DISCHARGES TO CARE HOMES FROM HOSPITAL

London Top Tips

THE PURPOSE OF THESE TOP TIPS

(WHAT IS IT, AND WHAT IS IT NOT)

- Evidence has highlighted **this as a challenging area.** (sources include partner testimony, Care Home Support plans and Capacity Tracker data)
- Requested by London's Care Homes Oversight Group to:
  - **Support more efficient, safer discharges from hospitals into care homes**
  - **Eliminate unwarranted variation** across the region.
  - Specifically in light of the coming **winter and further waves of Covid19**
- The intention is not to repeat anything in existing guidance, but to provide **an additional, practical guide, built from London's experience.**
- The tips are individually well-known, but the intention here is to bring them together, have universal buy-in and offer further helpful info, **including a collection of positive practice examples**.
- The primary audience is for hospital, discharge team and care home staff, but everyone in the system (from local to regional) may find them useful.
- These Top Tips are built by London, for London, and can be improved upon over time. Your views are welcome.

1. IMPROVED INFORMATION SHARING
ABOUT PATIENTS/RESIDENTS, TO CARE HOMES AND RESIDENTS/FAMILY

What is the issue?

- Strongest theme in the evidence and initial task & finish group discussions.
- Highlighted the vital need for key health and care information about patients from hospital teams at the time of discharge, to care home staff and also to individuals and their families themselves.
- This does not always happen, or it may be incomplete or of poor quality.

1. IMPROVED INFORMATION SHARING
ABOUT PATIENTS/RESIDENTS, TO CARE HOMES AND RESIDENTS/FAMILY

What does the national guidance say?

Hospital Discharge Service: Policy and Operating Model

- Hospital clinical and managerial leadership team… to… Maintain timely and high-quality transfer of information to Primary Care and other relevant health and care professionals on all people discharged.
- Upon discharge, people should receive information about who they can contact if their condition changes, ranging from re-admission to voluntary sector help for day-to-day tasks.
- Case managers will ensure all people (irrespective of their address) are discharged safely on time (from all NHS community and acute beds) and that they (or their representative or advocate if they lack capacity), have full information and advice about what is happening. This includes how their needs will be assessed, provision of follow up support as needed and if any charges will be applied to their care and support.
- Information essential to the continued delivery of care and support must be communicated and transferred to the relevant heath and care partners on discharge. This must include, where relevant, the outcome of the last COVID-19 test.
- Health and care systems should ensure effective information sharing, and full and carefully documented assessments of need, to ensure care providers can deliver the care and support people require.
- Information about the home circumstances for people should have been collected at the point of admission
- [for care homes] Where Trusted Assessment relationships and arrangements are not in place with acute providers, rapidly work with the discharge team to implement these approaches

NICE - Moving between hospital and home, including care homes

1. IMPROVED INFORMATION SHARING
ABOUT PATIENTS/RESIDENTS, TO CARE HOMES AND RESIDENTS/FAMILY

What further has London been learning?

- Common standards for info sharing. Key documents include: (1) discharge summary, (2) nursing transfer forms and (3) body maps. Information from care providers needs to be treated as trusted information
- Using digital solutions for assessments and care plan sharing eg: NHSmail, video assessments, calls, video MDT discussions, video tours of prospective care settings for patients in hospitals and for families, video meetings with care home staff.
- Use of trusted assessor, and adapting this to work during covid. Including adapting assessment forms, or using digital assessments.
- For transfer of medicines for patients at discharge into care homes, follow local pharmacy policies. This will allow a smooth transfer of info, particularly for patients with polypharmacy and those on high risk medicines and will allow for medicines reconciliation to take place during transfer of care
- Manage expectations with patients/families around their choices, decision-making and time one may spend in a care home, or future moves. Ensure they have key details, including contact details for questions, and info on how they can keep in touch with each other, and how the resident will be kept safe, and be cared for.

Please see key examples here: *NCL and Homerton docs and case studies, NHSmail and eRedBag, Trusted Assessor updated form*

2. BUILDING RELATIONSHIPS AND HAVING CLEAR ROLES AND RESPONSIBILITIES

What is the issue?

- Raised as a key enabler to improve discharges from hospital to care home
- Building relationships between staff in both the care home and hospital settings, across professional roles.
- Clarity on everyone's roles in the discharge process, with clear, responsive lines of communication.

2. BUILDING RELATIONSHIPS AND HAVING CLEAR ROLES AND RESPONSIBILITIES

What does the national guidance say?

Hospital Discharge Policy Action Cards

Hospital Discharge Service: Policy and Operating Model

- both detail roles and responsibilities of all staff involved in the discharge process

2. BUILDING RELATIONSHIPS AND HAVING CLEAR ROLES AND RESPONSIBILITIES

What further has London been learning?

