Document Details	
Title	**Community Hospitals Admissions Transfers & Discharge Policy**
Trust Ref No	875-70214
Local Ref (optional)	
Main points the document covers	Guidance on Safe Patient Admission and Transfer into Community Hospitals
Who is the document aimed at?	All Community Hospital staff
Author	Angela Cook Head of Nursing & Quality (Adults)
Approval process	
Approved by (Committee/Director)	Clinical Policies Group
Approval Date	12/07/2021
Initial Equality Impact Screening	Yes
Full Equality Impact Assessment	No
Lead Director	Director of Nursing and Operations
Category	Clinical
Sub Category	Community Hospitals
Review date	12/07/2024
Distribution	
Who the policy will be distributed to	All community trust staff and key partners in local acute trust
Method	Via safety alert stem and community beds working group
Document Links	
Required by CQC	No
Required by NHSLA	No
Keywords	Community Hospitals, CH, admission, discharge, transfer

Amendments History		
No	Date	Amendment
1	07/05/2014	Guidelines reviewed
2	04/11/2015	Formatting amended
3	01/06/2017	Guidance on admission criteria including NEWS
4	21/11/2018	Policy Reviewed and Updated
5	15/04/2021	Policy Reviewed and Updated

Contents

1 Introduction

Shropshire Community Health NHS Trust (SCHT) Hospital beds are a valuable resource and it is essential that they are used efficiently to be able to provide good patient care.

The Admission, Transfer and Discharge Policy aims to ensure safe/seamless 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.

Insufficient use of beds can lead to increased patient length of stay, impact negatively on patient outcomes, decompensation, patient and carer distress, higher re-admission rates to acute providers as well as increased workloads for staff and colleagues in the community.

2 Purpose

This policy is intended to provide guidance on the appropriate use of inpatient beds at the four Community Hospitals within Shropshire for direct admissions from the community areas and patient transfers from other hospitals. The policy covers both the administrative arrangements and clinical appropriateness of direct admissions and transfers including the admission criteria during periods of non–escalation and escalation in the Local Health Economy (LHE).

All admissions, transfers and discharges involving SCHT Hospital inpatient beds will follow an agreed pathway that takes into account the needs of patients and carers.

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.

This Policy should be read in conjunction with procedural documents.

3 Glossary / Definitions

Term / abbreviation	Explanation / Definition
ACP	Advanced Clinical Practitioner
Admission	Where a patient requires an in-patient facility and 24-hour care/treatment to meet their needs and achieve their goal of maximum independence. An admission is either from the patient's usual place of residence or from an emergency department.
AMU	Acute Medical Unit
ANP	Advanced Nurse Practitioner
CCC	Care Coordination Centre
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

Discharge	Where a patient no longer requires to be an inpatient to meet their needs. The patient is discharged home or transferred to an appropriate care facility
EDD	Expected Date of Discharge
End of Life/Palliative	A patient referred for End of Life or palliative care will have an advanced, progressive, complex or life limiting illness. This includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support
LHE	Local Health Economy
MDT	Multi-disciplinary Team
Out of Hours	The time between 17:00 and 08:00 and at weekends and bank holidays
Reablement	Support that enables people to optimise their independence
Rehabilitation	Rehabilitation (ability optimisation to ensure a safe discharge home, maximising function) for those who have been immobilised by an acute illness and/or accident but whose pre-morbid status was at a level where re-enablement is possible
SATH	Shrewsbury and Telford Hospital
SCHT	Shropshire Community Health NHS Trust
Single Point of Referral (SPR) /Capacity Hub	The Trust's services central referral management services
Step up	This describes a pathway for people who have a care need that cannot be managed within their own home or they cannot be left safety at home. At this time they may benefit from being stepped up into a community bed. Any patient stepped up will be deemed medically stable by the referring clinician
Step down	This describes a pathway for people who are transferred from an acute ward following diagnostic assessment and treatment who require time limited bed based reablement care before returning to their own home. This may include early supported discharge. Any patient stepped down will be deemed medically stable by the referring clinician
Transfer	This describes a pathway for people who are transferred from an acute ward following diagnostic assessment. The patient was admitted initially to another hospital and are then transferred to the community hospitals

3.1 Shropshire Community Health NHS Trust Community Hospital Provision

The Trust has four Community Hospitals:

Bridgnorth Hospital
25 beds: Bridgnorth Medical Practice manages the medical care at this hospital

Whitchurch Hospital
32 beds: Medical cover is provided by an ACP with support from a GP with a specialist interest in older/frail people

Ludlow Hospital
24 beds: Medical cover is provided by Portcullis Surgery and Station Drive in Ludlow area

Bishops Castle Hospital
16 beds: Medical cover is provided by Bishops Castle Medical Practice.

