Service	**COVID 19 Hospital Discharge Support Units- Kimberley East (Wessex Care)**
Commissioner Lead	Deborah Elliott
Contract Period	27 beds - April 9th – July 31st 2020

1. Introduction

This document sets out the service requirements for the provision of COVID 19 Hospital Discharge Support Unit (HDSU) at Kimberley East (Wessex Care)

It describes the services required of the Provider (the Care Home Provider) and refers to the role of other parties likely to be involved in the operation of the Service

The HDSUs are integral to Wiltshire Council and BSW CCG's support to the whole system to function during the COVID 19 pandemic.

2. Hospital Discharge Support Units

The purpose of COVID 19 HDSUs is to provide support to those patients who are COVID 19 positive (+ve) and/ or are COVID 19 negative (-ve) but displaying symptoms and radiological changes in line with COVID 19 diagnosis, who

- no longer require care in an acute hospital setting
- transferred from a care home setting, for those people who require increased support needs
- A person could be admitted from home, but where possible it is preferred, that the person is cared for at home.

The provider is expected to facilitate prompt discharges from acute hospital (or home if required), through the use of a trusted assessment for decision making (appendix 1)

3. Admission criteria and Exclusion criteria

Admission Criteria:

The Service will be available to all residents of Wiltshire (that are registered with a Wiltshire GP) who:

a) Are COVID 19 -ve but with symptoms and radiological changes in line with COVID-19 and currently a hospital inpatient (including community hospitals) who no longer needs care in an acute setting or Community Hospital (this may be a recovery or palliative pathway)

b) Are COVID 19 -ve currently in a Care Home but requires focused support from an alternative Care Home established as a Hospital Discharge Support Unit (HDSU) as their symptoms are consistent with COVID-19 and a GP has confirmed this and requested step up into a HDSU.

c) Are COVID 19 +ve and currently a hospital inpatient (including community hospitals) who no longer needs care in an acute setting or Community Hospital (this may be a recovery or palliative pathway)

d) Are COVID 19 +ve currently in a Care Home but requires focused support from an alternative Care Home established as a Hospital Discharge Support Unit (HDSU)

e) Patients with possible or confirmed COVID-19 should be placed in single rooms with en-suite bathroom facilities

f) Care Homes should consider creating cohort areas which differentiate the level of care required, as defined by swab results and where possible to support cohorting of staff.

It should be noted that these care homes should anticipate;

- A higher acuity of patients than has traditionally been transferred to include, for example, those requiring oxygen therapy. The ceiling of acuity will be patients requiring a maximum of 5 litres of oxygen (in line with Covid clinical pathway)
- Patients that do not require access to critical care, 24/7 consultant cover or rapid diagnostics.
- Patients who require clinical intervention and once no longer required the patient will be discharged onto the next step of their pathway which will be dependent on their need.
- That there will be a Treatment Escalation Plan (TEP) in place or the Nursing Homes will work in conjunction with the GP to ensure timely completion of the TEP within 24 hours of admission.
- End of life patients as either step up or step down; this may be for symptom management only and onward discharge to another setting or it might be required when death is imminent and cannot be managed in any other way.

Exclusion Criteria;

Patients meeting the following criteria cannot be admitted to Nursing Home bed;

a) Covid-19 negative patients and no symptoms or radiological changes suggestive of Covid-19 or patients awaiting a swab result
b) Acute stroke until CT scanning and thrombolysis or other acute interventions are complete.
c) Delirium unless there is an acute clinical need for a Nursing Home bed (these patients would be suitable for pathway 3- discharge to assess model)
d) Children under the age of 18 years
e) Patients whose needs can be met by discharge to Pathway 1 (home based care)
f) Patients with an unstable mental health condition.

4. Service Model

The Service Provider is responsible for delivering the services described in this specification, working in partnership with the other parties referenced in this document, including:

a) Referrers: Acute hospital wards/Community Hospital Wards/ Patient Flow Hub/Brokerage

b) The person's family and informal carers

c) Social workers – will support the person's discharge planning from the HDSU

The admitted person will:

a) be very likely to have high nursing needs during this recovery phase
b) be supported through their initial recovery phase, before being discharged home or transferred to Discharge to Assess (D2A) bed in another care home.

