STANDARD OPERATING PROCEDURE
ADMISSION PROCESS FOR
COMMUNITY INPATIENT UNITS

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Author/Lead **Job Title**	Carol Wilson Locality Matron
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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*19/06/19*	*Approved at Community CNG*
1.1	*14/07/20*	*Update due to changes to Inpatient Unit at Whitby and HDS*
1.2	*18/01/24*	*Reviewed and approved at Community CNG (18 January 2024).*

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1. INTRODUCTION

The Standard Operating Procedure (SOP) aims to ensure a safe and efficient way of admission patients into community inpatient units. Humber Teaching NHS Foundation Trust is committed to ensuring safe and effective practice when admitting, transferring or discharging patients from its inpatient wards.

The Trust will ensure that all staff, including clinicians, senior managers, general practitioners and all other relevant agencies, e.g., acute trusts, are fully conversant with the admission criteria and any escalation plans in accordance with capacity planning e.g. the Winter Plan Escalation Framework.

All patients will arrive on the wards with clear management and escalation plans which will inform the development of care plans within 24 hours of admission.

The Trust is committed to ensuring all staff are appropriately qualified and competent to deliver safe and effective clinical care over 24 hours, seven days a week for patients as agreed in the admission criteria categories.

The decision to accept an admission to a community hospital bed will be made by the senior nurse and or the Advanced Care Practitioner (ACP) on duty.

2. SCOPE

This SOP will be used across both in-patient units at Malton and Whitby hospitals. It includes both registered and unregistered staff that are permanent, temporary, bank and agency staff including students, on commencement of working within community services.

The purpose of this SOP is to establish safe and consistent pathways of care for patients for admission through to discharge. This SOP helps define the purpose of inpatient care at our community hospitals and how to access these services. It also sets the clinical standards to improve the admission of appropriate patients.

3. DUTIES AND RESPONSIBILITIES

Service Managers, Modern Matrons and appropriate professional leads will ensure dissemination and implementation of the policy 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.

Charge Nurses/Team Leads will disseminate and implement the agreed SOP. They will maintain an overview of associated training needs for their respective teams. The Charge Nurse/Team Leader will ensure mechanisms and systems are in place to facilitate staff to attend relevant training as part of their Performance and Development Review (PADR) 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 policy and Standard Operating Procedures as relevant to each clinical activity. They will make their line managers aware of barriers to implementation and completion.

4. PROCEDURES

The following section details the principles of admission into a community hospital bed.

4.1. Principles

- The “Home First” principle has been considered by the Hospital Discharge Team (HDS) and /or multi-disciplinary team in order to avoid an admission to a community bed.
- Admission for a period of treatment, MDT assessment, rehabilitation or non-specialist palliative care for patients who are medically stable but have recovered from the acute phase of their illness and whose condition does not require the resources of an acute hospital.
- Patient stay should not be expected to exceed three weeks (six weeks for complex rehabilitation) in total, an Estimated Date of Discharge (EDD) and a clear plan of treatment goals/ assessment to enable the patient to move forward along the patient pathway to their ultimate destination should be produced on admission.
- Before admission the principle of “Home today, why not?” should be considered and this should have been explored with the Hospital Discharge Service (HDS) prior to accepting the admission.
- A daily clinical review of the plan for every patient should take place focused on three questions:
    - Why not home?
    - What needs to be different to make this possible at home?
    - Why not today?
- The review process should explore why people require rehabilitation in a bedded setting. It is accepted that all of the patients will be medically stable in this setting.
- All patients should have an expected date of discharge (EDD) and be fully involved with their discharge planning. It is essential that expectations are set at the point of admission.
- Patients will be admitted if they have been assessed as having rehabilitation potential and the ability to follow an active programme or have a physical health need that is best served by being on the community ward as part of assessment.

- Consideration for patients with non-weight bearing status with specific rehabilitation goals will be made on an individual basis- this would be assessed as having potential to improve in a timely manner to a level of function that will allow the patient to return home with support or independence

4.2. Hospital Discharge Service

All referrals go through the Hospital Discharge Service (HDS) for all inpatient units and if appropriate a bed will be allocated. This could be allocated at either unit dependant on bed availability after discussion with the senior nurse/ACP on duty.

For patients whose needs are too great to return to their own home (about 5% of patients admitted to hospital) a suitable rehabilitation bed will be considered in our community bed facility. The ward MDT/senior in charge will ensure effective and timely discharge to support patient .

- Referrals to Humber Hospital Discharge Service hnf-tr.hospitaldischargeservice@nhs.net on 01947 899201, via a completed Trusted Assessor form.
- Patients require a senior nurse/clinical decision before a bed will be allocated.

4.3. Community Services Inpatient Units

Whitby Memorial Inpatient Unit

- 16 beds with a mix of single rooms and larger bays

Malton Fitzwilliam Inpatient Unit

- 20 beds with a mix of single rooms and larger bays.