- Find ways which build trust and communication between professionals across care settings (specifically between care homes and hospital teams). Softer examples like WhatsApp groups between nurses or more formal options, like single points of contact or champion roles, or trusted assessor roles. Educating or job sharing across sectors so all understand partner pressures and priorities
- Have easy responsive lines of communication open between care homes and hospitals. And clear agreed channels – eg contact phone numbers, single points of contact, use of NHSmail
- Make use of established relationships in the local system - existing relationships can bring other partners together. Eg commissioners and support brokers supporting closer ties between provider sectors. And can tie in wider partners, eg voluntary sector
- Have policies and procedures in place that clarify roles and responsibilities. For example Hospital Discharge Policy Action Cards, process maps
- Mutual aid policies and triggers in place to support on workforce or other capacity can build trust and relations between local system partners.

Please see key examples: SEL 6 boroughs case study, Merton case study

3. CARE HOMES NEED TO BE SAFE FOR NEW RESIDENTS

What is the issue?

Care homes need to be safe places to receive new admissions.

Regardless of Covid testing, they need to be set up to manage Infection Prevention and Control.

3. CARE HOMES NEED TO BE SAFE FOR NEW RESIDENTS

What does the national guidance say?

Hospital Discharge Service: Policy and Operating Model

[care homes should] Accept people discharged from hospital when able to do so safely. Care providers should consider whether they are able to meet the prospective clients' needs, taking into account relevant CQC regulations and provider duties (e.g. ability to isolate, sufficient PPE, and access to staff and resident testing). Ensure isolation of residents transferred from a hospital setting in line with care home isolation and infection prevention guidance (above) and be familiar with alerting mechanisms to local Health Protection Teams in the event of positive COVID-19 test results

Further detailed guidance in:

Admission and care of residents in a care home during COVID-19

Adult social care winter plan

3. CARE HOMES NEED TO BE SAFE FOR NEW RESIDENTS

What further has London been learning?

- Care Home risk assessments continue to be key to manage new admissions, as well as for managing visitation
- Integrated Discharge Team can also have a role ensuring that homes met required standards from Care Homes support package – IPC, PPE, clinical support
- There are various ways to isolate residents. Eg through physical aspects, or creating "airlocks" or "social bubbles"
- Support like a "Positive Behaviours team" to help residents where they struggle to understand or comply with IPC processes
- Various regional examples of alternative accommodation currently in place.
- Social distancing and infection prevention measures can impact individuals' wellbeing, and IPC measures need to be balanced against other human and care needs
- System responsibility, even if its care home delivery

Please see key examples: *Newham IPC care home toolkit*, *NW England ADASS Top Tips*

4. TESTING AND RESULTS RECEIVED PRE-DISCHARGE

What is the issue?

- There is a risk that people who are discharged from a hospital may be Covid positive and infect other residents if discharged to care home.

- Guidance has not always been clear on the approach to testing for Covid before discharge, and the logistics of doing so are challenging

4. TESTING AND RESULTS RECEIVED PRE-DISCHARGE

What does the national guidance say?

Hospital Discharge Service: Policy and Operating Model

- COVID-19 test results should be included in documentation that accompanies the person on discharge.
- DHSC/PHE policy is that people being discharged from hospital to care homes are tested for COVID-19 in a timely manner ahead of being discharged (as set out in the Coronavirus: adult social care action plan), regardless of whether they were residents of the care home previously or not. Where a test result is still awaited, the person will be discharged if the care home states that it is able to safely isolate the patient as outlined in Admission and Care of Residents in a Care Home guidance

Adult Social Care Action plan

- We can now confirm we will move to institute a policy of testing all residents prior to admission to care homes. This will begin with all those being discharged from hospital and the NHS will have a responsibility for testing these specific patients, in advance of timely discharge. Where a test result is still awaited, the patient will be discharged and pending the result, isolated in the same way as a COVID-positive patient will be.

Adult Social Care Winter plan

- Hospital clinical and leadership teams should additionally ensure COVID-19 testing of all people being discharged from hospital to a care home. COVID-19 test results should always be communicated to the care home before the individual leaves the hospital (unless otherwise agreed with the care home) and be included in documentation that accompanies the person on discharge.

DHSC letter on designated settings (October)

- Anyone with a Covid-19 positive test result being discharged into or back into a registered care home setting1 must be discharged into appropriate designated setting2 (i.e., that has the policies, procedures, equipment and training in place to maintain infection control and support the care needs of residents) and cared for there for the remainder of the required isolation period.
- These designated accommodations will need to be inspected by CQC to meet the latest CQC infection prevention control standards.
- No one will be discharged into or back into a registered care home setting with a COVID-19 test result outstanding. or without having been tested within the 48 hours preceding their discharge.
- Everyone being discharged into a care home must have a reported COVID test result and this must be communicated to the care home prior to the person being discharged from hospital. The care home's registered manager should continue to assure themselves that all its admissions or readmissions are consistent with this requirement.