3.2 Community Hospitals provide

- Rehabilitation
- Step up care
- Step down from secondary care
- End of Life care

4 Duties

4.1 Chief Executive

Has overall responsibility for maintaining staff and patient safety and is responsible for the Trust governance and patient safety programmes.

4.2 Director of Quality Nursing and Operations

Has overall responsibility for this clinical policy, ensuring that it is fully implemented across the Trust as best practice.

4.3 Service Delivery Group Managers, Locality Clinical Managers, Service Leads/Ward Managers and Team Leads

Has responsibility for ensuring that they have a planned program of training for staff in their team in accordance with the Trust wide Staff Mandatory Training Matrix and the implementation of this policy.

4.4 Staff

All staff including temporary staff are individually responsible for complying with this policy and are accountable for their own actions; therefore, it is important that the practitioner acquires the relevant skills and competencies to ensure safe practice**.** 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 completing DATIX Reporting Policy.

5 Guidelines for Admissions and Patient Transfers

Home must always be considered the preferred place for care and treatment. Direct admissions and transfers into a Community Hospital must be as part of an agreed pathway, not as the default position.

Patients need to be aged 18 years or over, medically stable and consent to admission/ transfer has been given by the patient/ family.

5.1 Example List of Patients who are Appropriate for Admission/Transfer to Community Hospital Beds:

For SCHT Community Hospital beds, these fall into four main categories as identified within the earlier definition:

Rehabilitation

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 (Pathway 2).

- Patients who require further therapy that cannot be provided through delivery of services in the community, but whose needs do not require the facilities and specialist services available from an Acute General Hospital.
- The provision of multidisciplinary assessment where this cannot be delivered at home.
- Non-weight bearing or partially weight bearing patients who have clear goals established which will enable them to return home.

Step up care

- Patients who require nursing care and treatment 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 or chest infections.
- The patient has medical, therapy or nursing needs that require 24-hour healthcare intervention that is a level that cannot be provided in the patient's own home or social care but can be managed outside of the acute environment.

Step down from secondary care

- Patients who are medically stable and clinically safe enough to be managed in a nurse-led care environment with General Practitioner medical support and limited diagnostic facilities available for the continuation of their treatment.
- The patient has medical, therapy or nursing needs that require 24 hour healthcare intervention that is a level that cannot be provided in the patient's own home or social care.
- Patients who are stable with a reversible delirium and have a medical plan.

End of Life care

- The provision of end of life care where the Community Hospital is the patient's/family's preferred place of death.
- The provision of end of life care where symptom control is complex and requires nursing input at a level which would not be able to be met at home.

5.2 Specialist Groups and High-Risk Patients

Patients who have specific care issues must be discussed with the senior nurse on duty before the admission/transfer can be accepted as this may depend on the skill set of the nurses working at the time.
These specific care issues include:

- Patients requiring nasogastric feeding
- Patients requiring Intravenous antibiotic
- Patients requiring vac therapy for wound management
- Patients with PEG/RIG tube
- Patients requiring isolation facilities
- Patients requiring specialist size equipment

Any issues and risks must be recorded as part of the handover documentation. These patients include:

- Any patient where specialised nursing or higher than usual levels of nursing is required.
- Patients with cognitive impairment, dementia or patients with a learning disability - a management plan is required prior to transfer to enable the ward staff to receive the patient to manage their mental health needs. A risk assessment should be initiated by the referring clinician to identify if it is appropriate to move patient with cognitive issues and or sensory issues which may mean that a move to another environment would be likely to significantly increase the chance of further confusion and impair timely discharge.
- If a patient has a diagnosis of COVID-19 the COVID-19 Positive Dementia Pathway for reference is in place for the support and advice.