4.4. Step-up Care

Goal: To enable patients with a long-term condition/frailty/rehabilitation need to receive nursing or therapy care, which is beyond the scope of the primary and community care teams and to receive additional support on a short-term basis to stabilise their condition.

Prior to admission to a community hospital bed the patient should be considered for Urgent Community Response Support at home to ensure all suitable options have been explored prior to admission.

Patients suitable for step up admission are patients who:

- Would otherwise require acute a hospital admission or re-admission, and do not require the level of medical or technical intervention of an acute hospital.
- Patients on a virtual ward who require 24-hour support but do not require acute admission
- Do not require out of hours clinical support services (beyond that which can be provided by current traditional OOH/ ACP/ GP services).
- Are expected to make sufficient recovery, within a time limit period, to be cared for within existing community resources or;
- Who are in receipt or some aspect of palliative care, e.g. symptom control, or end of life care (where appropriate and desirable for the patient).
- Step up will also include SDEC and A/E referrals from acute hospitals.
- Step up admissions will be a priority over step down admissions

4.5. Step-down Care

Goal: To facilitate the patient recovery phase following an acute admission, where the care / assessment required cannot to be provided in their own home or an alternative facility.

These are patients who:

- Are medically stable for transfer but require a period of ongoing 24-hour care in a community hospital bed due to their ongoing nursing or rehabilitation needs.
- Have been assessed prior to admission to have the ability and motivation to participate in active rehabilitation to their level of self-care/functional abilities.
- The plan of care has been fully discussed with the patient and carers and consent is gained, if a patient lacks capacity to consent then best interest decision making should be fully documented prior to admission.
- Escalation plans/RESPECT forms should be completed prior to admission
- Are expected to achieve rehabilitation goals within a time limited period.
- Have complex planning needs /rehabilitation goal which returns the patient to supportive living within the community or;
- Are undergoing a period of assessment prior to decision to discharge to community or care home facility. This will be dependent on the full support of the social care team and joint planning for onward timely placement.
- Are in receipt of some aspects of palliative care that cannot be provided within their home.

Step down care should form part of a clear patient pathway which should be commenced whilst the patient is an in-patient in the acute hospital. Step down will be offered at either unit that has a bed available with a completed and comprehensive trusted Assessement having been completed and a clear handover.

Once the level of dependency is reduced the patient should be discharged to appropriate community setting (home, supported living, or Virtual Ward etcDischarge and Transfer Policy N-032.pdf (humber.nhs.uk)

Prerequisite information when stepping down to the community ward

- A completed trusted assessment form is required at point of referral to Hospital Discharge team.
- Service users must be registered with a Scarborough/Ryedale/Whitby or Vale of York GPs.
- Service users must be aged 18 years or over.
- Confirmation that the patient is medically stable and evidence of the medical and nursing care plan. Information also includes evidence of baseline observations and NEWS along with a copy of the latest blood results and recent investigations to seek appropriate baselines should the patient's condition deteriorate.
- Confirmation that complex investigations are not required.
- Clear purpose of assessment, treatment and rehabilitation as documented on the TAF.
- Evidence that care and on-going management plan, cannot be achieved in the patient's own home.
- Evidence that clinical risk has been assessed and identified by the referrer and considered appropriate to support admission.
- Admission must be driven by patient need and their best interest, including family and carer needs.
- Minimum of seven days' supply of medication must be provided as part of the Discharge of care. If recently commenced on warfarin regime, minimum 3 days of dosing is required.
- The EPMA and discharge letter should also be sent with the patient to ensure smooth transition and to prevent an unnecessary delays in patients receiving medication particularly in the out of hours period

Prerequisite information when stepping up to the community ward

Patients admitted directly from the community must have been assessed by a senior clinician (GP, ACP/ Complex Case Manager, nurse practitioner, senior therapist). Relevant clinical information including a full set of physical observations, NEWS score, proposed treatment plans and anticipated length of stay, must be communicated via completed Holistic assessment on System one to the hospital discharge service prior to consideration for a community hospital bed.

Palliative care admissions should be GP led.

All admissions will be expected to take place within reasonable hours, 0800 to 1800 Monday to Sunday.(in exceptional circumstances agreement may be made outside these times)

4.6. Exclusion Criteria

The following patient groups are **not suitable for admission** to the community hospital bed base and therefore referrals will be rejected

1. Medically unstable or at high risk of significant deterioration requiring close monitoring and intervention. Some features may include:

    - High Fever (>38.5 deg C)
    - Low oxygenation (<92% SaO2 on air) – exception for Long Term Conditions if parameters are identified in the care plan
    - Abnormal Blood Gases
    - Tachycardia (heart rate >100bpm)
    - Respiratory rate >30 RPM
    - Unstable or low blood pressure (<90/66mmHg)
    - Reduced level of consciousness
    - Abnormal and unqualified or rapidly changing results, e.g. falling haemoglobin, high white cell count, worsening renal function
    - Untreated heard block

It should be noted that where some of the above criteria are present but are stable then they may not necessarily exclude admission, subject to this been agreed by a senior doctor/RC.