4. TESTING AND RESULTS RECEIVED PRE-DISCHARGE

What further has London been learning?

- Hospital discharge teams and care homes/designated places to communicate with each other about the Trust process, and what the care home/designated place expectations are. A personalised approach is needed for each individual and based on the care home/designated place ability to receive residents safely.
- Clear and agreed local pathways for testing and communicating results – with timescales and agreed points of contact for information sharing. Clear lines of communication needed in hospital to and from microbiology teams
- Agreed local protocols for covid+ patients, which are in line with the guidance on designated places – consistent practice that supports good flow and controls risk in care settings

5. FOLLOW-UP CARE

What is the issue?

- Ensuring speedy discharge is a clear priority to keep patients safe from deterioration from long hospital stays, and its crucial for bed supply.

- And with policies in place to deliver care in the community wherever possible, its vital that patients discharged receive wrap-around care post-discharge

5. FOLLOW-UP CARE

What does the national guidance say?

Hospital Discharge Service: Policy and Operating Model

- Upon discharge, people should receive information about who they can contact if their condition changes, ranging from re-admission to voluntary sector help for day-to-day tasks.
- Any ongoing care and support will have been organised, where required, by the case manager; including medication supply, transport home, any volunteer and voluntary sector support and immediate practical measures, such as shopping and turning heating on….though much of the support can be pre-planned during the person's hospital stay through early discharge planning
- Additional care and support needs for all individuals on discharge from hospital (where required) will be provided free of charge for up to six weeks to allow for post-discharge recovery and support services, and any assessments of ongoing care needs and financial eligibility determinations to be made
- [for Acute staff] To create a safety-net and increase confidence in discharging, consider:
  - Person initiated follow up - give people the direct number of the ward discharged from to call back for advice. Do not suggest going back to their GP or coming to A&E.
  - Telephone the following day after discharge to check and offer reassurance/advice.
  - Call people back with results of investigations and any changes or updates to an individual's management plan.
  - Bring people back under the same team/speciality.
  - Request community nursing follow up with a specific clinical need.
  - Request GPs to follow up in some selected cases.
- [to arrange] Local voluntary sector and volunteering groups helping to ensure people are supported (where needed) actively for the first 48 hours after discharge, ensuring 'Settle in' support is provided where needed.
- [for community health] Ensure people on pathways 1-3 are tracked and followed up to assess for long term needs at the end of the period of recovery.
- [For a care home] If providing reablement or rehabilitation, then monitor and share the effectiveness of that service.
- Adult Social Care Winter Plan [LAs must] Work closely with local NHS CHC teams, to ensure appropriate discussions and planning concerning a person's long-term care options take place, as early as possible after discharge

5. FOLLOW-UP CARE

What further has London been learning?

- Nominated person (e.g. therapist) to do a follow up call one day post discharge.
- Systematic Medication Reviews (SMRs) are key in preventing readmissions
- Lines of comms open for care homes to query about follow up care with primary care and community health. CCG to facilitate this where it may not be in place
- An understanding of patient outcomes at a later point, post-discharge. To ensure that all care is in place, and independence has been maximised

6. GUIDANCE TO CARE HOMES SHOULD BE CLEAR AND AS COORDINATED AS POSSIBLE

What is the issue?

- Care homes have been sent a great deal of guidance since the start of the pandemic.

- This has changed at times, sources have not always been consistent and the avenues for receiving it have been many.

6. GUIDANCE TO CARE HOMES SHOULD BE CLEAR AND AS COORDINATED AS POSSIBLE

What has London been learning?

- Alignment between partners – CQC, LA, NHS, PHE, Healthwatch, Vol sector, etc. to identify what relevant guidance exists and support care homes with clarification and simplification where possible. Also to use existing communication routes and points of contact (eg LA Single Points of Contact or NHS Clinical Leads) where possible. This approach is also relevant in how support offers are delivered
- Regular input from providers at partner groups to clarify info needs and how to relay messaging

Please see key examples here: *regional resource packs*

EVIDENCE COLLECTION AND RESOURCES

- Hospital Discharge Service: Policy and Operating Model
- Hospital Discharge Policy Action cards
- Adult social care action plan
- Adult social care winter plan
- High Impact Change Model
- Risk factors for outbreaks of COVID-19 in care homes following hospital discharge: a national cohort analysis
- North West England ADASS Infection control Top Tips
- NICE - Moving between hospital and home, including care homes
- Healthwatch Redbridge Care Homes reports
- Healthwatch Haringey Care Homes report
- Healthwatch Wandsworth Staff Experience during Covid report

Please sent suggested changes and further examples of positive practice to:

andre.lotz@nhs.net