5.3 Exclusion Criteria:

Patients unsuitable for admission are as follows:

- Children & young people under 18 years of age
- Patients requiring acute psychiatric treatment including acute management of alcohol and substance misuse.
- Patients that are not medically stable and/or clinically safe for transfer (those patients that require access to 24/7 medical supervision and specialist consultant input beyond what is provided to the Community Hospitals) or an

National Early Warning Score of 3 and above -a clinical conversation will need to take place.

- Late notice referrals for end of life care to avoid death in transit
- Patients requiring specialist stroke rehabilitation if unable to go to Bridgnorth Hospital
- Patients with limited potential for further functional gain or improvement
- Social Respite (except for patients who are in receipt of some aspects of palliative care and require a period of support to enable on-going care at home in end of life care)*
- Patients awaiting a pathway to long term care*
- Patients awaiting discharge to a nursing home*

*These patients will be considered on an individual basis and during periods of escalation across the Shropshire and Telford and Wrekin local health economy, the admission criteria can then be flexed to facilitate these admissions/transfers.

5.4 Patient Prioritisation

All Community Hospitals will routinely accept out of area rehabilitation transfers subject to local bed availability, bed pressures and discussions with the admitting GP.

When there is a waiting list for beds the Community Hospitals will accept in priority order.

1) Admissions from the community, A&E or Minor Injuries Unit who are medically stable and for rehabilitation.

2) Admissions and Transfer patients for Palliative/Terminal care where relatives live locally or the hospital is the patients preferred choice.

3) Transfers from an inpatient bed in the acute trust who are medically stable and clinically safe for transfer and for rehabilitation.

4) Transfers that are out of area rehabilitation transfers subject to local bed availability and local acute bed.

5) Admissions from the community, A&E or Minor Injuries Unit who are medically stable but without physical health/rehabilitation needs but require 24-hour care in a place of safety.

Any admission/transfer that the receiving nurse is unsure about should be discussed with the relevant GP and/or SCHT senior management team. Nursing staff can only initially refuse a patient on the grounds of patient safety.

5.5 Admission/Transfer Criteria for all Community Hospitals during High Escalation periods

In accordance with the Integrated Care System (ICS) winter plan and at times of escalation, the criteria for admission can be flexed with the agreement of the Locality Clinical Manager / Senior Management Team following the daily local health economy conference call. Patient Safety will, however, remain paramount. In these situations, patients requiring bed-based provision and who are likely (but not inevitably) to require on-going care in a residential setting may be accepted (Pathway 3). This includes patients awaiting packages of care to commence, with a date for discharge identified. Patients who are medically stable and do not have any rehabilitation needs will also be considered for transfer.

6. Admission/Transfer Process

- All requests for admissions/transfers to SCHT Community Hospital beds will be arranged through Single point of referral (SPR) during the hours of 08.00.hrs - 17.00hrs 7 days per week.

- Fact Finding Assessment (FFA) has been completed and identified the patient's treatment, rehabilitation, care and on-going management plan

- On receipt of a request for an admission, SPR/Capacity Hub will identify an appropriate bed and liaise with the relevant Community Hospital. Staffing on the ward and existing patient acuity need to be taken into account on acceptance of the patient. Consideration will be given to patients preferred choice of Community Hospital but this will solely be based on availability.

- Outside of operational hours, referrals will be accepted from Acute Hospitals, GPs, and Out of Hours medical service. Referrals should be made to the ward directly.

- Patients with specific care issues will be admitted/transferred to community hospitals where the staff have the necessary competencies or staffing levels to deliver the specialist care required. For example Bridgenorth for Stroke patients, Bishops Castle for fractured NOF.

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

- The senior nurse on duty will work closely with the referrer and will accept the patient providing the referral criteria is met, staff have the appropriate competencies to care for the patient and a suitable bed is available.

- Prior to admission a formal handover will be taken and fully documented.

- 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 Capacity Manager, Locality Manager or on call manager. Nursing staff can only initially refuse a patient on the grounds of patient safety.

