Barnsley Hospital NHS
NHS Foundation Trust

POLICY CONTROL SHEET

(updated August 2011)

Policy Title and ID number:	**CC4.9 & 4.10 Policy for Transfer and Discharge of Patients**			
Sponsoring Director:	**Chief Nurse/Chief Operating Officer**			
Implementation Lead:	Bed Manager			
Impact:	*(a) To patients*	**Yes**		
	(b) To Staff	**Yes**		
	(c) Financial	**Yes**		
	(d) Equality Impact Assessment (EIA)	Completed: **Yes / No**		
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	(e) Other			
Training implications:	*To be incorporated into induction:* **Yes / No**			

Date of consultation:	***Approval Process***	**Date**	**Local Consultation**	**Date**
	Executive Team		*Joint Partnership Forum*	
	Board Committee:		*Local Negotiating Committee*	
	• *Clinical Governance*		*Infection Control Committee:*	
	• *Non Clinical Governance & Risk*		*Health & Safety Committee*	
	• *Audit Committee*		*Quality Safety Improvements & Effectiveness Board*	
	• *Finance Committee*			
	• *RATS*		*Investment Board*	
	Trust Board Approval / Ratification		*Patients Experience Board*	
	Other:		*Other:*	

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For completion by ET for *new* policies only:				
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Policy for the Transfer and Discharge of Patients

Policy ID: CC 4.9 and CC 4.10

NOVEMBER 2007
(Amended December 2010 and July 2011)

SPONSORING DIRECTOR: CHIEF NURSE/CHIEF OPERATING OFFICER

Transfer and Discharge of Patients Policy

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TRANSFER AND DISCHARGE POLICY
(Policy ID: CC 4.9 and CC 4.10)

1. STATEMENT OF INTENT

The intention of this policy is to ensure Barnsley Hospital NHS Foundation Trust has systems in place to ensure the continuous flow of patients through the hospital to support both effective patient care and Patient safety.

The policy details the key principles of discharge and transfer processes including:

- The timely, safe and appropriate transfer of patients.
- Proactive discharge planning from admission to transfer of care or discharge home.
- Setting a discharge date within 24 hours of admission that is actively managed against the patients clinical management plan 7 days per week.

This includes:

- Maintaining effective organisational processes to ensure a Trust wide consistent standardised approach to hospital transfer and discharge for all patients.

- Maintaining effective bed management arrangements to support patient movement, transfer and discharge ensuring that infection control policy and procedure is integral to these processes.

- Ensuring compliance with relevant NHS Litigation Authority (NHSLA), Risk Management Standards, Health and Social Care Act (2008), Clinical Governance Standards and by promoting best practice and sharing learning.

- The Trust Board have the assurances that appropriate systems are in place for the transfer and discharge of all patients.

2. INTRODUCUTION

For the purpose of this policy:

Discharge is defined as the process followed when a patient leaves the care of the Trust and it is not intended that they will need to return for any further treatment as an inpatient.

Transfer consists of two areas these are:

Intra-hospital – this is a transfer of a patient from one Clinical area to another.

To other Hospitals/health Care settings: this is a transfer of a patients from The Trust to another setting usually hospital but could be other healthcare setting to receive further

clinical care and treatment. This may involve transfer back to the Patients original admission place.

Definition of patient groups

Adult: A person over 16 years of age, (who is not in full time education.)MK

Paediatrics (Child/Young Person): A person who is aged 0-19 years (and is within full time education/ is receiving a statement of education.)MK

Maternity: A female who is pregnant/ or has delivered a baby within 28 days.

Elderly Person:
The services that the Trust provides for older people are designed to meet the needs of people with (often multiple) long term conditions, who present with the clinical syndromes associated with frailty. These people are typically over 75 and experiencing falls, loss of mobility, confusion or incontinence. They require careful multidisciplinary assessment and management, preferably in partnership between primary, secondary and community care.

Vulnerable person:
A vulnerable adult is a person who Is or maybe in need of community care services by reason of mental or other disability, age, or illness and, is unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation

3. AIMS OF THE POLICY

1. Ensuring Board level commitment to, and leadership of the development of effective discharge and transfer processes.

2. Ensuring that all patients are discharged as soon as possible after being identified as medically fit for discharge.

3. To ensure that patients receive their care in an appropriate environment designed to prevent or minimise the transmission of infection.

4. The aims will be achieved through meeting the following core objectives:

5. Proactive discharge planning from admission to transfer of care or discharge home.

6. The Infection Prevention and Control Team will work closely with the Bed Management Team /Clinical Teams to ensure that patient management processes do not increase infection control risks, whilst balancing the need to meet national / Trust targets.

4. IMPLEMENTATION

This policy applies to all areas within the Trust and all staff must be aware of their role in implementing the policy in their area of work.

Within this policy, arrangements are made for the, transfer or discharge of patients according to their patient group. These groups are categorised as follows:

- Adult
- Maternity
- Paediatrics

The 'Operational Discharge Procedure (Adult patients)' is contained in (Appendix 1). This also includes:

1 (a) The 'Discharge Against Medical Advice Procedure'
1 (b) The Transfer Procedures: Procedure for the transfer of Adult patients to another hospital

The Operational Discharge Procedure for Women's & Children's - Paediatrics and Maternity (Appendix 2)

Procedure for the transfer of Neonates to another Neonatal Unit/Ward (Appendix 3)

Procedure for In-Utero transfer of a woman (Appendix 4)

Procedure for all patients for transfer between clinical areas/Departments in the hospital (Appendix 5)

Guidelines for the transfer of adult patients between hospitals (Appendix 6)

The Trusts 'Infection Prevention and Control Management for Admission, Transfer and Discharge and moving (between clinical area and departments such as X-ray) Of Infected Patients Procedure (Appendix 7)

5. MANAGEMENT ARRANGEMENTS

This policy makes explicit and mandatory the actions required of key clinical and management staff in discharge and transfer and infection control procedures to ensure patient safety, whilst ensuring a balance between optimal care for patients and the effective management of resources. It sets out the roles and responsibilities of the Executive Team in the management of these processes and the responsibilities of individual divisions.

The responsibility for discharge and transfer involves every level of management. All members of staff have a responsibility to ensure the effective implementation of this policy and its associated procedures.

There are certain key officers with a specific function as outlined below:

The Chief Executive will:

- Have overall responsibility for transfer of care/ discharge of all patients.

The Chief Operating Officer will:

- Ensure that relevant policies and procedures are in line with national guidance and updated accordingly.

- Ensure that Divisional Directors are aware of their responsibilities to ensure appropriate clinical involvement in discharge and transfer procedures.

Directors will:

- Have collective responsibility for the Trusts systems of internal control and management by ensuring that appropriate discharge and transfer processes are in place and that these systems are functioning effectively.

Divisional Directors / Assistant Divisional Directors will:

- Ensure that this policy and its associated procedures are fully adhered to by their staff within their area of responsibility.

- Ensure that each new intake of junior doctors receives appropriate training in discharge and transfer procedures.

- Ensure that daily and additional ward rounds in their divisions are conducted to ensure that patients are discharged and transferred appropriately and in a timely fashion.

Consultants will:

- Comply and adhere to the Trusts Discharge and Transfer Policy and associated procedures.

- Undertake and ensure that daily and additional ward rounds are conducted to identify patients for discharge to maintain capacity and patient flows.

- Be fully responsible for the medical appropriateness of discharge and transfer.

- Ensure that an electronic D1 is completed for all patients on the day of discharge.

(NB: The responsibilities of the Consultant will also fall to the nominated deputy and the Consultants medical team).

Bed Manager will:

- Have responsibility for the efficient and effective management of transfer and discharge processes across the Trust by working within the Trusts Discharge and transfer procedures.

- Have delegated responsibility and should facilitate the utilisation of all Trust bed stock, in order to maximise patient throughput and ensure efficient use of Trust resources (this

will require balancing the demand for optimal levels of elective activity with emergency activity).

- Ensure that bed management does not increase infection control risks whilst balancing the need to meet national / Trust targets.

- Report failures in the discharge and transfer and infection control processes via the incident reporting system.

- Be responsible for the production and subsequent review of the Discharge and transfer Policy.

Case Managers

- The Case Managers will work closely with the Bed Managers and clinical teams to promote efficient/ effective transfer and discharge processes in the medical division working within the Trusts discharge and transfer procedures.

Infection Prevention and Control Team will:

- Work closely with the Bed Managers/Clinical Teams to reduce the infection control risks associated with transfer, discharge and movement of patients between departments, both internally and externally.

- Provide information and support, advising on appropriate isolation measures for infected and symptomatic patients.

Lead Nurses will:

- Be accountable for ensuring that this policy and its associated procedures are fully adhered to within their area of responsibility.

- Ensure that all staff are familiar with and understand the requirements of the Discharge and Transfer Policy and procedures.

- Ensure that infection prevention and control principles are integrated into practice.

- Facilitate the Trusts bed escalation processes at times of increased demand for beds.

- Ensure that arrangements are in place to facilitate internal / external transfers to take place at the earliest opportunity to maintain patient flow.

Assistant Directors of Nursing and Head of Midwifery will:

- Ensure that nursing teams comply with all aspects of the Discharge and Transfer policy and associated procedures.

- Investigate non compliance in relation to the policy and procedures.

Employees and Clinical Staff will:

- Co-operate and assist with the implementation of this policy and all associated procedures.

- Bring to the notice of management any problems or failings in, discharge and transfer procedures.

- Promptly report failure in procedures via the IR1 system in accordance with the Trusts policy and procedure on reporting incidents.

- Ensure that the D1 and any other documentation required facilitating a patients discharges is completed as soon as it is deemed that the patient is to be discharged.

Chief Pharmacist will:

- Ensure that there is a responsive system in Pharmacy to prepare drugs required for the discharge and transfer of patients, to avoid unnecessary delays.

Complaints Manager will:

Produce and disseminate a quarterly report detailing all complaints received that will also include those relating to transfer and discharge. This report will be discussed at the Patient Experience Group and at local Divisional Governance meetings.

6. MONITORING AND EFFECTIVENESS

There will be a number of ways to assess the effectiveness of the Trusts discharge and transfer policy and procedures:

- Each Divisional will be expected to report quarterly to Clinical Governance Committee on any adverse incidents associated with discharge and transfer of all patients. This will include any relevant action plans to assure the Clinical Governance Committee that each Division is adhering to the Discharge and Transfer policy.

- The complaints summary prepared by the Complaints Manager for the quarterly complaints review will be presented to the Governance Committee to provide assurance that the Trust is adhering to the Discharge and Transfer Policy.

- Any member of staff who feels that, discharge or transfer procedures have been carried out in an unsafe or clinically inappropriate manner will be advised to complete an IR1 form which will be escalated immediately to the Divisional Director for review.

7. REVIEW DATE

This policy will be reviewed 2 years after its approval or sooner if a change in National legislation or local procedures make it necessary.

Barnsley Hospital NHS
NHS Foundation Trust

ADULT DISCHARGE PROCEDURE

BARNSLEY HOSPITAL NHS FOUNDATION TRUST

Author: Cheryl Greenwood
Date: February 2010
Review: February2012

1. Introduction

This discharge procedure is specific to Barnsley Hospital (NHS) Foundation Trust and sets out the process that should be followed when discharging any adult patient from Barnsley Hospital Foundation Trust. The principles of the procedure are integral to effective discharge and underpin best practice in discharge planning.

The procedure has been developed in accordance with "The Community Care (Delayed Discharges etc.) Act 20003", and sets out jointly agreed processes that have been established between the BHNFT and Social Services for assessing the health and social care needs of patients to effect safe and timely discharge from the acute setting.

2. Underpinning Principles

- The engagement and active participation of patients and, where appropriate with the permission of the patient their carers, is central to the planning of a successful discharge. Where possible the return of patients to their home setting should be facilitated. When this is not appropriate to meet the patients needs, the aim should be smooth transfer of the patient to a suitable level of care.

