STANDARD OPERATING PROCEDURE
NORTH YORKSHIRE ICB INTERMEDIATE CARE BEDS

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Name of Trust Strategy/Policy/Guidelines this SOP refers to:	Community - Referral and Triage for Neighbourhood Care Services.pdf (humber.nhs.uk) Community - Hospital Discharge Service SOP22-032.pdf (humber.nhs.uk)

VALIDITY – All local SOPS should be accessed via the Trust internet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
1.0	*26 May 2023*	*New SOP. Approved at Community Services Clinical Network Group (26 May 2023).*

Contents

1. INTRODUCTION

The overarching aim of the ICB intermediate care beds is to facilitate timely discharge.

- To provide ongoing assessment to determine future care and support needs.
- To provide support during a period of ill-health to maximise level of independence and/or return to previous level of independence where possible.
- To gain confidence with mobility and all self-care tasks by having access to therapeutic interventions.
- Provide access to services to maximise independent living, e.g., assisted technology and signposting to relevant agencies.
- Health and social care professionals to work in partnership with carers and family to give the confidence to offer appropriate levels of support to aid independent living.

Any health conditions can be treated and improved through access to appropriate nursing intervention and medical care and review, which complements re-enablement and is appropriate to the environment.

The beds are commissioned for 28days from admission and this is funded by North Yorkshire ICB. If an extension is required for ongoing rehabilitation this should be discussed and agreed with the allocated social worker and Humber therapy team prior to the end of the funding.

2. SCOPE

- This standard operating procedure (SOP) outlines the role and responsibilities of the staff within Humber Teaching NHS Foundation Trust and the York and Scarborough Trust Hospital Discharge Service, North Yorkshire Council, Silver Birches and Larpool Lane Care homes. It will apply to a maximum of 7 beds at Silver Birches (Filey) and 9 beds at Larpool Lane (Whitby).

It outlines its key functions and the procedure for patient flow into the Intermediate Care beds.

3. DUTIES AND RESPONSIBILITIES

Humber Teaching NHS Foundation Trust Hospital Discharge Service

- Will provide a single point of contact
- Will provide a triage service to for all referrals into Intermediate Care beds from acute partners in partnership with the senior carer / care home manager.

Intermediate Care Staff Humber Teaching NHS Foundation Trust

- Will assess all patients admitted for intermediate care bed based rehabilitation, following the agreed documentation standards outlined in Community Services Assessment and Documentation SOP22-007.pdf (humber.nhs.uk).
- Will liaise regularly with social care staff regarding discharge plans for each patient
- Will complete admission and discharge assessments and relevant outcome measures on S1 to capture the outcome of the admission.
- Will provide an update to senior carers within Silver Birches / Larpool lane following each visit. In addition to a verbal handover a summary of the visit will be documented in the Therapy section within the patients' individual folder at the home
- In partnership with the assigned social worker will arrange and attend discharge planning meetings as required.
- In partnership with NYC (North Yorkshire Council) / Care home staff and the patient / carers will identify and explore any risks associated with discharge and future care needs.

NYC

- Will familiarise themselves with the processes within this SOP.
- Will allocated a dedicated worker for patients admitted to Silver Birches as part of integral discharge planning in conjunction with HTFT
- Will attend the scheduled Monday, Wednesday and Friday MDT calls regarding admissions / discharges.

Larpool Lane and Silver Birches Staff

- Will continue to complete their own admission paperwork and care plans as defined by NYC standards.
- Will familiarise themselves with the processes within this SOP.
- Will continue to keep Humber staff appraised of their individual admission requirements – as outlined in Appendix 1

4. PROCESS

Humber Criteria for Intermediate Care beds (to be read in addition to Larpool Lane and Silver Birches criteria in appendix 1)

Inclusions

- Registered with a GP practice in the North Yorkshire Place. (in extremis pressure this may require to be flexed after discussion and agreement at systems bronze call)
- Medically stable – screening tool (TAF) and News Score to be used by health staff.
- Have potential to improve following a health crisis which has affected their independence, but do not require 24-hour nursing care.
- Able to engage in rehabilitation.
- Patients/Service Users must be able to consent to the care at Silver Birches / Larpool Lane.
- Require a time limited period to improve daily living skills and determine future levels of support.