- In accordance with the winter plan and at times of escalation, the criteria for admission can be flexed with the agreement of the SCHT Senior Management Team. Patient Safety will, however, remain paramount.

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

6.1 Patient Management Arrangements and Responsibilities

In addition processes are required from our external referring organisations:

- **Out of Hours Service / Shropdoc –** Appropriate assessment by a Doctor of patient and completion of all Shropshire Community Health NHS Trust Community Hospital documentation including SCHT drug charts, DNACPR and VTE forms as appropriate and this documentation should arrive with the patient on the ward or the patient be clerked in upon arrival to the ward.

- **Accident & Emergency** – Either the A&E Doctor (minimum level at staff grade) or medical/surgical/Orthopaedic team doctor should contact the appropriate Community Hospitals GP/or Out of Hours Doctor to discuss the patient. Once agreed the appropriate assessment of patient and completion of a photocopied A&E card / frailty assessment (if completed), appropriate prescription chart and any medication, medical management plans and DNACPR (if required) should be sent with the patient. Clinical handover to receiving ward staff.

- All patients admitted from A&E need to be seen on arrival to the Community Hospital by a GP/ Out of Hours Doctor within 4 hours.

- **Referring GP** – The referring GP assesses their patient to be medically stable and within the Community Hospital inclusion criteria and National Early Warning Score (NEWS2) guidance. Contact is then made to the Care Coordination Centre (CCC) who will arrange for the transfer to the Community Hospital via the capacity hub. The patient's GP (unless they are working within the capacity as a Community Hospital GP) will not be required to complete the clerking in of the patient.

6.2 Transfers to Community Hospitals

Patients are transferred to the community hospitals from acute providers.

- Transferring Wards from an 'Out of County' Hospital – Transferring staff must arrange transport to facilitate arrival to a Community Hospital bed Mon to Fri 9am-3pm. For patients travelling a long distance or repatriation, a prior agreement on time of arrival is required.

- Following acceptance to a community hospital bed, SaTH local ward to ward transfers should only take place between 0800 and 21.30, this therefore means the arrival of the patient into the ward should not occur after 21.30hrs Only under exceptional circumstances at times of escalation level 4 should this timescale may be extended outside of these hours. Patients following the Dementia Pathway should not be considered out of these timescales.

- For patients requiring a step up bed from A/E if out of hours will need to have a conversations directly with the ward around bed capacity and suitability of the patient. There is no time limit on this.

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

- All transfers to SCHT community hospital beds will be arranged through SPR during the hours of 08.00.hrs-17.00hrs 7 days per week.

- The patient's clinical information and management plan must be available prior to transfer and must be reinforced by a verbal handover.

- The community hospital nurse receiving the verbal handover will use the Community Hospital Pre-Transfer Handover Checklist (see attachment) to ensure all the relevant information is gained.

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

- 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.

- The senior nurse on duty will complete a Patient Transfer Form and admission checklist 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 locality clinical manager or the on-call manager.

6.3 Transfer Procedure

The senior nurse on duty will complete the patient transfer handover document which takes into account the following:

- Patient's condition summarised/ reason for transfer.
- Resuscitation Status
- Respect Form
- NEWS2
- Important medications
- Oxygen requirements
- Infection Status, confirmed or suspected including Covid –19 status
- Equipment/Aids
- Mobility Status/Weight baring status in the presence of a fracture
- Likely / final discharge destination
- Relatives informed
- Patients notes or clinical summary

6.4 Transferring Clinician's Responsibilities:

When patients are transferred to the community hospital from a local acute provider, 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.

Documentation required on patient transfer:

- Transfer letter - to include a full summary of the patient's medical condition, recent NEWS2 scores, Physiological assessment, Infection status.
- History of treatment and investigations undertaken including x-rays and dementia screening.
- Outcome of risk assessments including Venous Thromboembolism and frailty.
- Confirmation of all outstanding clinical investigations and any outpatient appointments including transport arrangements.
- Clinical management plan including up to date Prescription / Medication Administration Record.
- 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.
- Copy of clinical management plan to include MDT goals and rehabilitation aims.
- Supply of discharge medicines (to be sent with the patient).

