of incomplete documentation, such incidents will be reported back to the transferring organisation. Staff will complete a DATIX Untoward Events Report form (accessible on the Trust Intranet) which will be used to analyse trends and highlight areas of concern.

NB Primary Care admissions to Community Hospitals during the Out of Hours period will always require clerking by the Out of Hours Medical Service. It is likely that this service will be acting as the referring agent and clerking packs are available for the Out of Hours Doctors to enable this function to be completed in the patient's own home prior to admission.

Judith Brown
Director of Community Health Services
March 2012