- Patients and their carers are made aware, through early communication, of the range of options for their future care needs in order to avoid confusion and complications in the discharge planning process that could ultimately result in unnecessary discharge delays.

  NB. For patients and carers whose first language is not English consideration should be given to the use of link workers and language line. Consideration should also be given to providing information in a format that meets the diverse needs of patients, for example those who are hearing impaired or visually impaired.

- Wherever the discharge destination the patient should be well prepared physically, socially and psychologically for the transfer to their own home or an agreed alternative.

- A patients discharge should be planned across primary, secondary and social care services at the earliest opportunity and should be commenced prior to admission for elective patients or as soon as possible after admission for emergency patients. Planning a patients discharge should be undertaken on a multi-disciplinary basis.

- Patients who are vulnerable or at risk or requiring adult protection intervention will be referred to the appropriate safeguarding officer at the earliest opportunity.

- Following the processes that have been established around discharge planning the Single Assessment Process which will dovetail into the Community Care (delayed Discharges etc.) Act 2003.

3. Objectives To Be Achieved When Planning The Discharge Of A Patient

3.1 Within 24 hours of admission all patients will have had senior medical assessment and an estimated date of discharge (EDD) will be documented in the patients records (for

elective patients the EDD should be set prior to admission) The estimated discharge date should be communicated to the patient and, where appropriate their carer(s) early in the patients stay.

3.2 Wherever possible we will aim to hold a daily senior clinical review of all patients and their management plan and EDD will be updated accordingly.

3.3 All staff involved in the patients care should be fully aware of the estimated discharge date and actively working towards it on a daily basis 7 days per week.

3.4 The estimated discharge date should be realistic based on the time it is anticipated that will be required to carry out any tests or interventions and for the patient to be clinically stable and fit for discharge.

3.5 Timely referral to the multidisciplinary team so that all assessments required are carried out and completed without delay prior to the patients discharge to ensure that any support that is needed is identified, organised and in place. Alternatively the outcome of these assessments will inform the Multidisciplinary Team of the most appropriate care option that is required to facilitate the patients safe discharge.

3.6 All patients are fully informed of subsequent follow up arrangements and are aware of the appropriate sources of contact should any problems occur post discharge.

3.7 Every patient will have an electronic D1 completed on discharge. The D1 is copied to the patients GP, patient, pharmacy and case notes. The D1 will provide a summary of the patients care whilst in hospital and should contain the following information as a minimum:

- Initial reason for admission
- Investigations carried out and available results
- Procedures / treatments carried out
- Definitive primary diagnosis where confirmed or reason for not being available
- Medication details (including details of any changes)
- Management plan post discharge
- Follow up arrangements
- Information provided to the patient
- Specific information for BHNFTs coding department to ensure that the PCT is accurately charged and to collect data for local and national recording (HES, HRG etc)

3.8 Wherever possible we will aim to discharge patients on the morning of the day of discharge.

4. Simple discharge and complex discharge

4.1 The majority of patient discharges from hospital will be “simple discharges “and relate to patients who:

- Will usually be discharged to their usual place of residence

- Do not require complex discharge planning and care delivery
- Their length of stay is predictable
- No longer require acute care
- Can be discharged directly from A/E, the MAU or ward areas

4.2 Complex discharges relate to patients who:

- Need to be discharged to a care option other than their own home eg. Intermediate Care Services or nursing / residential care.
- Have complex ongoing health and social care needs that require assessment, planning and delivery by the multi disciplinary team
- The length of stay and estimated date of discharge is more difficult to predict

5. Admission and Discharge Team

5.1 The Admission and Discharge Team provide a 7 day service / 365 days per year 07.30 – 21.00.

5.2 The role of the team is to:

- Wherever possible prevent admissions through referral to multi-agency services

- Track and coordinate simple discharges by maintaining communication links with ward areas to assist with problem solving actual and potential issues that may impede the discharge process.

- Act as a resource and assist in expediting the discharge process in the surgical, orthopaedic and gynaecology divisions by trouble shooting and problem solving and case managing complex discharges.

- Monitor actual and potential delayed discharges or transfers of care on a daily basis

- Maintain accurate information about the numbers and causes of delays in the Trust providing feedback to the Trust, reporting this information to the DOH via the SITREP reporting process.

6. Case Managers (medical division)

6.1 The medical divisions Case Managers provide a service Monday to Friday (excluding bank holidays) Monday to Friday 09.00 – 17.00.

6.2 The role of the Case Managers is to:

- Act as a resource and assist in expediting the discharge process through proactive planning, problem solving and trouble shooting.

- Monitor actual and potential delayed discharges or transfers of care in the medical division reporting this on a daily basis to the Admission & Discharge Team.

- Maintain communication links with ward areas visiting each medical ward or ward where there are medical outliers daily to identify any actual or potential issues that may impede the discharge process.

- Case manage complex discharges

7. Case management

7.1 Clinical staff retain responsibility for the discharge planning process, reducing delays is the responsibility of all staff however the Admission and Discharge Team and the Case Managers have responsibility for centrally monitoring delays and implementing escalation strategies in order to prevent delays on a patient by patient basis.

8. Assessing Needs For Discharge

8.1 On admission to hospital the nurse who is responsible for the patients care will commence the care planning process which includes initiating a discharge plan for the patient.

8.2 All patients should be interviewed and have a social screening performed within 72 hours of admission (Trust target). Any patients identified as having social care needs will have a contact assessment completed in according with the single assessment process. This interview with the patient (and where appropriate their family) should be person centred to identify any problems or issues that could affect the individual been safely discharged from hospital.
Patients must always be **informed** and **consent** to the assessment process, and from the outset should be fully aware that staff may need to share their details with other agencies to support discharge.

8.3 The contact assessment will identify the probable outcomes of their inpatient episode indicating the anticipated length of stay and any possible future care needs and not everybody admitted to hospital will require community care services after discharge.

Please note probable outcomes of care include:

- discharge to the patients own home with no support required to support safe discharge

- referral to intermediate care services for a period of rehabilitation

- referral to social services to access community based services or a permanent care option.

- Referral to palliative care services

9. NHS Continuing Care

9.1 It is a legal requirement that **all** patients requiring social services are assessed against Continuing Care criteria to determine whether they are eligible for NHS funded care . All

patients should have a Continuing Healthcare Checklist completed to assess their eligibility for funding.
If the patient triggers on this checklist a Decision Support Tool should be completed and faxed to the Continuing Care panel to assess the level of funding that the patient will receive either in their own home or in a care home.
If the Decision Support Tool is not fully completed prior to the patients discharge the Continuing Care Coordinator must be informed and she will become responsible for its completion.

10. Palliative Patients

10.1 For any palliative care patients whose discharge is being considered / planned who is thought to be in the last days/ weeks of life the Fast track discharge check list should be followed and the patient referred to the End Of Life Discharge Liaison Sister who will support ward staff to discuss / ascertain the patients and their carer(s) wishes in this situation and provide support to staff if needed in discharging the patient to their preferred place of care wherever possible .

10.2 A Fast Track Tool should be completed in respect of all palliative patients with less than 3 months to live as these patients will automatically receive fully funded continuing care wherever they wish to receive that care.
Patients with less than 3 months to live who have had a fast track assessment completed which is signed by the Consultant have the right to decide where they want to die and this includes the right to remain in hospital

10.3 The completed Fast Track Tool should be forwarded to the Continuing Care Panel but will not in any way delay the patients discharge as NHS funding for this group of patients is automatic.

10.4 Any palliative patient who has months to live who requires support with their discharge from hospital where there are complex discharge issues can also be referred to the End Of life Discharge Liaison Sister for advice.

11. Patients Requiring Social Service Assessment

11.1 Barnsley Hospital Foundation Trust has a statutory duty under the Community Care (Delayed Discharges etc.) Act 2003 to notify the relevant local authority (Social Services) of a patients likely need for social services.
Under the Act BHNFT is required to make a reasonable attempt to identify the local authority responsible for providing community care services to the patient.

11.2 Please note - If on assessment:

- The patient requires intermediate care services a Assessment Notification (section 2) should not be issued to Social Services.

- The patient needs and is eligible for NHS Continuing Care on discharge, a Assessment Notification (section 2) should not be issued.

- The patient needs and is eligible for NHS Continue Care on Discharge, but also requires social service input for example benefits advice a Assessment Notification (section 2) should be issued.

- It is unclear whether the patient needs and is eligible for NHS continuing care but the patient is assessed as likely to require community care services on discharge, a Assessment Notification (section 2) should be issued (with the patients consent).

- It is likely that the patient will need community care services on discharge, a Assessment Notification (section 2) should be issued (with the patients consent).

12. Referral requirements

12.1 The re-imbursement process requires a two stage referral process to Social Services;

- Completion of a Section 2 Notification as soon as discharge planning needs have been identified.
  The section 2 is the trigger for assessment and should be issued to Social Services at least **72 hours prior to the expected date of discharge**

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- Completion of a Section 5 to notify Social Services that the patient is fit for discharge, and confirmation of that date this should be at least **24 hours prior to the patients discharge.**

13. Referral Process

13.1 As soon as it is possible to make a reasonable judgement that a patient is likely to need community care services when they leave hospital an Assessment Notice (section 2) should be issued to Social Services with a Contact Assessment that has been completed in collaboration with the patient, and, with their consent the relatives or carers.
This applies to all adults in the trust who are identified as requiring SS and also applies to patients who are already known to them. The Contact Assessment should make it clear whether reinstatement of an existing care package is appropriate or whether reassessment of their needs is required.

13.2 The Community Care (Delayed Discharge Act etc) requires the NHS body to:

Consult the patient before making a referral to Social Services. The patient may refuse to consent to a referral to Social Services or they may state that they do not need Social Services intervention as their family/carer will look after them.

Before deciding not to issue a assessment notification, the responsible nurse should establish whether a patient who says they can manage alone will be safe to discharge without Social Services support or whether the patients carer(s) are willing and able to provide all the support required.

13.3 If the responsible nurse does not think that the patient can manage alone or that the carer(s) are able to provide the necessary level of support the nurse should issue a

assessment notification to Social Services and explain this and their concerns to the patient and carer(s)

13.4 Following the notification of assessment social services should make all reasonable effort to perform an assessment and prepare a care plan. If this is rejected by the patient consideration may need to be given as to whether there are capacity issues around the patient fully understanding the risks of going home with no support or whether there are safeguarding issues, for example, the relatives will not accept the risks identified to the patient by the multidisciplinary team.

13.5 If the patient still refuses any support from social services, is deemed as having capacity to make that decision and there are no safeguarding issues identified, then the NHS will need to consider providing NHS services to help the patient go home safely or where this is not an option discharging the patient without any support ensuring that the patient and carer(s) are fully aware of all the risks and that this is clearly documented on the discharge plan.

Note: Social Services assessment should be commenced as soon as the patient is deemed fit for assessment <u>not</u> when the patient is medically fit for discharge. The assessment and where appropriate a carers assessment will be carried out in accordance with the requirements of the NHS and Community Care Act 1993.

13.6 The Admission and Discharge Team and the Case Managers are responsible for issuing assessment notifications to Social Services who will issue a receipt to confirm whether they are accepting or declining the referral (if the referral is declined the reason must be documented on the receipt).

The date and time of the receipt is recorded on the contact assessment and the Admission and Discharge Team/ medical units Case Managers will then progress chase all referrals that are made to Social Services.

13.7 The Admission and Discharge are responsible for monitoring the outcomes of all referrals against reimbursement timescales in accordance with the Community Care (Delayed Discharge etc Act 2003) and subsequently reporting delays in discharge via the SITREP reporting process.

13.8 The nurse responsible for the patients care should ensure, wherever possible that referrals for assessment to other health care professionals are made simultaneously, thereby minimising delays awaiting completion of multiple assessments.

13.9 The discharge date should be determined and agreed by **all** members of the multi-disciplinary team when all the necessary health and social care assessments have been completed. When the discharge date is agreed the Discharge Notification (section 5) should be issued to Social Services. The section 5 gives notice of the confirmed discharge date and should be issued at least 24 hours prior to the expected date of discharge.