6.5 Responsibilities of the Admitting Clinical Staff on Arrival of the Patient to the Community Hospital

Medical Practitioner

The admitting Medical Practitioner will as part of the admission process- (this applies to all Community Hospital contracted GPs plus Shropdoc GPs for all admissions to Community Hospitals whether from home, via triage or transferred from the acute hospitals):

Examine and write up any medication and care documentation for patients within 4 hours of admission if direct admissions from the Community, A&E or Minor Injuries Unit.

Transfers from another hospital wards to be clerked in the next working day (unless a detailed medical care plan arrives with the patient, covering their original illness provisional diagnosis and the management plan including medication sheet for the patient or the nurse in charge has a clinical concern regarding the patient).

EOL patients require clerking in within the 4-hour window. This is if an internal or external transfer.

Covering GP will attend or advise on their patient within an agreed timescale according to the urgency indicated by the referral supported by other factors such as the NEWS2 score. This may necessitate urgent referral back to the acute hospital or a paramedic response if GP cannot attend.

Nurse

Nursing staff will monitor the appropriateness of transfers, report missing documentation, inform GP of arrival for in hour's transfers and respond as appropriate to any deterioration or unstable patient. Complete admission documentation including completion of all assessments including VTE as appropriate.

Review any existing DNACPR orders (in line with the Trust's Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy and any Advanced Care Plans.

Continue rehabilitation plans until an MDT assessment can be completed.

Post transfer patients will undergo a MDT assessment and the identified pathway will be reviewed and recorded for quality purposes.

Nursing staff will complete a Datix for any exceptions to this policy or internal Standard Operating Procedures and have the right to refuse admissions if these are not followed. The nurse in charge will escalate incidents to the Locality Clinical Manager or On Call Manager as appropriate.

7. Patient Safety

The nurse in charge of the Ward/Locality Clinical Manager/GP has the right to refuse admission of a patient when they feel that admission would not be in the best interests of the patient or compromise care given to existing patients. This decision will be made following discussion of the patient's medical/social condition with appropriate health care team involved in the patients care and Locality Clinical Manager / On Call Manager.

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 escalate these concerns to the Capacity Manager, Locality Clinical Manager or On Call Manager. Patient Safety will remain paramount.

7.1 Safety of Admissions/Transfers into the Community Hospital from all Sources

Red flag scenarios are collections of symptoms and signs suggestive of clinical risk to the patient, but which are not necessarily associated with altered physiology. Failure to recognise the significance of these scenarios can have serious adverse clinical consequences for the patients.

- Cardiac chest pain at rest lasting longer than 20 minutes.
- Headache of dramatically sudden onset, with or without scalp tenderness and/or jaw claudication.
- Palpitations associated with syncope.
- Cauda equina syndrome.
- Painful swollen calf.

8. Infection Prevention and Control

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 or a suspected infection.

If a patient/client being transferred is suspected or confirmed as being infectious the senior nurse on duty must contact SCHT Infection Prevention and Control Team within normal working hours prior to the transfer being carried out and BEFORE transport is arranged.

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 Shrewsbury & Telford Hospitals. 01743 261000

If a patient is suspected or confirmed with COVID-19, follow IPC guidance on these patients in regard to testing and test results prior to transfer. Ensure the correct facilities are available to safely manage the patient once they arrive on the ward ie- Cohorted bays or side rooms.

The IPC Isolation Policy has a matrix for the allocation of side rooms.

The transfer form/FFA must be completed by the transferring facility to include in the discharge planning element 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.

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 (e.g. 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.
- In the event of escalation, due to a lack of bed capacity across 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.

9. Discharge

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).

Following admission to SCHT Community Hospital, completion of an initial multidisciplinary (MDT) assessments, patients and family/carers should be advised of the proposed planned date of discharge and plan.

9.1 Discharge Principles

The discharge planning process should be commenced from admission in conjunction with the patient and family/carers.

The MDT will work with the patient and family towards the Estimated Date of Discharge (EDD) and establishing the Clinical Criteria for Discharge. Medicines checks and discussion with Medicines Management Team.