2. Infections: Patients with a known or suspected contagious infection will only be accepted after approval from the Health Care Acquired Infection (HCAI) team and a clear plan is in place.
3. Complex functional illness requiring specialist care, including medical care (will include complex functional illness where there is a significant risk of harm). Patients in whom there has been an acute confusional state (delirium) related to a physical cause, e.g. an acute infection which is causing increased NEWS scores and indicates escalation, endocrinological imbalance and where further physical investigations are required.
4. Individuals with organic, functional or mixed disorder who exhibit extremes of challenging behaviours including extreme physical violence, extreme sexual dis-inhibition.
5. Where no diagnosis can be offered and is requiring continued specialist services.
6. Access to complex, frequent or specialist diagnostic imaging services.
7. Patients awaiting pre-booked investigations within 48 hours that needs to be undertaken within an acute setting.
8. Specialist services that are provided elsewhere, e.g. specialist palliative care services or mental health services.
9. Under 18 years of age.
10. Social respite (except patients who are in receipt of some aspects of palliative care and require a period of support to enable ongoing care at home in end of life care).11.Patients who require in-patient alcohol detoxification regimes.

4.7. Admission Process

Referrer's Responsibility

It will always be the legal responsibility of the referrer to assess the clinical situation and management of risks of the patient care. The referring professional/organisation must accept legal responsibility to ensure that the information they give is accurate and timely, respecting confidentiality. This is required by the completion of a TAF for acute transfer and the holistic assessment for community step up admissions. .

- The decision to refer the patient to the community ward must be taken by the patient's senior clinician (GP, community matron, ACP/ nurse practitioner, senior therapist) as part of pathway of care.
- It is expected that prior to referral, the admission will be discussed with the patient, family, care. This should include the rationale for referral and an indication of expected duration of stay in the community hospital (including expected outcomes and management plan). This will be supported with the admissions leaflet for patients and families.
- If a patient lacks capacity to consent then best interest decision making should be fully documented prior to admission
- Escalation plans/RESPECT forms should be completed prior to admission
- Patient's consent for referral and transfer obtained.
- A referral with a completed documentation will be required and needs to be emailed to the hospital discharge team ensuring all necessary information has been collected and that the patient meets the criteria and has no exclusion criteria. hnf-tr.hospitaldischargeservice@nhs.net.
- Once the patient has been accepted, the referrer will arrange the transfer of the patient.
- Once the patient is accepted, the referring organisation must arrange transportation arrangements with the patient arriving before 5pm.
- Referrer must ensure that all relevant documentation transfers with the patient:
  - Copy of Electronic Prescribing and Medicines Administration (ePMA) prescription chart.
  - If a patient has waited for transfer in another part of the hospital it should be clear when the patient has received medication.
  - Copy of discharge letter including details of discharge medication (step up)
  - All current medications should accompany the patient to ensure continuity of medicines, with a minimum supply of 7 days (or complete course of treatment, for example IV antibiotics and RED drugs)

- Prescribing, administration and on-going monitoring of specialist drugs should have a management plan
- Copy of MDT documentation
- Copy of the most recent episode of care including medical & nursing care plan
- Copy of investigation results
- Future management plan including details of any pre-booked appointments
- Copy of social care assessments and family/carer involvement
- Copies of relevant documentation of clinical priority issues, including tissue viability assessments, infection control information, falls risk, communication issues, and special needs should accompany the referral documentation
- End of Life care/Supportive/Palliative: If a decision has been made about the treatment of the patient, including Do Not Attempt Resuscitation or a valid Advance Directive/ Respect, **these must be communicated before admission**; information about advance care plans, including preferred priorities of care
- Specialist equipment must be considered and planned prior to admission. In some circumstances it may be necessary for the appropriate equipment to be loaned to the Community Hospital in order to appropriately care for the patient

- The nurse in charge of the community ward will notify the RC/ACP when the patient arrives on the ward.

On admission to the ward

- All patients will be assessed on arrival and mandatory assessments completed in required timescales. The clinician will review the patient's clinical needs and ensure appropriate assessment/treatment is started and medication prescribed.
- The RC/ ACP will perform medical clerking within 4 hours of arrival on to the ward. Where this occurs in the Out of Hours period as defined by the medical cover specification for each community hospital then this task will be carried out by the Out of Hours GP service. On these occasions the RC/ACP will review the clerking within 24 hours.
- The nurse will record all patients own drugs (PODs) using the appropriate Systm1 form. Pharmacy staff will check and sign off medicines reconciliation.

All patients, within 48 hours of admission, will have:

- Respect form/Escalation plan will be in place.
- Patient will receive the patient booklet and this will be explained and discussed with the patient
- Been assessed in terms of goal setting and outcomes
- A planned date of discharge

Respect/Escalation plan should be completed for all patients and documented in the clinical record, but it will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.