14. Withdrawal of notice

Assessment Notice (Section 2)

14.1 Barnsley Hospital NHS Foundation Trust will need to withdraw the Assessment Notice (section 2) when:

- The patients health improves and the patient no longer requires community care services to support discharge
- There is a deterioration in the patients condition and the patient is unfit for assessment
- The patient needs to remain in hospital for a further course of treatment
- The patient is assessed as needing NHS Continuing Care, and community services are no longer required
- The patient arranges for their own care and therefore does not require community services
- A relative or carer offers to care for the patient so that community care services are no longer required
- There is a change in the patients ordinary residence after the Assessment Notice has been issued so that a different Social Services department becomes responsible

Discharge Notification (section 5)

14.2 The Trust will need to withdraw the Discharge Notice if:

- The patient is not fit for discharge on the date given on the discharge notice
- The patient is already delayed but their health deteriorates whilst they are waiting for community care services to be put in place.

14.3 When a new discharge date is known, the Discharge Notice (section 5) should be reissued.

15. Process for withdrawing Assessment and discharge Notices

15.1 The Trust is required to withdraw either the Assessment Notice or Discharge Notice as soon as it is clear that a patients need for community services has changed.

15.2 Written confirmation of the withdrawal will provided by either the Case Managers or the Admission and Discharge Team by completing the appropriate section of the notice that is been withdrawn.

16. Social services responsibilities

16.1 All patients who are discharged home in receipt of a social services care package should be discharged with a care plan that is signed and agreed by both the patient and social services.

16.2 Barnsley Social Services provide services to those people who they have assessed against the Fair Access to Care Services criteria and who are assessed as having critical or substantial needs but they will advise anyone who expresses a wish to see a social worker whilst in hospital.

17. Assessment of discharge needs

17.1 If it is unclear that a patient requires permanent care the assessment should ideally be done in a more appropriate setting than an acute ward therefore a referral to intermediate care services for assessment of need may be indicated.

17.2 The majority of patients will not fulfil the criteria for assessment of need by Intermediate Care Service and the assessment for permanent care will be undertaken at Barnsley Hospital (NHS) Foundation. The Multidisciplinary team are responsible and will determine whether the patient requires residential or nursing care to support their discharge.

17.3 The assessment for permanent care should be undertaken in conjunction with the patient and their carer(s).

17.4 When a patient has been assessed as requiring a care home the patient and their carers will be issued with the Home of Choice Protocol (Appendix 2). This allows the patient and their carer 14 working days to find a suitable home. If a suitable care home is not found within this timescale social services may transfer the patient to an interim placement until such time that the patient / carer locate their home of choice.

17.5 Particular care must be taken to ensure the continuity of care for any patients who are to be discharged to any districts outside Barnsley. The relevant details of these patients must be forwarded to the Admission and Discharge Team/Case Managers as soon as it is identified that either social support or intermediate care services will be required to facilitate discharge.

17.6 The Admission & Discharge Team will ensure that the necessary referrals go to the out of borough agencies and correspondingly monitor and progress chase the outcome in order to ensure that these patients are appropriately discharged with the necessary support and no unnecessary delays in discharge occur.

17.7 The Admission and Discharge Team will monitor and progress the outcome of referrals to out of borough agencies in accordance with the requirements of the Delayed Discharge Act.

18. Process for discharge out of hours

18.1 Most patient discharges from the ward areas occur within normal working hours and for elderly patients it is best practise to discharge during daylight hours to avoid them becoming disorientated.

There will be occasions however when a competent elderly patient wishes to be discharged whatever the time of day.

18.2 Discharging from A/E out of hours

If a patient is deemed medically fit and safe to discharge from A/E, and their wish is to be discharged regardless of the time of day this should be documented on the patients A/E card and the patient allowed to go home.

If the patient requires hospital transport to get home this should be arranged.

Any medication required should be obtained and sent home with the patient.

If a patient is medically fit but is deemed vulnerable, for example frail elderly and there a no relatives to support the discharge out of hours the relevant division will be contacted to accept responsibility for this patient and they will be admitted overnight and discharged home the following day provided that the relevant support is in place to enable a safe discharge.

18.3 Discharging from MAU out of hours

If a patient is deemed medically fit and safe for discharge from MAU, and their wish is to be discharged regardless of the time of day this should be documented on the patients collaborative assessment sheet and arrangements made for the patient to go home.

If the patient requires hospital transport to get home this should be arranged.

Any medications required should be prescribed and obtained from the pharmacy and sent home with the patient.

If a patient is medically fit for discharge but is deemed vulnerable, for example frail elderly and there are no relatives to support the discharge out of hours the patient will remain in hospital overnight. The patient will be discharged the following morning provided that the relevant support services are in place to enable a safe discharge.

18.4 Discharging from general wards out of hours

The majority of patients will be discharged in hours. If a patient is deemed medically fit and safe to discharge regardless of the time of day this should be documented in the patients care plan and arrangements made for the patient to go home as above.

When a frail elderly / vulnerable patients discharge is dependant on hospital transport there is a cut off point of 22.00 hours when the discharge must be cancelled and

rearranged for the following morning. The relatives or any other relevant parties must be informed that the discharge is cancelled.

19. Intermediate Care Services

19.1 Barnsley Metropolitan Borough Council and Care Services Direct have a broad range of Intermediate Care Services which include in- patient facilities and specialist multi-disciplinary teams able to deliver care in the patients own home. These services may enable people to return home from hospital earlier than would otherwise be possible by offering a rehabilitation programme in their own environment
The services are aimed primarily at older people but can be accessed by adults of any age. If it is thought that the persons needs can be best met within intermediate care services.

The services available to support discharge include:

- Mount Vernon Hospital – 56 rehabiltation beds and an 18 bedded stroke rehabilitation unit
- Community Rehabilitation Unit Keresforth
- Hospital at Home Team
- Rapid Response Team
- Highfield Grange locality centre

19.2 Reasons for referral to the Intermediate Care Service are as follows:

- For complex assessments
- To support early discharge (Rapid Response)
- For further medical, nursing and therapy intervention and assessment
- To access multi – disciplinary rehabilitation programmes
- Palliative / terminal care

19.3 The patient (and where appropriate their carers) should be involved at all stages of the referral and assessment process and should be fully informed and consenting to the referral .Any suitable patients (who are medically fit) who would benefit from intermediate care services should be referred to the Intermediate Care Team via the Admission and Discharge Team / and or the Case Managers. The referral documentation is the contact assessment.

19.4 The Intermediate Care Team will initially screen the referral for appropriateness. The team will assess the patients capabilities and needs to establish the most suitable service for the patient.

19.5 All referrals will normally be seen within 24 hours of the initial referral. The Admission and Discharge team and / or the Case Managers will monitor and progress chase outcomes of the referral

20. Nurse Led Discharge

20.1 Nurse led discharge is intended to provide patients with a quicker and more efficient discharge process.

20.2 The key principles underpinning nurse led discharge include:

- Patient safety is paramount
- Benefits to the patient and BHNFT
- Co-ordination and co-operation between the members of the MDT
- Communication between all involved in the discharge process
- To support and not replace multi-disciplinary care

20.3 Integrated Care Pathways, local protocols and patient criteria have been developed in the Trust to support Nurse Led Discharge.

21. Nursing Discharge Arrangements

21.1 The nurse responsible for the patients care should ensure that all discharge arrangements necessary for safe discharge are in place prior to the patient been discharged.

21.2 Where it is anticipated that the patients medical condition will result in the need for a sickness certificate this should be issued for a period consistent with the anticipated incapacity to a maximum period of 14 days (DOH July 2001).
The patient should be advised to see their GP if a sick note is required for a longer period.

22. Discharge Medication

22.1 The hospital pharmacy is open 08.45 – 17.45 Monday to Friday, 09.00 – 1230 Saturday and holidays and 0900 – 1200 Sunday for routine discharges. Out of hours there is an on – call service for **emergency discharges only.**

Out of hours there is an on – call service for **emergency discharges only**

In order to maintain patient safety whenever discharges are planned the medication must be ordered during the above opening hours due to the out of hours service been provided by a single person. This person has to take responsibility for screening the prescription, dispensing, clinical checking and labelling and this is a high risk process that ideally should be performed by two people.

22.2 The electronic D1 (e-D1) should be completed as early as possible in the discharge process as dispensing cannot proceed until the medication section is completed and the e - D1 can be printed off

Please note:

Not all e-D1s need to go to pharmacy :

- Not all patients need medication on discharge
- Not all prescriptions will need to be dispensed (where there have been no changes and the patients own medications are being used)

22.3 There has to be a clear indication for any patient who requires their medications to be dispensed in a Monitored Dose System (Venalink) in line with The Barnsley Health and Social Care Medication Policy For Domicillary Care.

Please note:

Monitored Dose Systems (Venalinks) must only be requested Monday to Friday before 16.00.
Setting up these systems is very labour intensive and high risk therefore requests after 16.00 or at the weekend will be declined.

23. Psychiatric Assessments

23.1 Any patient who requires psychiatric services (Not including memory services) should be referred directly to the Home Based Treatment Team 09.00 – 22.00 Monday to Friday .

23.2 Out of hours patients should be referred to the Crisis Intervention Team

23.3 The Admission and Discharge Team and/or the Case Managers are responsible for monitoring their response to the request to ensure that they make initial contact within their 48 hour timescale. Subsequently the team will monitor the outcome of the assessment.

23.4 Referrals are made via the Contact Assessment which is faxed directly to the Home Based Treatment Team.

24. Homeless Patients

24.1 Any patient who is deemed medically fit and subsequently discharged but who is of no fixed abode should be advised to go to the Homeless section based at the Civic Centre in Barnsley town centre to discuss their individual situation with the homeless Social Work team. They should take a completed contact assessment with them.

As a courtesy the Social Work team at the Civic Centre should be notified by the discharging nurse to expect the patient

24.2 If the patient requires monetary assistance to get to the Civic Centre the dedicated hospital social work team can provide this.

24.3 Patients should not be discharged to the Civic Centre after16.00 hours in order to give the centre reasonable time to assess the patients needs.

Please note if nursing staff are concerned about any aspect of a homeless patients discharge they should seek further advice / guidance from either the Admission and Discharge Team or the medical units Case Managers.

25. Paediatric Discharges

25.1 The discharge procedures for paediatrics is separate to the adult discharge procedure. The policy runs in parallel with the Trusts adult discharge procedure but includes specific protocols to be followed when discharging a child or neonate.

26. Community Nursing Services

26.1 Patients and their carers should be informed of, and consent to, referral to Community Nursing Services All referrals for community nursing services including Community Diabetes Specialist Nurses should be made via the Communications office based at Mount Vernon Hospital (ext 3211) and should be made as soon as the discharge date is determined but as a minimum one day prior to the patients discharge.

26.2 Patients referred for Community Nursing Services should be discharged with an electronic D1 detailing the reason for referral and any other relevant information to support this.

26.3 If the patient requires dressings, catheter equipment etc they should be sent home with 4 days worth of supplies to enable the District Nurse to obtain a prescription for these items from the patients GP.

Please note the District Nurse should be invited to attend any multi disciplinary team meetings for patients who have complex discharge needs.

27. Patients who self discharge against medical advice

See ‘Discharge Against Medical Advice Procedure’ (appendix 1a)

28. Information to be given to the patient on discharge

28.1 Standard information given to all patients on discharge:

- A verbal explanation about their discharge medication

On rare occasions when patients are discharged without their medications and no relative/friend is available to collect them arrangements may be made through YAS for home delivery.

NB patients must not be discharged without their medication if this will result in a delay to them accessing the next prescribed dose of any medication. (As per medicine's management code of practice.)

- A verbal explanation regarding follow up arrangements (including, specialist appointment and out-patient appointments)

- Advice regarding who to contact if they have any problems post discharge for example: GP, Specialist Nurse etc.

