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![C:\Users\XYZ\AppData\Local\Microsoft\Windows\INetCache\IE\ISQHTT4K\Vanamo_Logo[1].png]() **Promise Care Services Ltd**

# ADMISSION TO HOSPITAL AND DISCHARGED HOME

Scope

* **Policy Statement**
* **Policy**
* Care coordinator responsibilities
* Documentation
* Hospital admission procedures
* **Related Policies**
* **Related Guidance**
* **Training Statement**
* **Addendum** - Discharge planning checklist and Admission transfer checklist

Policy Statement

This organisation recognises that admission to hospital or the discharge from hospital to home can be an incredibly stressful time for both the service user and the families involved.

We will respond effectively to planned and emergency admissions to the hospital and confidentially share information with all relevant services or agencies to ensure the needs of our service users are met to ensure that safe admissions are facilitated.

It is essential for safe and effective discharge planning that there is full involvement with the service user and their families or those who care for them. We recognise the importance of effective communication, information in accessible formats and that the continuity of care is maintained to achieve timely and safe discharges back to their home.

Every service user has a care plan including risk assessments, their medical history and medication. Within the care plan is the contact details of who should be contacted in an emergency, these details are checked regularly at care plan reviews.

The care plan highlights the service users wishes in the event of an emergency. A record of these wishes is held in the office.

Following any discharge from the hospital, a review of the care plan takes place as soon as possible which includes reassessing moving and handling issues or medication changes to ensure a safe transfer for the service user.

Covid-19

We regularly monitor and follow government guidance for Covid 19 when working in other people’s homes and the infection prevention control guidance for those people being admitted to hospital or discharged back to their home.

Care coordinator responsibilities

* Ensure all relevant contact numbers and the first point of contact details are up to date and recorded in the care plan.
* Record immediately when a service user is admitted to the hospital.
* Record all discussions and communications.
* Record that service user’s preferences have been considered for notifying next of kin or named contact, recording who was contacted and the date and time.
* If the initial attempt is unsuccessful keep a record of the attempts made until they have successfully spoken to the service users named contact.
* Record as soon as possible that they have contacted the commissioning body (If relevant) stating who they spoke to, along with the date and time.
* Record immediately the date visits need to be suspended from.
* Cross-reference the dates and times of suspended visits with the care worker’s schedule.
* When the coordinator has confirmed that the service user is staying in the hospital the relevant care worker must be advised of when the service user was admitted to the hospital and the times and dates that visits have been suspended.
* The coordinator must check that the staff member has received the information.
* The out of hours service must also be notified of any admissions to the hospital at the evening handover.
* The coordinator will check with the hospital daily to confirm the service user is still in that hospital and any expected discharge date.
* Once a discharge date is arranged, all workers involved in the care of that service user must be informed and attention given to the time of the first visit after discharge.
* Any changes to the delivery of care, especially risks and medication must be clearly communicated to the care worker and recorded.

Documentation

* The manager or a designated person will use the care plan review form to record any changes that happened whilst the service user was in the hospital and update the care plan.
* If changes are substantial a new care plan will be produced.
* A checklist is used for recording discharge information when receiving a verbal handover from staff or information from relatives.
* The discharge coordinator based in the hospital will be the person responsible for liaising with the manager to ensure a safe discharge which will enable the service user to continue their recovery at home.
* A discharge summary should accompany the service user on leaving the hospital and returning home. In the absence of a discharge summary, the hospital ward should be contacted as soon as possible.

Hospital Admission Procedure

* Planned visits are recorded in the service users care plan in the visit records.
* Unplanned visits must also be recorded in the visit records and the office notified immediately.
* If required, the care worker should prepare an overnight bag/ clothes and medication for the service user.
* The service user’s hospital passport should travel with them to the hospital.
* The service user’s home should be left in a clean and tidy condition and the bed made ready for the service users return home.
* The care worker must ensure the property is locked and secure before leaving.
* If there is any soiled linen the care coordinator should inform the service users family/ contacts. Where this is not possible, arrangements will be made for removal and laundering, and the necessary arrangements made to enable this to happen.
* Staff must not return to the property when the service user is not present unless there is a specific reason for doing so that must be authorised by the Manager.