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It is anticipated that the length of stay will not extend beyond 14 days, but this will vary dependent on the patients' needs, see clinical discharge criteria.

5. Services to be provided

The Service Provider is required to deliver a service that:

1. Follows the Government/Public Health England guidance for COVID 19 in care home settings. (appendix 2 Admission and Care of Residents during COVID 19 Incident in a care home) (appendix 3 Managing the COVID 19 pandemic in care homes)
2. Accepts admissions 7 days a week, including Bank Holidays.
3. Accepts admissions between the hours of 8am-8pm
4. Acknowledges that the Provider could be asked to receive admissions outside of these times, but this would need to be agreed with the Provider, such admissions would be kept to a minimum and only be requested when hospitals are under significant pressure.
5. Ensures that people are cared for in an appropriate setting
6. Provide a service that is compliant with the Care Quality Commission Essential Standards of Quality and Safety
7. Facilitates the prompt transfer from acute care, transfer on the day of referral or within 24hrs.
8. Develops person-centered care plan(s) that provide enabling care and support to assist people who are recovering from an acute episode or period of ill health to regain their confidence, motivation and ability to undertake activities of daily living, and deliver this plan.

6. Staffing

The Service Provider shall ensure:

a) That all staff are trained to appropriately support people who are COVID +ve, barrier nursing, safe disposal/cleaning of bedding/clothing/equipment
b) That a dedicated team of staff is available to care for patients in isolation/cohort rooms/areas as an additional infection control measure. This should be implemented whenever there are sufficient levels of staff available (so as not to have a negative impact on non-affected patients' care)
c) That all staff are trained as required for their duties in Service User relations, equal opportunities, the Health and Safety at Work Regulations, safe lifting procedures, the

use and adjustment of all equipment used in the provision of the Service, disability and blind and hearing-impaired awareness and telephone / minicom skills

d) That it has policies in place complying with the multi-agency codes of practice for the protection of vulnerable adults

Details on:

e) Therapy support to HDSU
f) Social worker support

Can be found in appendices

7. Health needs and equipment

7.1 It is expected that the Service Provider will be skilled and equipped to care for people with a range of health needs. Staff are to be suitably trained to provide responsive and high-quality care, involving other professionals as necessary.

Staff skills required include the following, however this is not an exhaustive list:

a) Ability to recognise, record (including NEWS) and report any change in person's conditions in a timely manner and take the correct action to meet changing needs.
b) Use of correct preventative pressure relieving equipment. All people should receive a pressure risk assessment within 4 hours of admission and a minimum weekly pressure risk review.
c) Adhere to the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance and decontamination of equipment in accordance with the Medicines and Healthcare Products Regulatory Agency (MHRA) guidance
d) Appropriate nutritional management, including thorough documentation of food and fluid intake, competence with the Malnutrition Universal Scoring Tool

7.2 Where a person is being referred from acute care it is the responsibility of the **referrer** to ensure that, ahead of the person's admission to the HDSU, the person is supplied with:

a) any bespoke equipment and aids, e.g. mobility aids that they may require to facilitate a safe discharge
b) 28 days of medication
c) 3 days of continence pads, catheter equipment
d) 3 changes of dressings
e) If Home Oxygen therapy is required a HOOF (Part A) has been completed and the oxygen installed prior to discharge

7.3 The Service Provider is responsible for ensuring that a full range of standard (non-bespoke) equipment is available to meet the range of needs of the client group. This will typically include:

- Grab rails
- Commodes
- Raised toilet seats

(Appendix 4 - Policy of the provision of equipment to care homes 2020)

8. Communication

8.1 The Service Provider is expected to be skilled and competent in documenting the person's needs:

a) All documentation should be kept up to date, considering, the possible variances in the person's conditions
b) Management of documentation and information should be compliant with Records Management Code of Practice