28.2 Patient specific information includes:

- Any information specific to the patients condition, for example colostomy / catheter care

- Post operative information

- Post procedure information

- Dietary information

- Benefits information

- Age Concern

Please note the information given to patients on discharge is not exhaustive (the above lists are examples of the types of information that we given to patients on discharge).

29. Documentation to accompany the patient upon discharge (adult patients)

29.1 Throughout the discharge procedure staff should ensure that accurate, comprehensive records are maintained, in line with Barnsley Hospital Foundation Trusts and Professional standards. Specific documentation to accompany the patient on discharge includes:

D1 (Electronic Discharge Letter)

An electronic D1 must be completed for every patient who is discharged from BHNFT. The D1 will provide a summary of the patients admission and discharge and as such must provide an accurate patient record.

1 x copy is given to the patient
1 x copy sent to the GP
1 x copy for pharmacy
1 x copy must be filed in the patients case notes

For Patients Referred to Community Nursing Services

A copy of the electronic D1

For Patients Referred to Community Matron

A copy of the contact assessment

30. Patient Transport

30.1 The discharging nurse will confirm transport arrangements for every patient 24 hours before their discharge.

30.2 All patients should have an assessment of their transport requirements including a home assessment where necessary (see Eligibility Criteria For Non –Emergency Patient Transport – Appendix 4).

30.3 Ambulance transport should only be used for a patient discharge when absolutely necessary all alternative forms of transport should be considered for example, relatives, taxis or medicars.

30.4 Patients will be advised that they will only receive transport if they meet the eligibility criteria for patient transport.

31. Do Not Attempt Cardio Pulmonary Resuscitation

31.1 A 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) order will be considered on admission for all patients who are thought to be at significant risk of cardiac arrest. This will be reviewed weekly, or where there is a change to the patients condition.

31.2 At times patients who have a DNAR order filed in their notes are discharged to their own home or transferred to another care setting, for example patients who are terminally ill. These decisions should be reviewed before transfer and in instances where it would not be appropriate to attempt resuscitation ambulance control should be informed of the DNACPR status when booking the ambulance. The DNACPR should accompany the patient on discharge and when travelling by ambulance be given to the ambulance crew. It should be left in the nursing notes in the patients own home or with staff if admission is to hospital or care home. If transfer is to the patient's own home or care home it is essential that the patient or family are aware of the DNACPR form and explanations about resuscitation status have been given. If the family/patient are not aware the form should stay within the hospital setting until consultation has occurred and the GP should be informed.

31.3 The copy of the original form must be filed in the patients notes for audit purposes, marked copy by making 2 thick diagonal lines and writing COPY through it in large capital letters).

32. Aids and Adaptations

32.1 If a patient requires equipment to support their discharge either the therapist or the nurse must requested it from Home Loans based at Kendray Hospital on an ER1 form.

32.2 Any equipment required to support discharge must be in place prior to discharge.

32.3 Please note that Home Loans have 7 working days to provide any necessary equipment.

33. Infection Control

33.1 Barnsley Hospital NHS Trust has a separate policy for discharging infected patients; "Infection Control management For the Admission, Transfer and Discharge of Infected Patients"

33.2 The policy runs in parallel with the Trusts adult discharge procedure but contains specific procedures and protocols to be followed when discharging an infected patient.

34. Discharge disputes

34.1 Patients should participate in their own discharge arrangements. However if the patient disputes the care arrangements that have been made for them or refuses to be discharged the Lead Nurse/ Matron should attempt to resolve any issues regarding the discharge informally.

34.2 If the issues cannot be resolved at this level the situation should be escalated to the Consultant to discuss this with the patient, reinforcing that they are fit for discharge and can no longer remain in a hospital bed

34.3 If this is not resolved at this stage the relevant Disputes or Home of Choice Procedure should be implemented.

34.4 Patients who are competent can exercise the right to refuse help from Social Services. Should this occur it may be appropriate to refer to the district nurse, or the district social work team and an early visit arranged (with the consent of the patient).

34.5 The Patient Advice & Liaison Service (PALS) is also available to speak to any patients, members of the public regarding any concerns or complaints.

34.6 Where a complaint cannot be resolved it should be referred to the complaints department to be dealt with by the hospital as a formal complaint. There are a number of policies /procedures in place to support the resolution of complaints /disputes.

- BHNFTs 'Information For Patients About Making A Complaint ' (Complaints Procedure).
- The 'Joint Operational Procedures To Facilitate Timely Discharge For People Needing Long Term Care In A Care Home' (Home Of Choice).
- The 'Joint Operational Procedures To Facilitate Timely Discharge For People When There is A Dispute Regarding Care Arrangements' (Dispute Procedure).

- NHS Continuing Care Review

35. Delayed Discharges

35.1 National targets are in place aiming for a reduction in delayed transfers of care. These are monitored through SITREPS (situation reports). The definition of a delay for SITREP purposes is:

A delayed transfer of care occurs when a patient is ready for transfer from acute care, but is still occupying a bed designated for such care. A patient is ready for transfer when

- *A clinical decision has been made that patient is ready for transfer* ***AND***
- *A multi-disciplinary team decision has been made that patient is ready for transfer* ***AND***
- *The patient is safe to discharge /transfer.*

35.2 Close monitoring of delays enables the respective organisations to work more collaboratively together to address problems and improve services. The Admission and Discharge Team at Barnsley Hospital Foundation Trust are responsible for monitoring delays against SITREP definitions and the reimbursement timescales set out in the "Community Care (Delayed Discharges) Act 2003".

Delayed discharges are reported internally via the Bed Managers Bulletin and externally via the SITREP process.

Discharge Against Medical Advice

1. INTRODUCTION

1.1 It is the duty of the Barnsley Hospital NHS Foundation Trust to take reasonable steps to ensure that patients who wish to discharge themselves from hospital are aware of the implications and risks of doing so. This document provides / sets out good practice in the management and support of the patient who wishes to self-discharge from hospital.

1.2 When practitioners communicate with patients, relatives and carers whose first language is not English consideration should be given to the use of link workers and language line to assist in expressing concerns and explaining the risks involved regarding patients who wish to taken their own discharge against medical advice. Consideration should also be given to providing information in a format that meets the diverse needs of the patients, for example those who are hard of hearing or partially sighted.

2. PATIENTS DEEMED TO HAVE MENTAL CAPACITY

Health care practitioners should:-

2.1 Attempt to find the real reason for concerns and try to dissuade the patient from self-discharge by resolving the problems, if possible.

2.2 Make every reasonable attempt to convince the patient of the need for further medical care, including the potential consequences of the decision to refuse further care.

2.3 Should the patient persist in their wish to self-discharge and discontinue treatment, medical staff should be contacted and asked to review patient and discuss consequences of discharge at this state in their treatment and care.

2.4 If after review, medical staff agree that the patient may be discharged, the patient should be discharged in accordance with Barnsley Hospitals discharge policy and procedures.

2.5 If the patient refuses to wait for medical review nursing staff should endeavour to get the patient to sign the Discharge Against Medical Advice Form. This should be filed in the patient case notes and it should be documented in the patients nursing records that they have refused medical review.

2.6 If medical staff consider that self-discharge is not in the best interests of the patient. The patient must be informed of reasons why.

2.7 Where it is considered that self-discharge is not in the best interests of the patient but the patient persists with this course of action the patient should be asked to sign the 'Discharge Against Medical Advice' form which should be filed in the patients case notes.

Please note : If the patient refuses to sign this form staff should document the refusal, time and date and witness signature on the 'Discharge Against Medical Advice' form and place it in the patients medical notes.

2.8 The medical practitioner should record discussions with the patient in the patients case notes. All discussions between medical, nursing staff and the patient should be clearly documented in the patient's notes and an IR1 form completed.

2.9 The relevant agencies must be notified as soon as possible that the patient has taken their own discharge against medical advice (including the patient's GP, Consultant in charge and Social Services where appropriate).

2.10 **Please note relatives and carers cannot take discharge against medical advice on behalf of the patient. The only person, who can self-discharge if mentally competent, is the patient.**

3. PATIENTS WHO LACK MENTAL CAPACITY

Health care practitioners should:-

3.1 Attempt to find the real reason for concerns and try to dissuade the patient from self-discharge by resolving the problems, if possible.

3.2 If patient persists in wish to self-discharge and discontinues treatment, medical staff should be contacted and asked to review patient and discuss consequences of discharge at this state in their treatment and care.

3.3 If the doctor considers the patient is deemed incompetent by lack of mental capacity to understand the full implications of self-discharge and discontinuation of treatment, there is a duty on the doctor to act in the patients best interests.

The doctor formally responsible for the patient should formally undertake a capacity assessment and if the patient is deemed not to be capable the patient should be detained in their best interest. A multidisciplinary best interest meeting may need to be held as soon as possible.

Please note: Particular attention should be paid to whether there are deprivation of liberty issues (if in doubt seek advice from the safeguarding Adult Department or Social Services).

3.4 Reference should be made to the appropriate section of the Mental Health Act (1983). It may be necessary to involve psychiatric services and in these cases the relevant section of the Act should be used to detain the patient. (Refer to Policy for patients detained on wards under the Mental Health Act)

3.5 If may be necessary to seek further advice from the patient's Consultant at this stage.

3.6 All discussions between medical and nursing staff and patient should be clearly documented in the patient's notes.

3.7 The Directorate Manager or Senior Manager must always be informed if the patient is to be held under the Mental Health Act.

4. PATIENTS UNDER 18 YEARS WHO ARE DEEMED COMPETENT

4.1 In the case of Gillick it was established that a child under the age of 16 years will have the capacity to consent to medical treatment when they have achieved sufficient understanding and intelligence to enable them to understand fully what is proposed (these are now referred to as the Fraser Guidelines.

4.2 Confusion arises when the health professional considers that the child is competent under Fraser Guidelines, but their wishes conflict with those of the parent.

4.3 A child who is under the age of 16 years who is deemed competent (under Fraser Guidelines) and any competent 16/17 year old has a right to consent to treatment which cannot be overridden by those with parental responsibility. CONSENT CAN HOWEVER BE OVERRIDDEN BY THE COURT. If the person with parental responsibility (see section 5 of this document) requests that a competent child be discharged against medical advice, but the child wishes to remain in hospital, the child's wishes will prevail.

4.4 Although competent children can, in law, give valid consent to treatment, they do not have the same right to refuse treatment. If a competent child under the age of 18 years refuses treatment then they can be overridden by the consent of the person with parental responsibility.

4.5 In practical terms it may not be possible to force the child/young person to stay in hospital, any attempts to restrain may leave the health professional open to charge of assault. If the child/young person's health is likely to be adversely affected then it is preferable to seek a court order.

4.6 If a competent child refuses treatment and the appropriate adult agrees with the child but the health professional considers that the treatment is in the best interests of the child, the only solution may be to seek an Order from the Court.

5. CHILDREN UNDER 18 YEARS WHO LACK CAPACITY TO CONSENT

5.1 In relation to a young person of 16/17 years of age who lack capacity to consent or a child under 16 years who does not satisfy the Fraser guidelines parental consent will always be required. If the appropriate adult wishes to take the child out of the hospital against medical advice but the health professional considers that the treatment is In the best interests of the child they need to carefully consider whether treatment should proceed despite the parent's refusal. If parent/s and doctors do not agree after a further discussion then a second opinion should be sought. An application may need to be made to the Court for guidance with regard to what is best for the child.

5.2 The safety of the child/young person must be paramount. The child/young persons health and development must not be impaired. Need to establish that they are not at risk of significant harm if they were to be removed against medical advice.

5.3 **Parental Responsibility – please refer to the Trusts consent policy**

The appropriate person with parental responsibility is:

- Both the mother and father if they have been married since the child's conception.
- The mother only in respect of unmarried couple (depending on the child/young persons date of birth – see Trusts Consent Policy).
- Both the mother and the father of an unmarried couple if there is a parental responsibility agreement or residency order.
- The Local Authority where the child is the subject of a Care Order. If the terms of the order allow the mother may have some parental responsibility of a child. On person is however required to give consent and therefore Local Authority consent is sufficient.