Individuals who are in the following categories will be considered, but on an individual basis:

- Short term/medically stated non-weight bearing to be assessed on an individual basis based on rehabilitation need.
- Mild memory impairment.

Exclusions

- Specialist rehabilitation services that are provided elsewhere, e.g., mental health services, stroke, neuro rehab.
- Under 18 years of age.
- Social respite
- Patients with a diagnosis of Dementia cannot be transferred to Silver Birches in keeping with their CQC Registration

During the stay in the Intermediate care bed.

- Therapy staff will be allocated and available for assessment for patients admitted to Silver birches and Larpool lane in line with locality service operating hours. All care will be documented on S1.
- Any Equipment needs will be reviewed on receipt of the TAF prior to admission to ensure that the home and therapists are able to meet these needs. Each home will hold a small stock of equipment that is to remain in the home when the patient is discharged. This will be provided by the Medequip contract.

- If specific equipment is required to facilitate the admission this is to be ordered via the TECES website for the patient on same day delivery / next day as required by the discharging ward therapist to ensure it is present prior to admission.

- Patients admitted to an intermediate care bed are discussed on MDT calls with involved parties on a Monday, Wednesday and a Friday. The purpose of this is to review the patient progression and also to review discharge planning. Updates are captured by NYC staff for audit/data capture purposes.

- If the patient has equipment provision needs on discharge this will need to be ordered by the TECES website by the prescribing clinician for delivery to the patients home address. Used equipment from the ICB bed must not be transported from the care home to the patients unless a specific risk assessment is completed taking in to account moving and handling considerations and IPC risk factors.

- Wheelchair assessments if dependent for discharge should be high priority fo completion

- Self administration of medication – senior carers at Silver Birches and Larpool Lane will consider suitability for patients to administer their own medication and provide support to enable them to do so. Patients who are able to self administer their own medication complete a consent form provided by the home.

- If required contact can be made with the therapists by calling Single point of contact on 01653 609609. A message needs to be left for the Intermediate Care team.

- If transport is required for discharge this is requested by the patients allocated NYC worker. There may be occasions where the intermediate care team will take a patient home as part of a discharge home visit where this is clinically indicated.

- The ICB policy regarding discharge and choice will be used as a framework for discharge discussions with patients if required.

Documentation

- All patients currently receiving intermediate care in an ICB funded bed will have a (locality) bed based intermediate care referral opened and be allocated to the appropriate bed based intermediate care caseload.

- Documentation will be completed as per Community Services Assessment and Documentation SOP22-007.pdf (humber.nhs.uk)

- Outcome measures will be completed on admission and discharge. These will be recorded on sysm1 and the findings shared with NYC for audit and data capture purposes

- All activity will be recorded against the (Locality) bed based intermediate care referral held on S1 and this will be closed when the patient is discharge.

  A summary of each clinical visit is recorded in the Therapy section of the individuals file within the home.

- If ongoing services are required from Humber Teaching NHS Foundation Trust community services relevant referrals will be made via the single point of contact – for example community OT, district nursing. If follow up from NYC is required regarding adaptations a referral will be made on 01609 780780

- Home from hospital services can be accessed via Referral Form - Home from Hospital | Referral Forms | Carers Plus Yorkshire to support the patient on discharge.

Reporting on unsafe discharge or poor-quality Trusted Assessor Form (TAF):

The Datix system is used to log unsafe discharges and escalate to partners as required.

5. REFERENCES

North Yorkshire County Council SOP.docx

Legal entitlement of Silver Birches - Care Quality Commission (cqc.org.uk)

Legal entitlement of Larpool Lane – Care Quality Commission (cqc.org.uk)