Patients, family and carers should be involved and have timely and appropriate information in order to make an informed choice on their care following discharge. The involvement of the patient and family/carer is an

integral and essential part of the discharge process. SCHT staff will adhere to the local health economy Patient Choice Policy.

The ward staff will work closely with any existing Care Co- coordinator or lead professional involved in the patients care prior to admission.

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 Discharging Nurse with the support from the Discharge Coordinator will utilise the Discharge Checklist to ensure completion of the various components of discharge, e.g. tablets to take home, transport, referral to appropriate specialist professionals, provision of information and documentation to the Patient, GP and other key professionals and the provision of basic foods is available at home for the patient, prior to discharge.

9.2 Key Points for Achieving Timely Discharge and Reducing Length of stay include:

An EDD will be established within 24-48 hours of admission by the multi-disciplinary team, and the patient and family/carer informed (maximum of 72 hours).
Patients should be provided with the 'Planning to go Home' Information sheet and appropriate letters as per the Patient Choice Policy
Patients will be reviewed daily on the ward rounds by the MDT, evaluating individual care plans that involve active therapy, treatment or opportunity for recovery in accordance with patient needs.

The EDD will be pro-actively evaluated against the discharge plan on a daily basis as part of Red 2 Green work streams and formally reviewed at each ward round and MDT meeting ensuring that all changes are communicated to the patient/family.

Senior Review Meetings with the discharge ward co- ordinators and the Capacity Manager in designated times when the Acute Trust is on escalation levels 3 and above.

The ward staff and community teams, Nursing and Therapy, will pro-actively work together to identify appropriate management strategies for the patient and to facilitate the smooth transition of care from hospital to home. This includes early supported discharge from ICS, home assessments and equipment instillation from the IDT community based therapy therapists and support with self-management from the IDT nursing staff.

Appropriate written discharge care plans including follow up arrangements will be provided to patients in line with the Patient Choice Policy. (Covid discharge leaflet – "another place of care" and "home")

9.3 Patients with Complex Discharge Needs, 'Reluctant Discharges' and Delayed Transfers of Care

Every attempt must be made to ensure that patients are discharged in line with their expected 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.

The multi-disciplinary team will identify potential reluctant discharges and discuss these with the ward sister/charge nurse and the Locality Clinical Manager in the first instance.

Where the patient or carer appears to be reluctant to discharge the nurse in charge will refer to the System Wide Choice Policy and issue the appropriate letter.

The Choice Policy supports people's timely, effective discharge from an NHS inpatient setting, to a setting which meets their diverse needs and is their preferred choice amongst available options. It applies to all adult inpatients in Shropshire and Telford & Wrekin NHS settings, and needs to be utilised before and during admission to ensure that those who are assessed as medically fit for discharge can leave hospital in a safe and timely way**.**

A delayed transfer of care is when a patient is ready for discharge and is still occupying a bed. This is when a clinical decision has been made that patient is ready for transfer, the multi-disciplinary team decision has been made that patient is ready for transfer and the patient is safe to discharge/transfer.

Daily weekday discussions are held with local authority colleagues to determine organisations responsible for each delay before recording on the daily sitrep. Each delay is pro-actively managed escalating concerns within the Community Trust and partner organisations to facilitate discharge.

10. Consultation

These guidelines are subject to three yearly review and at each review, the Ward Managers, Service Delivery Group Manager, Locality Clinical Managers and Medical Advisors and Associate Medical Director are consulted to invite comments on the document.

11. Monitoring Compliance

Clinical incidents regarding admissions and transfers will be reviewed via the individual hospitals quality and safety groups and escalated as appropriate to the Adult Service Delivery Group (SDG) and operational Quality and Safety committees.

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

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

- Patient safety incidents reports (including inappropriate admissions) – reviewed at Service Delivery Group (SDG) on a monthly basis.

- Complaints.

- Readmissions to the acute hospital within 24 hours.

Shropshire Community NHS Trust will monitor and review the implementation of the policy locally and undertake audits as required to review the appropriateness of admissions/transfers to Community Hospitals.