5.4 Issues around consent and refusal are complex. Full discussion should take place with the parent/s and child/young person. Second opinions should be sought where necessary.

5.5 Full explanation should be given outlining the benefits, consequences/alternatives. The explanation should be sufficient to enable the parent/s child/young person to make a balanced judgment to decide whether or not to stay in hospital.

5.6 In all instances discussions must be recorded in the case notes and the appropriate form completed (Appendix 2). If the parent/s refuse to sign the form this must also be recorded in the case notes.

5.7 As appropriate the following will need to be informed:

- General Practitioner
- Health Visitor/School Nurse
- Social Worker
- Named Nurses Safeguarding Children
- Police (where a Police Protection Order or Emergency Protection Order is required)

6. ASSOCIATED POLICIES

6.1 Barnsley Hospital NHS Trust Consent Policy 2011.

BARNSLEY HOSPITAL NHS TRUST DISCHARGE AGAINST MEDICAL ADVICE FORM	Patient

To be completed by medical staff

I confirm that the patient named below has the capacity and ability to understand the nature and purpose of the proposed treatment and is able to weigh the risks of the treatment and the proposed discharge of:

Patient ……

Advice and information given ……

……

Date and time of discharge ……

Discharged to (if not patient's home address) ……

……..

Copy to:-

General Practitioner informed by: Telephone ☐
Fax ☐
E-mail ☐

Name ……

Address ……..

……..

Tel No ……..

Other agencies informed please state

……

……

……

Date …….. Time ……

Signed …….. Status ……..

Print Name ……..
[A copy of this form is to be placed within the medical records immediately]

BARNSLEY HOSPITAL NHS TRUST DISCHARGE AGAINST MEDICAL ADVICE FORM	Parent/parental responsibility

To be completed by medical staff

I confirm that I have explained to the parent/person with parental responsibility the potential risks (as set out above) that might arise out of the decision to

Discharge …… against medical advice.

I also confirm that the parent/person with parental responsibility has the capacity and ability to understand the nature and purpose of the proposed treatment and is able to weigh the risks of that treatment and the proposed discharge of …….

Advice and information given …….

……

Date and time of discharge …….

Discharged to (if not patient's home address) …….

……..

Copy to:-

General Practitioner informed by: Telephone ☐
Fax ☐
E-mail

Name ……..

Address ……..

……..

Tel No ……..

Other agencies informed please state

……

……

……

Date …….. Time …….

Signed …….. Status ……..

Print Name ……..

[A copy of this form is to be placed within the medical records immediately]

JOINT OPERATIONAL PROCEDURES TO FACILITATE TIMELY DISCHARGE FOR PEOPLE NEEDING LONG-TERM CARE IN A CARE HOME

1. PURPOSE

1.1 The purpose of this joint procedure is to minimise delays in discharge for **all** patients assessed as needing long-term care in a care home. In implementing this procedure, the requirements under the Community Care Delayed Discharges Act 2003 must be adhered to.

1.2 It identifies target timescales from the multi-disciplinary assessment to date of discharge and the process for resolving problems if discharges are not achieved within the timescale.

1.3 Nothing in this procedure removes the need to follow standard procedures relating to patient confidentiality. Where the procedure refers to carers, family of the patient's representative those providing information, advice or letters of confirmation must ensure that patient confidentiality rules are followed.

2. PROCEDURE

2.1 If a community care assessment indicates that a long-term care placement is required the Multi-Disciplinary Team will agree a target date by which the patient should be discharged. **Start form JOP 1 and issue leaflet 'Discharge to a Care Home'.**

2.2.1 Day One

The care manager will identify and advise the patient and relative/carer of care homes, which meet the patient's needs. The care manager will advise the patient and relative/carers or representatives of the funding arrangements for the placement eg. Local Authority, Self-funding or NHS funding. This will be inclusive of any Registered Nursing Care Contribution procedures.

In case of local authority funded placements the usual fee paid by Social Services will be advised by the care manager. **Update form JOP 1.**

2.2.2 The patient and relative/carer or representative will be given written and verbal advice regarding the timescales and expectation covering the discharge process as follows: -

2.2.3 Due consideration will be given to any change in patient circumstances which may affect the agreed discharge date.

2.3 Day Fourteen

If a discharge date is not agreed within 14 days, the PCT will convene a meeting within 7 working days to agree arrangements and a date for transfer to appropriate interim or long-term care arrangements, which meets the assessed needs of the patients. Those invited to the meeting will include the patient, relative/carer or representative, care manager and a member of the multi-disciplinary team. **Update form at JOP 1.**

Following the meeting a letter will be issued to the patient detailing interim arrangements. **(JOP 4)**

A letter is sent to the Care Home **(JOP 5)** detailing the contractual arrangements for this interim placement.

A leaflet 'Discharge to a Care Home – a Guide for Patients and Carers' supports this process and includes details of the complaint's process.

The care manager will appraise people of their rights to make a complaint but will also inform them that discharge will not be held up whilst the complaint is investigated. A copy of the Social Services Complaints Leaflet should be made available on request.

3. AUDIT TRAIL

3.1 The care manager will keep an individual patient record of their progress through this process. Copies of this should be places with the patient's notes and sent to the appropriate Trusts' Director when the process is completed regardless of how far the form is completed. The part completed form should be used to refer cases to the appropriates Trusts' Direct. If the process terminates part way then this should be indicated at the bottom of the form. A new form should be initiated if the process is started again.

JOINT OPERATIONAL PROCEDURES TO FACILIATE TIMELY DISCHARGE FOR PEOPLE NEEDING LONG-TERM CARE IN A CARE HOME

CHECKLIST FOR PROTOCOL OF CHOICE

Surname:…… Forename:…… NHS No:…… Ward/Location: ……

Checklist	Date	Initials
Patient fit for discharge (needing long-term care in a care home). Leaflet 'Discharge to a Care Home' issued.		
Process discussed with patient/representative.		
Funding arrangements agreed.		
Trust letter **(JOP 2)** given to patient providing written confirmation of the expected discharge arrangements.		
Date of start of first 14 day period (dd/mm/yy): / /		
Referred to Organisations' appropriate Director to convene a Discharge Planning meeting.		
Meeting with Patient/Representative/MDT: Meeting confirmation letter sent **(JOP 3)** Meeting Date: …… (dd/mm/yy) Invited to attend …… …… Designated key worked is (name) ……		
Interim placement agreed		
Letter **(JOP 4)** issued to patient detailing interim arrangements.		
Letter **(JOP 5)** sent to interim Care Home.		
Process Terminated on (dd/mm/yy): / / Reason: …… **START NEW FORM IF PROCESS RESTARTED**		

Copy Form to: Patient's Notes and Trust Director

[NHS TRUST LOGO]
[Trust Address]

[Direct dial contact number]
[E-Mail Address]

[Date]

[Name of Patient]
[NHS No]

Dear Mr/Mrs/Miss/Ms (Name)

DISCHARGE TO A CARE HOME

We are please that you are now able to be discharge, as confirmed by your Medical Consultant. Your health and social care assessment has been completed and the nurses, doctors and care manager have discussed and agreed with you what your needs will be when you are discharged. As you are aware, it is recommended that your current needs would be best met in a care home.

I am sure you will understand that acute and community hospital beds are in great demand and that we need to ensure that they are available for patients who do need in-patient care. Your Care Manager will give you a list of care homes within the Barnsley area. We ask you to seriously consider this option and to make a decision so that we can assist you to move within fourteen days of the vacancy being identified.

If you do not feel able to do so we will need to identify an interim placement for you to move to whilst you consider your longer-term arrangements.

If you wish to talk things through with someone who can help and support you, please contact your Care Manager or Ward Sister. We hope that you will be happy in your new home and thank you for your cooperation.

Yours sincerely

Trust Director

Cc Patient's representative and/or carer, Care Manager and Patient's notes.

[NHS TRUST LOGO]

[Trust Address]

[Direct dial contact number]
[E-Mail Address]

[Date]

[Name of Patient]
[NHS No]

Dear Mr/Mrs/Miss/Ms (name)

DISCHARGE TO A CARE HOME – MEETING CONFIRMATION

We understand that you have been unable to confirm arrangements for your discharge from hospital.

I am now able to confirm that a meeting will take place on …… at ……. am/pm to discuss this issue. The meeting will be held at ……..

Yours sincerely

Trust Director

Cc Patient's representative and/or carer, Care Manager and Patients Notes

Letter to patient following Trust panel meeting **JOP 4**

[NHS TRUST LOGO]

[Trust Address]

[Direct dial contact number]
[E-Mail Address]

[Date]

[Name of Patient]
[NHS No]

Dear Mr/Mrs/Miss/Ms (Name).

DISCHARGE TO A CARE HOME

Following a meeting on …….. I am now able to confirm that an interim placement has been secured for you at ……. Care home starting on ……..

Whilst you are there you or your representative will be able to continue to view other homes to identify a place of your choice and the Care Manager will continue to assist you. However, once there you made decide to stay permanently in which case we may be able to make arrangements for you to do so.

If you are unhappy with the decision you are entitled to make a complaint using the PCT or Social Services complaints procedure. Please note that, if you do make a complaint, your discharge from hospital will still go ahead whilst the complaint is investigated.

We hope that you will be happy in your new home and thank you for your co-operation.

Yours sincerely

Trust Director

Cc Patient's representative and/or carer, Car Manager and Patient's notes.

Letter sent to the interim care home **JOP 5**

[NHS TRUST LOGO]

[Trust Address]

[Direct dial contact number]
[E-Mail Address]

[Date]

[Name of Patient]
[NHS No]

Dear Mr/Mrs/Miss/Ms (name)

DISCHARGE TO AN INTERIM CARE HOME

We write to confirm that we wish to place ……., previous of ……., referred to below as the 'User', in ……, at a fee of £ per week.

The placement is to take effect from and is an interim placement for a maximum of two weeks. During this period, both the purchaser and the provider may terminate these arrangements upon written notice of one week. If the user chooses to remain with you, at the end of the interim placement, the usual financial arrangements eg. Local Authority self-funding or NHS funds will apply. This user will reside with you on the basis that you agree to comply with the Terms and Conditions, which are ultimately adopted by the Council and it's providers. Your acceptance of this user within your home is deemed to be acceptable by you of these conditions.

The user has been assessed as being in need of ……..

The user's Care manager will be …….

Yours sincerely

Trust Director

Cc Patient's representative and/or carer, Care Manager and Patient's Notes.

Barnsley NHS Foundation Trust

ELIGIBILITY CRITERIA FOR NON-EMGERNCY PATIENT TRANSPORT

Patients attending the hospital at any locations within the Trust are expected to make their own travel arrangements to and from those appointments.

The arrangements may be travelling by public or private transport, or being brought to and from the hospital by a relative/carer/friend.

The Trust recognises that there are some patients for whom this is not possible and transport may be available for patients who fir the following criteria.

Requires transport on a stretcher

Specialist moving and handling expertise required to transfer patient to and from home, e.g.

- Bariatric patient
- Difficult access to/from vehicle

Required to travel with one or both lower limbs extended and/or supported

Full time wheelchair user with own chair

Clinical/medical condition prevents patient walking more than 200 metres e.g.

- Respiratory disease
- Cardiac disease
- Arthritis of spine or lower limbs
- Temporary restriction related to clinic/medical condition

Clinical/medical condition prevents patient from independent travel, e.g.

- Communication difficulty
- Cognition difficulty
- Uncontrolled illness
- Severe temporary/permanent visual problems
- Neurological illness
- Mental health problems
- Learning difficulties

Reason for attendance prevents patient from independent travel, e.g.

- Eye procedure
- Chemotherapy
- Sedation

Requires an escort throughout the journey, e.g.

- Under 16 yrs old
- Communication difficulties
- Mental health problems

Each request for transport will be individually assessed.

Exceptions:
It should be recognised that there may be instances when it is necessary for the Trust to approve patient transport which is outside of the criteria, for example, Amber Bed alert or Declaration of a Major Incident. In these situations authorisation must be provided from a senior colleague. Bed Manager 395/219 Bleep holder etc.