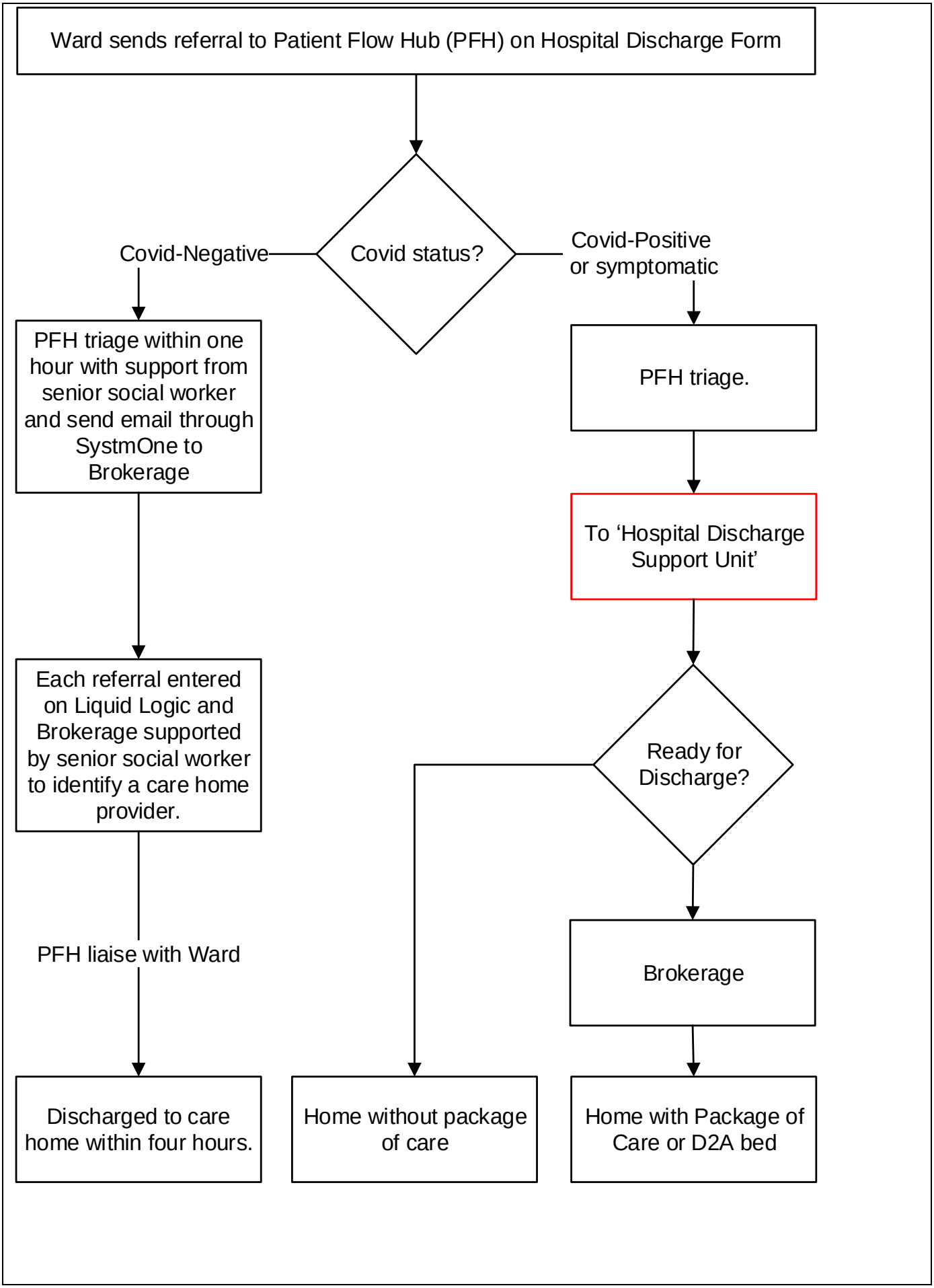
8.2 The Service Provider must keep a written summary of decisions taken in relation to individual people, which must then be retained in the person's Care Plan documentation to be kept within the care home, this could be written or electronic, which adheres to GDPR principles.