12. Associated Documents

- Reducing the Risk of Venous Thromboembolism Policy
- Prescribing Protocol for VTE Prophylaxis for In-patients and Post-discharge 2146-69206
- Community Hospital Medical and nursing admission and assessment documentation
- Cardiopulmonary Resuscitation (CPR) and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)
- Community Trust Escalation Policy
- Clinical Criteria for Out of Hours Standard Operation Procedure
- Standard Infection Control Precautions: Hand Hygiene and Personal Protective Equipment Policy 1081-52864
- Clinical Record Keeping Policy
- Clinical Observations and recognition of the deteriorating patient policy including NEW2, SBAR and sepsis recognition.
- Standing Operating Procedure for Clinical Management of Patient Admissions to Community Hospital Inpatient Wards Ludlow, Bridgnorth, Bishops Castle & Whitchurch
- Shropshire and Telford & Wrekin System Wide Choice Policy]
- SCHT Surge and Escalation Plan
- Admission Escalation Plan

13. References

- Guide to Reducing Long Hospital Stays (NHS Improvement 2018)
- Royal college of Physicians Acute care toolkit 1: Handover (2015).
- The Royal College of Physicians Acute care toolkit 6 The medical patient at risk: recognition and care of the seriously ill or deteriorating medical patient (May 2013).
- The Royal college of Physicians Acute care toolkit 3: Acute medical care for frail older people.
- National Institute for Health and Clinical Excellence (2007)
- Acutely ill patients in hospital. recognising and responding to deterioration. NICE Clinical Guideline 50. London.
- NHS England Patient Safety Alert: NHS/PSA/RE 2016/005 Resources to support safer care of the deteriorating patient (adults and children) July 2016.
- QNI Discharge Planning document. Best Practice in Transitions of Care (2016)
- Covid 19 guidance for health professionals

14. Appendices

Community Hospital Pre-Transfer Handover Checklist

Community Hospital Pre-Transfer Handover Checklist

Community Hospital (CH):		**Date:**		**Time:**	
Patient First Name:		**NOK Name:**			
Patient Last Name:		**NOK Relationship:**			
DOB:		**NOK Contact no:**			
NHS No:		**NOK aware of transfer:**			
Address:		**NOK Address:**			

Reason for transfer to CH:		**Patient ETA at CH:**
Relevant medical history:	**(e.g. consider is patient Diabetic and if a treatment plan is in place)**	
Known Allergies:	**(consider meds, dressings and food):**	

Most recent observations	**Blood Sugar**	**EWS**	**Temp**	**HR**	**BP**	**RR**	**Sats % on air**	**O^2 Therapy (%)**	**Sats % on O^2**
Date:									
Time:									

VTE completed/Date?	Yes No Date:	**VTE prophylaxis required/prescribed**	Yes No n/a
Does patient need a side room? If so why? **(EOL/IPC known infections?)**	Yes No	**Does patient require any special equipment?** **(Mattress etc.)**	Yes No
Is patient EOL?(end of life)	Yes No	**Is EOL care plan in place?** **(EOL Medication prescribed?)**	Yes No
Is there a DNACPR in place?	Yes No		Yes No
Is patient confused/ disorientated/ wandering? (1:1 in place?)	Yes No	**Has patient fallen in hospital?**	Yes No
Skin condition (Waterlow score/SSKIN/ wounds?)		**Bowels last opened?** **(stool type)**	
Eating & drinking? **(Note any issues)**		**Urinary Catheter?** **(date inserted? Reason?)**	Yes No
Any further information/ comments (FFA?Pathway?)			

Documentation to be sent as below with patient on transfer to Community Hospital **(request at time of verbal handover)**	**RN at receiving CH requested document to be sent on transfer (tick below as applicable)**	**Sent with patient on transfer to CH** **(Datix if copy not received)**
Patient notes		
Vitalpac print out for 72hrs observations prior to transfer		
VTE assessment form		
DNACPR form (if applicable)		
EOL Care plan (if applicable)		
Prescription chart		
A&E Cas card (if applicable)		

Name of RN at sending ward providing verbal handover		**Hospital:**	**Ward or ED:**
Name of RN at receiving ward receiving verbal handover		**Hospital:**	**Ward:**