Barnsley Hospital NHS
NHS Foundation Trust

Appendix 2

Operational Procedure for Discharge

Paediatrics and Maternity Services

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Discharge Procedure
Women's & Children's Services

1. Introduction

Children and young people and their patients/carers must be the central focus and be involved with, the discharge planning process. Hospital stays should be kept to a minimum through the co-ordinated delivery of care. Integral to the successful discharge of patients is multi-professional team working. Planning for discharge should begin before admission for elective patients or as soon as possible afters admission for emergency patients.

2. Aims

The main aims of co-ordinated discharge are to ensure that: -

- Necessary health, therapy and social assessments are carried out prior to discharge, to ensure that support and facilities in the home setting are appropriate to the needs of the individual patients, or to inform the service of the most appropriate place of transfer for the patient.

- Children and young people and their patients/carers are aware of and involved with, discharge arrangements, follow up care and sources of contact if problems occur.

- The General Practitioner (GP) and community services are aware of the patient's needs.

- The recommendations set out in the National Service Framework for Children, Young People and Maternity Services (2003) are met.

NB Particular care must be taken to ensure that continuity of care for all children and young people who are discharged to districts outside Barnsley is also maintained.

3. Arrangements for Discharge and After Care

On admission to hospital the nurse responsible for the child's care will attend to their immediate needs and commence the care planning process on the discharge checklist. This should take place as soon as possible or within 12 hours of admission. The care planning process includes initiating a discharge plan.

Relevant social aspects and services prior to admission will be documented, including details of agencies already involved in providing support. Any agencies involved with providing services for the child or young person must be notified of their admission, whether admitted to the ward or discharged home from the Children's Assessment Unit.

All children and young people have 24 hour access back to the unit, which may be extended by medical staff or over the weekend period. There is however no medical staff cover for ENT patients at the weekend so these patients should be referred direct to

A&E. Children and young people who have plaster of paris insitu are also better advised to return to A&E.

Some children and young people are on an 'Open door' policy which enables fast tracking through A&E should they require further admission for the existing condition. When a child or young person is placed on the list (which is updated monthly) the parent/carer is given a letter from their consultant.

Hospital admission may have resulted in an unpleasant experience for the child or young person. To help in the reduction of stress and anxiety of further hospital admissions, the Hospital Play Service is available, on request, for home visits. This can be discussed prior to discharge.

4. Discharges from Neonatal Unit

All babies must be registered with a GP before discharge home.

All babies identified at risk must have a Children's Community Nurse Team referral.

All babies known to social services or where concerns have been raised about home circumstances or parenting skills must have a case conference with the Multidisciplinary Team before discharge.

All babies on home oxygen therapy must fulfil the discharge criteria before discharge.

All babies born at Barnsley District General Hospital but booked for delivery at a place other than Barnsley District General Hospital must be referred to the child protection team before discharge.

A community midwife referral must be completed for all babies and taken to the office on day of discharge, located outside ward 11.

If a baby has not had a routine hearing screen on the neonatal unit then an appointment must be made with the audiology department.

All babies who were breech presentations must be referred to specialist outpatient clinic for hip check.

For all babies identified as at risk from TB, a referral form from children's outpatients must be obtained for follow up.

Any baby requiring a 6 week ophthalmic check which is not done before discharge must have an outpatient's appointment made and given to patients/carers before discharge.

5. Assessments by Allied Health Professionals (Physiotherapy / Occupational Therapy / Dieticians)

Discharge assessments by allied health professionals should be arranged by the nurse responsible for the patient's care, as soon as the patient is fit for assessment.

NB An anticipated date of discharge for each patient will be determined by the multi-disciplinary team.

6. Other Arrangements

The nurse responsible for the child or young person's care will ensure that they and their parents/carers are fully involved in the planning of their discharge.

The nurse responsible for the child or young person's care will ensure that any take home medication is prescribed WELL before discharge.

When the patient is referred to the Children's Community Nursing Team or District Nursing Service, the nurse responsible for the child or young person's care should ensure that enough supplies (dressings, catheters, syringes etc) for seven days, are sent home with them.

The nurse responsible for the child or young person's care should ensure that their family take all property and valuables home on or before the day of discharge.

The day before discharge the nurse responsible for the child or young person's care must ensure that appropriate arrangements are made for their transport home.

7. Records

Throughout the discharge procedure staff should ensure that accurate, comprehensive records are maintained, in line with Trust and Professional standards.

All children and young people about who there are concerns of deliberate harm must have an identified GP on discharge. (Refer to Child Protection Package).

INFECTION CONTROL
Infection control measures must be maintained at all times as per trust policy

8. Discharge to Community Children's Nursing (CCN) Team

The CCN Team are based in Children's Outpatient's, first Floor. The current service hours are Monday to Friday 08.30 – 17.00. There is no out of hours service. When a planned discharge from the children's ward or neonatal until necessitates the involvement of the CCN Team the appropriate referral form must be completed. This may be backed up by a telephone call to the office on ext. 2519.

If the referral is urgent then a phone call may in the first instance be made to the CCN Team followed up by a written referral.

An answer machine is in operation to leave contact names but no patients details must be left.

9. For Patients Referred to District Nursing Services

Children requiring wound checks or suture removal should be referred to the District Nursing Service and the parent/carer given the time of the clinic or visit. This should be recorded in the notes.

10. Discharges to Community Midwife

The community midwives can be contacted between 9-5 pm seven days a week.

The baby's midwife should be contacted direct on her mobile from the phone number lists. Refer to the Community Midwife Off Duty to know if they are working. If they are off duty, contact with another midwife in the team must be made.

All phone contact must be followed up with the completion of the community midwifery referrals form which should be taken to Ward 12 (Postnatal Ward). If a baby is to receive follow up by a Children's Community Nurses this should be detailed on the referral form.

11. Contacting the Midwife Out of Hours

The midwife on call, (is identified by a C on the off duty), her home number is on the phone number list. This should be followed up with a referral form as detailed above.

Midwives visit up to 28 days post delivery.

Confidential information must not be left on the mobile phone answering service.

NB. Ensure that any community nursing team is informed of any infection the child may have on discharge.

12. Doctors' Discharge Letters

A discharge form (D1) is completed by the medical staff responsible for the patient's care, this outlines all essential aspects of their admission and discharge including take home medication and follow up appointments which are planned.

1 x copy in hospital records
1 x copy to pharmacy
1 x copy to be sent home with patient
1 x copy to the GP

A more detailed discharge letter is routinely sent to the GP within two weeks and a copy is kept in the patient's medical records.

13. Discharge Against Medical Advice

When a parent or carer wishes to discharge their child against medical advice, a member of the medical team responsible for the patient's care or the on call doctor must be notified and should explain to the parent or carer the risks of refusing to remain in

hospital. If the parent carer still chooses to leave the hospital they should be asked to sign a *Discharge Against Medical Advice* Form.

1 x copy should be retained in the patient's medical records.

If the patients/carer refuses to sign the form:

- A record of refusal should be made in the child's medical records.
- The child's GP should be notified by phone and a detailed letter sent by the medical staff.

If appropriate other agencies (Police, Child Protection Team, Social Worker, Community Children's Nursing Team), should

- be notified by the nurse responsible for the patient's care as soon as possible.

PLEASE NOTE THAT OCCASIONALLY THE RISK PRESENTED TO A CHILD OR UNBORN CHILD WILL BE SIGNIFICANT ENOUGH TO WARRANT CONTACTING THE POLICE AND SOCIAL CARE IMMEDIATELY IN ORDER THAT THE CHILD IS RETURNED TO THE HOSPITAL. IF NECESSARY POLICE CAN OBTAIN A POLICE PROTECTION ORDER.

- An eIR1 incident form should be completed.

Barnsley Hospital NHS Foundation Trust

Women's and Children's Services

Guideline for the Examination of Newborn Babies by Midwives (N96)		Barnsley Hospital NHS NHS Foundation Trust	
Author: Dr Saeed / G Jepson	Guideline group	Reference number:	
Issue Number 1	Maternity	Authorisation date: Reviewed: Next review date:	06/12/10 12/13

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Introduction

Rationale

The purpose of this guideline is to ensure:
That babies who fit the inclusion criteria can be discharged by a suitably trained and qualified midwife
That babies who do not fit the inclusion criteria are discharged by the paediatric staff
There is a process in place for cover by suitably qualified midwife on a weekend to perform the examination

Scope

This guideline applies to all Midwifery staff who work within the Maternity Unit at BHNFT and in Community

Principles

To ensure that babies women who choose to deliver at BHNFT receive care which is evidence based and follows best practice guidance

Background

Examination of all the newborn babies soon after birth is a well established screening test which is recommended by NICE guidance and the National Screening Committee. NICE recommend that with regard to the newborn infant “a complete examination should take place within 72 hours of birth” and that the “recommendations made by the NHS national Screening Committee should be carried out”

The NHS National Screening Committee recommend that the Newborn and Infant Physical Examination Programme is followed which advocates that babies receive a “top to toe physical examination to check for problems and abnormalities” within 72 hours of birth.

The examination should consist of an overall physical check with specific examination of the babies:

- Eyes
- Heart
- Hips
- Testes (in boys)

The examination can be undertaken by paediatric staff and midwives who have undergone a recognised training programme (N96)

Many women now request early discharge from hospital. This process can be delayed because of the requirements for a neonatal examination prior to discharge. The paediatric doctors are

required to prioritise care, and are not able to perform the discharge examination “on demand”, especially at the weekend when paediatric cover is limited.

There is a need therefore, for the provision of a service which allows babies who fit the inclusion criteria to be discharged by a suitably qualified midwife on a daily basis.

Guideline Outline

Babies suitable for examination by midwives

All babies born after 36 weeks gestation by normal vaginal delivery, elective caesarean section or instrumental delivery providing there were:

- No prior involvement of the paediatric staff (babies who are well but have had paediatric involvement may be examined and discharged by the midwife following discussion with the paediatrician)
- No birth trauma
- No obvious congenital abnormalities

Babies not suitable for examination by midwives

The following will need a paediatric assessment/intervention:

- Any baby with a condition/ behavior which is cause for concern (e.g.) uncommon rash, spots, appears jittery
- Any baby with a diagnosed or suspected congenital abnormality
- Any baby that has suffered birth trauma
- Any baby with abnormal investigation results
- Any baby born to parents where there are social concerns
- Any baby born to a woman with a known infection (i.e.) Herpes, HIV, Hepatitis, GBS
- Any baby that has been on the Neonatal Unit
- Any baby that displays signs of jaundice within the first 24 hours

Equality Impact Assessment

Women’s and Children’s Services are committed to ensure that both current and potential service users and their families will not be discriminated against on the grounds of religion, gender, race, sexuality, age, disability, ethnic origin, social circumstance or background. The principles of tolerance, understanding and respect for others are central to what we believe and central to all care provided.