Related Policies

Care and Support Planning

Continuity of care and support workers

Co-operating with other providers

Service users home security

Service user’s records

Related Guidance

Hospital discharge and preventing unnecessary hospital admissions:

https://www.scie.org.uk/care-providers/coronavirus-covid-19/commissioning/hospital-discharge-admissions

Moving between hospital and home:

https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/moving-between-hospital-and-home-including-care-homes

Stepdown of infection control precautions and discharging Covid-19 patients and asymptomatic SARS-CoV-2 infected patients:

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

Training Statement

On induction, care staff are required to read this policy and understand the documentation required. Staff receive ongoing training to enhance their knowledge and skills on how to reduce hospital admission through supervisions, group or one to one discussions and other identified training. It is important that staff have the knowledge and skills to respond quickly to the changing needs of the service user and that they understand the importance of recording and reporting changes quickly. Staff will only be expected to work within their competency levels and be able to access the necessary support when required.

All staff, during induction, are made aware of the organisation's policies and procedures, all of which are used for training updates. All policies and procedures are reviewed and amended where necessary and staff are made aware of any changes. Observations are undertaken to check skills and competencies. Various methods of training are used including one to one, online, workbook, group meetings, individual supervisions and external courses are sourced as required.

Date Reviewed: May 2023

Person responsible for updating this policy: **IFEYINWA ODOEMENAM**

Next Review Date: May 2024

Appendix

**Discharge Planning Checklist –** when a service user is in hospital and the hospital is planning to discharge them.

|  |  |  |
| --- | --- | --- |
| **Details Required** |  | **Actions required/Notes** |
| Name of person completing the checklist |  |  |
| Name of the discharge caller. Ward/unit and hospital |  |  |
| Record the date and time |  |  |
| Confirm the name and date of birth of the service user being discharged |  |  |
| Summary of what has happened to service user whilst in hospital |  |  |
| Relevant Covid status information |  |  |
| Medication on discharge |  |  |
| What Medication is being sent with the service user at discharge? |  |  |
| Any moving and handling issues or falls while in hospital |  |  |
| Changes in their health needs |  |  |
| Any new equipment requirements |  |  |
| Changes in their mental capacity status |  |  |
| Pressure Area concerns/ Waterlow score |  |  |
| Any changes in family circumstances |  |  |
| Has the social services team been informed by the hospital of the expected date of discharge? |  |  |
| Confirm access arrangementsIs there a key safe?Does the transport have a key safe number?Does the care staff have the key safe number? |  |  |
| Notify all workers at the end of the call and include discharge information and timing. (EDD) Ask the care worker to repeat back the information |
| Do care workers need additional training? |  |  |
| Have the next of kin been made aware of EDD? |  |  |
| What is the expected date and time of discharge |  |  |
| Is transport being used? |  |  |
| What time is the care visit scheduled and will this still meet the service users needs? |  |  |
| What date and time can an updated care plan, risk assessment and MAR be arranged? |  |  |
| What has been arranged by the hospital or social services |  |  |
| What have the family or NOK arranged |  |  |
| Next Steps/ any contingency plans |  |  |
|  |
| Signed complete: |
| Date: |

**Admission Transfer Checklist –** When a service user has been admitted to the hospital, to promote good communication and support a timely and safe discharge.

|  |  |  |
| --- | --- | --- |
| **Details Required** |  | **Actions required/Notes** |
| Name of person completing the checklist |  |  |
| State organisation name and address (if required)  |  |  |
| State service users name and date of birth |  |  |
| Relevant Covid-19 status information |  |  |
| State when they were admitted |  |  |
| State why they were admitted |  |  |
| Have they been admitted to a ward or unit? |  |  |
| Ask to be transferred to that ward/unit |  |  |
| Ask the ward if there is a planned discharge date |  |  |
| Inform them of the number of hours, days and activities they had been receiving from your service |  |  |
| State any relevant history e.g falls, nutrition, urine infections, bowel habits, confusion, pain, communication, dementia, safeguarding issues, pressure area issues, Waterlow score |  |  |
| Advice on next of kin details |  |  |
| Take the name of the person you are talking to and record the date and time |  |  |
| Further Notes |  |  |
| Signed complete: |
| Date: |