9. Referral Process

The HDSU's will be managed by Wiltshire Patient Flow Hub who will assess the clinical suitability of the patient.

a) The Patient Flow Hub staff will clarify with care homes the COVID-19 status of an individual and any COVID-19 symptoms, during the process of transfer from a hospital to the care home. The information will also include;
    - The date and results of any COVID-19 test.
    - The date of the onset of symptoms.
    - A care plan for discharge from isolation.

b) Duties and powers under the Mental Capacity Act 2005 still apply during this period. If a person thinks it is more likely than not that the person lacks the relevant mental capacity to make the decisions about their on-going care and treatment, a capacity assessment should be carried out before a decision about their discharge is made. During the emergency period professionals may want to consider a proportionate approach to such assessments to enable timely discharge.
c) The Patient Flow Hub will ensure all discharge arrangements are in place including but not limited to Home Oxygen Ordering (HOOF Part A) and Discharge Drugs (TTAs)


Ward sends referral to Patient Flow Hub (PFH) on Hospital Discharge Form
Covid status?
Covid-Negative
Covid-Positive or symptomatic
PFH triage within one hour with support from senior social worker and send email through SystmOne to Brokerage
PFH triage.
To 'Hospital Discharge Support Unit'
Each referral entered on Liquid Logic and Brokerage supported by senior social worker to identify a care home provider.
Ready for Discharge?
PFH liaise with Ward
Brokerage
Discharged to care home within four hours.
Home without package of care
Home with Package of Care or D2A bed

Daily Reporting

The service provider will be required to report on bed status, by 8am each day.

Daily COVID 19 D2A bed status Email to: Covid-19Brokerage@wiltshire.gov.uk AND GWH.ictreferrals@nhs.net Each day, by 8am, the following information:	
Number of occupied beds – **as of 8am for the day of the report**	
Number of void beds **– as of 8am for the day of the report**	
Number of admissions in the last 24hrs	
Number of discharges in the last 24hrs	
Number of deaths in the last 24hrs	
As many care homes do not have administrative support until 9am, it is possible to send the email any time BEFORE 8am (including the evening before) but the report must reflect the occupied and void beds for 8am for the day you are reporting on	

10. Discharge pathways

The service will provide a recovery pathway with three key discharge pathways:

a) Return home – the person will be supported by a social worker and occupational therapist to plan their return home
b) Transferred to a Discharge to Assess care home, for continued recovery and assessment of future care needs
c) Palliative care pathway – if requires end of life care

Transfers back to acute hospital from community Nursing Homes should only take place if clinically beneficial and following a discussion with an on- call consultant.

Clinical Criteria for Discharge from HDSU:

From a swab result:
If they have been swabbed, you should count 14 days from the positive swab result. If they are step up patients who have not been swabbed it will be from the day of their presenting symptoms. However, it is important that patients are 48 hours free of symptoms (clinical improvement with at least some respiratory recovery, absence of fever (> 37.8°C) for 48 hours, no underlying severe immunosuppression), this may be longer than 14 days from positive swab or symptom onset. Also due to patients potential underlying pathology, they may need further time to rehabilitate, where possible this should happen in a person's usual place of residence but in some circumstances, it may be necessary to keep them in a bedded facility i.e. if there are other people at home in the shielded category and very vulnerable category.

Should patients be tested again:
If testing is available then patients should be tested, however, with limited capacity currently, patients can be transferred without a swab result. The discharge planning advice in the updated PHE guidance does provide further information to help patients and other household members to stay safe following discharge.

https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/guidance-for-stepdown-of-infection-control-precautions-and-discharging-covid-19-patients updated on the 23rd April 2020.

11. Transport

11.1 The discharging ward will be responsible for arranging the person's transport to the service.

11.2 Discharge from the hot beds

a) The transport provider for any 'step down' need is Ezec
b) contact number is 0300 777 5577 – press 1

12. Service Outcomes

1. Transfer from hospital to care home within 24hrs
2. Length of stay in HDSU
3. Outcomes for the person
    a. Return home
    b. D2A bed
    c. RIP
    d. EOL care

Appendices

1 D2A Trusted assessment
2 Admission and Care of Residents during COVID 19 Incident in a care
3 Managing the COVID 19 pandemic in care homes
4 Care home equipment policy

Further appendices to follow:

- Therapy support to HDSU
- Social worker support on discharge
- Step-up pathway, including HDSU