Roles and Responsibilities

All midwives and paediartric doctors working within the Maternity Unit at BHNFT and in Community are responsible for ensuring this guideline is followed

Audit / Monitoring

Any adverse incidents arising from the implementation of or failure to implement this guideline will be addressed through the Trust's Accident / incident (IR 1) reporting system and actioned according to the Trust's Risk Management Strategy
Any incidents requiring a Case Review, Root Cause Analysis or Serious Untoward Incident review will be addressed accordingly

Training

All midwives undertaking the examination of the newborn will have received the relevant training and be able to show evidence of competency in the procedure

Dissemination and Access

A hard copy of the handbook is available in all areas. An electronic copy is available via the Intranet or the Practice Facilitator Midwife

Review

This guideline will be reviewed within three years of authorization. It may be reviewed within this period if there are any reports, new evidence, guidelines or external standards suggesting that a guideline review is required

References

UK national Screening Programme. NHS Newborn and Infant Physical Examination Programme.2010 - www.nsc.uk/ch_screen/child_ind.htm

National Institute for Health and Clinical Excellence. Routine postnatal care of women and their babies. Section 1.4.11.2006

Glossary of Terms

BNHFT – Barnsley Hospital NHS Foundation Trust
GBS – Group B Streptococcus
HIV – Human immunodeficiency Virus
NHS – National Health Service
NICE – National Institute for Health and Clinical Excellence

Appendices

Appendix 1 – Obstetric Guideline Outline

Appendix 1

Obstetric Guideline Checklist

Guideline for the Examination of Newborn Babies by Midwives (N96)	**Lead Professional** Dr Saeed/G Jepson	**Review Date** 06/12/13

Formatting	Included/attached
Headings	included
Quality Impact Statement	included
References	included

Consultation Process	Date Disseminated/Presented	Relevant information
Initial circulation to Guideline Group and relevant parties (draft 1)		
Amended draft sent to development lead		
Final Draft presented to Guideline Group for ratification	05/10/10	Ratified 05/10/10
Amended/final Draft presented to Women's Governance group for Ratification	06/12/10	Date ratified: 06/12/10

Archiving	Date of distribution	Date of retrieval of old guideline	Date of Archiving
Distribution and Retrieval	N/A		

Training Package devised	Date	
Training Package Delivered	Date	

Audit/ Monitoring	Method	Date Commenced	Date Completed
Audit Process			
Monitoring process			

Barnsley Hospital NHS Foundation Trust
Women's and Children's Services

Guideline for Ringing out a Late Discharge

Definition:

Any antenatal or postnatal of a woman and/or baby who are discharged from the hospital after 17.00 hours and require a visit from the community midwife the next day.

Guidelines:

- Ensure that the woman is aware how to contact a midwife in the case of emergency.
- Refer to the community midwifes rota sheet.
- Ring the midwife on call in the patient's team.
- If there is not a midwife on call in the patient's team ring a midwife from another team who is on call and she will pass on the information to the appropriate midwife the next day.
- Do not leave any discharges till the next day as a discharge may be missed.
- Write in the ward community discharge book the patient's name and whom the discharge has been given to.

Barnsley Hospital NHS Foundation Trust
Women's and Children's Services

Early Discharge Checklist

Information for N96 midwife

	Yes	No
❖ Mother and baby satisfy criteria for early discharge		
❖ Any pre-existing medical condition in the mother		
❖ Any abnormal ultra sound results		
❖ Any family history of: Developmental Dysplasia of the Hip		
Congenital Heart Defects		
Sibling abnormalities/medical conditions		
❖ Significant period of Malpresentation i.e. breech		

❖ **Comments**

……
……
……
……

Signature …… Date ……

Barnsley Hospital NHS
NHS Foundation Trust

MATERNITY UNIT

Transfer of Post Natal Mothers into Community Care at Midwives Discretion

Patient Name;	
Date of Birth;	
Unit Number;	
Address;	

CONFIRM DISCHARGE ADDRESS

Date of Transfer Home…….

Checklist:

1. Clinical observations must be within normal limits
2. the wound/perineum is satisfactory
3. all blood results are within normal limits
4. Full post natal examination of mother
5. Assess domestic arrangements and reconfirm the type of help the woman will have at home.
6. Discuss methods and availability of contraception
7. Give the mother an explanation of the follow up care provided by the community midwife, GP, health visitor and when she can expect this to happen
8. Advise the woman of the importance of 6 week post natal examination and arrange an appointment when necessary
9. TTO's when necessary
10. Record findings
11. Give necessary documentation to mother
12. Discuss 'Red book'
13. Register baby GP/Town hall
14. Healthy start

Signature…….....Print Name…….

Designation……..Date……..

Barnsley Hospital NHS Foundation Trust

The Postnatal Flow Chart

The postnatal period is the time following delivery during which time the pelvic organs return to their pre-pregnant state.
This is an important time; the midwife needs to care for a woman's psychological and physiological state.

The postnatal procedure group have devised a flow chart that will assist a midwife to use her skills of observation and assessment to provide holistic postnatal care.

It has been suggested that midwives spend a substantial amount of time undertaking traditional routine clinical observations and examinations that are not always necessary or evidence based. (Bick et al 2002)
For example:

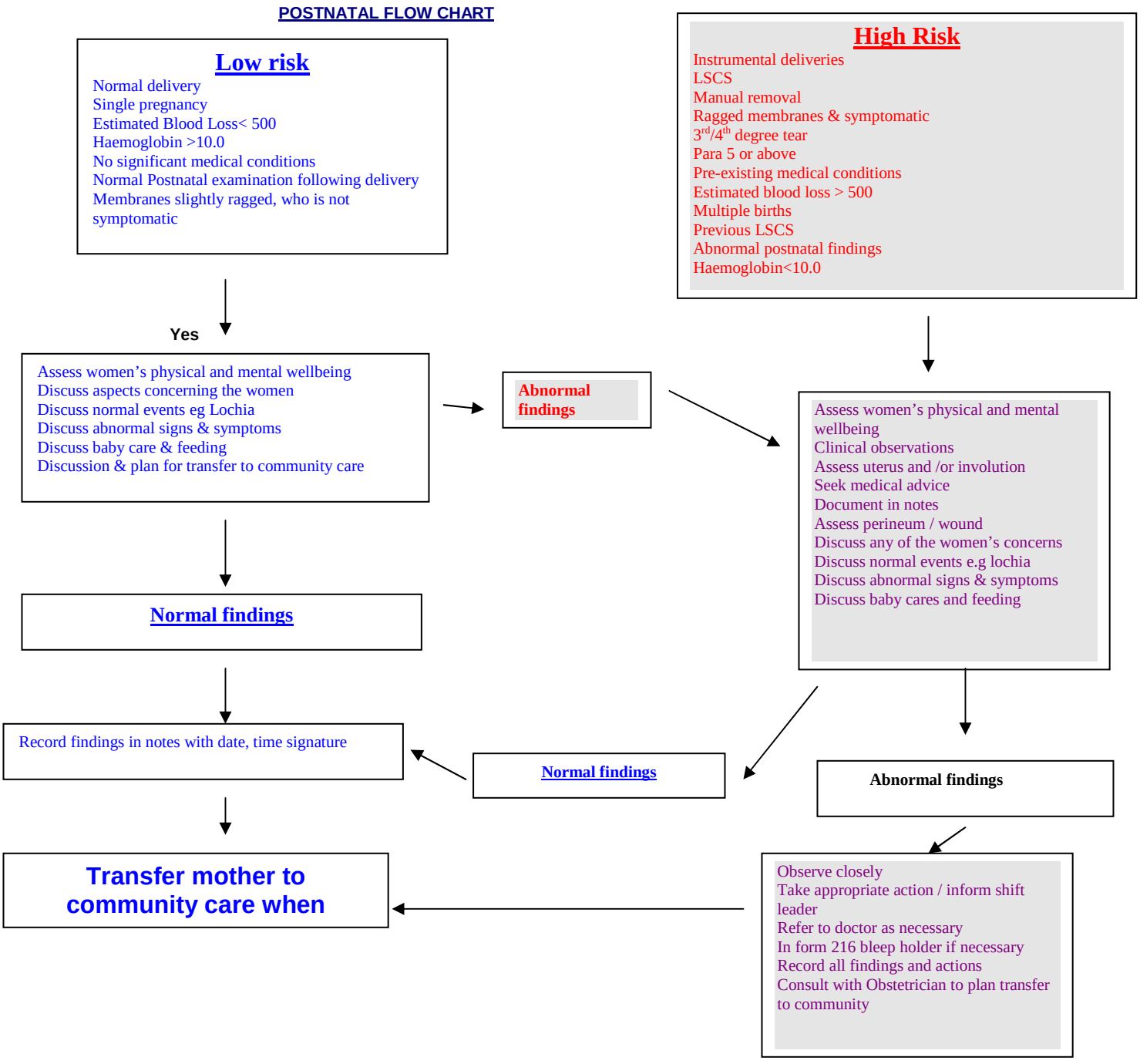
Fundal height assessment regarding involution
Assessment of lochia

Evidence that routine midwifery assessment of uterine involution and observation of lochia to prevent morbidity is inconclusive and may be of limited value. (BLIPP Study, Marchant et al 1999)

The flow chart represents a more informal approach to postnatal care, giving more time and opportunity for the woman to voice her concerns, whilst also empowering the midwife to practice individualised care.

For further information, please refer to:

Postnatal Care: Evidence and Guidelines for Management.
Bick et al (2002) Churchill Livingstone.
London


POSTNATAL FLOW CHART
Low risk
Normal delivery
Single pregnancy
Estimated Blood Loss< 500
Haemoglobin >10.0
No significant medical conditions
Normal Postnatal examination following delivery
Membranes slightly ragged, who is not symptomatic
High Risk
Instrumental deliveries
LSCS
Manual removal
Ragged membranes & symptomatic
3rd/4th degree tear
Para 5 or above
Pre-existing medical conditions
Estimated blood loss > 500
Multiple births
Previous LSCS
Abnormal postnatal findings
Haemoglobin<10.0
Yes
Assess women's physical and mental wellbeing
Discuss aspects concerning the women
Discuss normal events eg Lochia
Discuss abnormal signs & symptoms
Discuss baby care & feeding
Discussion & plan for transfer to community care
Abnormal findings
Assess women's physical and mental wellbeing
Clinical observations
Assess uterus and /or involution
Seek medical advice
Document in notes
Assess perineum / wound
Discuss any of the women's concerns
Discuss normal events e.g lochia
Discuss abnormal signs & symptoms
Discuss baby cares and feeding
Normal findings
Record findings in notes with date, time signature
Normal findings
Abnormal findings
Observe closely
Take appropriate action / inform shift leader
Refer to doctor as necessary
In form 216 bleep holder if necessary
Record all findings and actions
Consult with Obstetrician to plan transfer to community
Transfer mother to community care when

Guideline for Postnatal Care		Barnsley Hospital NHS NHS Foundation Trust	
Author: F Stead / G Jepson	Guideline group	Reference number:	
Issue Number 2	Maternity	Authorisation date: Reviewed: Next review date:	09/2009 06/2011 06/2014

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- Process for developing an individualised Postnatal Care Plan
- Process for giving information to parents to enable them to assess their newborns condition and respond to problems.
- Process for ensuring that the parents have contact details for relevant healthcare professionals
- Process for ensuring there is a coordinating healthcare professional
- System for postnatal visiting following hospital discharge
- Documentation of Postnatal Care.

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Appendix 1 – Obstetric Guideline Outline

Introduction

Rationale

The purpose of this guideline is to ensure:

- All women have an individualised postnatal care plan which is tailored to their needs
- Women are given the support, information and education needed to empower them to care for themselves and their newborn babies and to recognise signs of illness in their babies
- Women have the information to enable them to access health professionals if they have concerns regarding their baby's health
- A seamless transfer from hospital to community care

Scope

This guideline applies to all Healthcare Professionals involved in the delivery of postnatal care in the Maternity Unit and Community at BHNFT

Principles

To ensure all women and their babies receive indivdualised postnatal care that is evidence based and follows best practice guidance

Background

Postnatal care is about empowering women to care for themselves and their newborns in order to promote long term physical and emotional wellbeing.
The woman should be involved in the planning, timing and content of each postnatal care contact so that care is flexible and tailored to meet her needs. Postnatal care is undertaken in partnership with the woman and is offered not imposed upon her.

Communication is a cornerstone of good clinical practice. During the postnatal period women should have access to information that will enable then to safely care for their newborn infant. The healthcare professional has a "unique opportunity" to support women and their families during pregnancy and the postnatal period and therefore has a role to play in health education aimed at reducing infant mortality. The CESDI (1998) report's section on the Prevention of Sudden Unexpected Deaths in Infancy suggests that women should be "taught to recognise significant features of illness in babies and seek medical attention early if the baby is unwell

Guideline outline

Process for developing an individualised Postnatal Care Plan

For most women and their babies the postnatal period is uncomplicated and trouble free. Each woman should have a care plan which reflects her individual circumstances based on her physical, emotional, social and psychological needs. It should reflect her cultural and religious wishes. The plan should be developed in conjunction with the woman in the antenatal or immediate postnatal period

After delivery the woman is assessed to determine what her individual needs are. This will enable the midwife to formulate an immediate plan of care for the woman and her baby which will promote their well being and facilitate bonding.

This plan of care will be reviewed at each postnatal contact and documented in the postnatal records. The care plan as it evolves should empower the woman to care for herself and her baby by incorporating health education and promoting normality

Process for giving information to parents to enable them to assess their newborns condition and respond to problems.

At each postnatal visit parents are offered information and given advice regarding the normal parameters for their baby's health, social and behavioral capabilities. Parents are encouraged to be present at any physical examinations of the baby. The healthcare professional can use this opportunity to reiterate the features and behaviors of a normal healthy baby. This will enable parents to recognise any deviations from normal.

Parents can then identify the signs and symptoms of common health problems. They can then assess their baby's general condition and respond to problems by contacting a relevant healthcare professional or emergency service if required.

Parents should be given advice regarding the physical health and wellbeing of their baby's in relation to the following:

- Infant feeding
- Jaundice
- Skincare
- Thrush
- Constipation / Diahorrhea
- Colic
- Temperature control
- Safety: in the car and home
- Prevention of Sudden infant death syndrome
- Health promotion: Vitamin K, Newborn blood spot test, hearing screening, immunisation programme, benefits of attending child health clinics and support groups in the area.

All details of patient contacts and the information given and discussed should be recorded in the postnatal records.

Process for ensuring that the parents have contact details for relevant healthcare professionals

Parents will be given details on discharge of whom to contact when problems occur and how to access further review and treatment, including:

- The hospital telephone number with 24 hour access
- The telephone number of their Community Midwife
- The telephone number to register the birth
- Information on breastfeeding support

Parents will also be advised to contact their own GP if they have concerns and in an emergency dial 999 for an ambulance or bring the baby to the Emergency Department

Process for ensuring there is a coordinating healthcare professional

- On transfer to the ward the woman's care is delegated to a named midwife who is responsible for the delivery of care for the duration of her shift. Thereafter the woman will be allocated a midwife to care for her according to midwifery shift patterns. Wherever possible the woman will be allocated to the same midwife to facilitate continuity.

- The named midwife is responsible for the planning and delivery of care and documentation in the postnatal notes. Upon discharge from hospital the woman's named community midwife will assume responsibility for coordinating postnatal care. If the woman's own midwife is not available then another midwife from her team to take on the responsibility for care until she returns to work.

- The named midwife is responsible for coordinating care with other professionals where necessary.

- The Health Visitor will take over the role of coordinating healthcare professional upon discharge by the Community Midwife

Process for debriefing

- The woman should be offered time to discuss her birth experience and ask questions in the postnatal period. The opportunity should be offered at each postnatal visit, giving the woman the choice as to, if, when and with whom she discusses her experience. The woman's perception of her birth experience is a personal and dynamic process and should be reviewed in accordance with her own wishes not the healthcare professionals.

- There is provision for the women to reflect on her birth experience with a healthcare professional in the postnatal records.

- Following a traumatic birth the maternity staff and other healthcare professionals should support women who wish to talk about there experience, encourage them to make use of support from family and friends and consider the effect of the birth on the partner

System for postnatal visiting following hospital discharge

- Effective communication between healthcare professionals is paramount when transferring care from hospital to community.

- Hospital discharges are given daily to a nominated Community Midwife from each team. The discharges are then disseminated to the appropriate midwife within the team who will visit, usually the next day.

- Further post natal visits are negotiated between the woman and the midwife (i.e.) frequency, time and venue. The community Midwife can visit for no less than 10 days and no more then 28. The coordinating healthcare professional will then be the Health Visitor.

- The woman should be made aware of the timescales for the changes in healthcare provider and given relevant contact details

Documentation of postnatal care.

All interactions with the woman and her family should be recorded in the maternal / baby postnatal records. A management plan which includes full details of both the information discussed and the care given should be documented.

The management plan should include:

- Transfer of relevant information from the antenatal, intrapartum and immediate postnatal period.
- Assessment of risks to the mother and baby and the plan of care for the immediate postnatal period. This is reviewed and documented at each contact.
- Maternal observations to be recorded and frequency.
- The time of the first urine void and volume and a plan for bladder care.
- Details of the baby daily examinations, first feed and demonstrations of baby cares.
- Details of any member of the multidisciplinary team who needs to see the woman or baby and review dates.

Any information, discussions and advice given to parents to enable them to assess their newborn's general condition and identify signs and symptoms of common health problems to enable parents to respond to problems should be documented in the postnatal records.

Details of the relevant healthcare professionals, their roles and contact numbers regardless of the place of birth should be documented on the postnatal records and given to the parents.

The coordinating healthcare professional for women with multiagency or multidisciplinary needs should be documented in the postnatal records. For example women with mental health problems or child protection issues.

Equality Impact Assessment statement

Women's and Children's Services are committed to ensure that both current and potential service users and their families will not be discriminated against on the grounds of religion, gender, race, sexuality, age, disability, ethnic origin, social circumstance or background. The principles of tolerance, understanding and respect for others is central to what we believe and central to all care provided.

Audit / Monitoring

Postnatal care will be audited on an annual basis within the maternity unit. The results will be reviewed and presented to the multidisciplinary audit meeting. Any deficiencies will be actioned via the audit action plan to try and improve safety and learn from previous mistakes. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

Any adverse incidents relating to booking before postnatal care planning will be monitored via the incident reporting system. Any problems will be actioned via the case review and Root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety

Training

Any training will be given as documented in the Maternity Training Needs Analysis. This is updated on an annual basis.

Dissemination

A hard copy of this guideline will be available on the Postnatal Ward and in Community
An electronic copy will be available on the maternity intranet or via the Practice Facilitator Midwife

Review

This guideline will be reviewed within three years of authorization. It may be reviewed within this period if there are any reports, new evidence, guidelines or external standards suggesting that a guideline review is required

References

Clinical Negligence Scheme for Trust's (2009 / 10) Maternity Clinical Risk Management Standards. Standard 5. Criterion 9.

National institute for health and Clinical Excellence (2007) Postnatal Care

Perinatal Institute Postnatal notes – Version 8.1m, 8.1B

Nursing and Midwifery Council (2004). Standards for Records and Record Keeping

Glossary of Terms

BHNFT – Barnsley Hospital NHS Foundation Trust
CNST – Clinical Negligence Scheme for Trusts
NHS – National Health Service
NICE – National Institute for Health and Clinical Excellence
NMC – Nursing and Midwifery Council
MOEWS – Modified Obstetric Early Warning Score

Appendices

Appendix 1 – Obstetric Guideline Checklist

Appendix 1

Obstetric Guideline Checklist

Guideline for Postnatal Care Planning	**Lead Professional** Fiona Stead / Gill Jepson	**Review Date** 2014

Formatting	Included/attached
Headings	included
Quality Impact Statement	included
References	included

Consultation Process	Date Disseminated/Presented	Relevant information
Initial circulation to Guideline Group and relevant parties (draft 1)	03/09/09	
Amended draft sent to development lead		
Final Draft presented to Guideline Group for ratification	08/09/09	Ratified
Amended/final Draft presented to Women's Governance group for Ratification	14/09/09	Date ratified: 14/09/09

Archiving	Date of distribution	Date of retrieval of old guideline	Date of Archiving
Distribution and Retrieval			

Training Package devised	Date	
Training Package Delivered	Date	

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Audit Process			
Monitoring process			

Discharge Procedure
Children's Services

1. Introduction

Children and young people and their patients/carers must be the central focus and be involved with, the discharge planning process. Hospital stays should be kept to a minimum through the co-ordinated delivery of care. Integral to the successful discharge of patients is multi-professional team working. Planning for discharge should begin before admission for elective patients or as soon as possible afters admission for emergency patients.

2. Aims

The main aims of co-ordinated discharge are to ensure that: -

- Necessary health, therapy and social assessments are carried out prior to discharge, to ensure that support and facilities in the home setting are appropriate to the needs of the individual patients, or to inform the service of the most appropriate place of transfer for the patient.

- Children and young people and their patients/carers are aware of and involved with, discharge arrangements, follow up care and sources of contact if problems occur.

- The General Practitioner (GP) and community services are aware of the patient's needs.

- The recommendations sent out in the National Service Framework for Children, Young People and Maternity Services (2003) are met.

NB Particular care must be taken to ensure that continuity of care for all children and young people who are discharged to districts outside Barnsley is also maintained.

3. Arrangements for Discharge and After Care

On admission to hospital the nurse responsible for the child's care will attend to their immediate needs and commence the care planning process on the discharge checklist. This should take place as soon as possible or within 12 hours of admission. The care planning process includes initiating a discharge plan.

Relevant social aspects and services prior to admission will be documented, including details of agencies already involved in providing support. Any agencies involved with providing services for the child or young person must be notified of their admission, whether admitted to the ward or discharged home from the Children's Assessment Unit.

All children and young people have 24 hour access back to the unit, which may be extended by medical staff or over the weekend period. There is however no medical staff cover for ENT patients at the weekend so these patients should be referred direct to A&E. Children and young people who have plaster of paris insitu are also better advised to return to A&E.

Some children and young people are on an 'Open door' policy which enables fast tracking through A&E should they require further admission for the existing condition. When a child or young person is placed on the list (which is updated monthly) the parent/carer is given a letter from their consultant.

Hospital admission may have resulted in an unpleasant experience for the child or young person. To help in the reduction of stress and anxiety of further hospital admissions, the Hospital Play Specialist is available for home visits. This can be discussed prior to discharge.

4. Discharges From Neonatal Unit

All babies must be registered with a GP before discharge home.

All babies identified at risk must have a Children's Community Nurse Team referral.

All babies known to social services or where concerns have been raised about home circumstances or parenting skills must have a case conference with the Multidisciplinary Team before discharge.

All babies on home oxygen therapy must fulfil the discharge criteria before discharge.

All babies born at Barnsley District General Hospital but booked for delivery at a place other than Barnsley District General Hospital must be referred to the child protection team before discharge.

A community midwife referral must be completed for all babies and taken to the office on day of discharge, located outside ward 11.

If a baby has not had a routine hearing screen on the neonatal unit then an appointment must be made with the audiology department.

All babies who were breech presentations must be referred to specialist outpatient clinic for hip check.

For all babies identified as at risk from TB, a referral form from children's outpatients must be obtained for follow up.

Any baby requiring a 6 week ophthalmic check which is not done before discharge must have an outpatient's appointment made and given to patients/carers before discharge.

5. Assessments by Allied Health Professionals (Physiotherapy / Occupational Therapy / Dieticians)

Discharge assessments by allied health professionals should be arranged by the nurse responsible for the patient's care, as soon as the patient is fit for assessment.

NB An anticipated date of discharge for each patient will be determined by the multi-disciplinary team.

6. Other Arrangements

The nurse responsible for the child or young person's care will ensure that they and their parents/carers are fully involved in the planning of their discharge.

The nurse responsible for the child or young person's care will ensure that any take home medication is prescribed WELL before discharge.

When the patient is referred to the Children's Community Nursing Team or District Nursing Service, the nurse responsible for the child or young person's care should ensure that enough supplies (dressings, catheters, syringes etc) for seven days, are sent home with them.

The nurse responsible for the child or young person's care should ensure that their family take all property and valuables home on or before the day of discharge.

The day before discharge the nurse responsible for the child or young person's care must ensure that appropriate arrangements are made for their transport home.

7. Records

Throughout the discharge procedure staff should ensure that accurate, comprehensive records are maintained, in line with Trust and Professional standards.

All children and young people about who there are concerns of deliberate harm must have an identified GP on discharge. (Refer to Child Protection Package).

8. Discharge to Community Children's Nursing (CCN) Team

The CCN Team are based on ward 38 at BHNFT, the current service hours are Monday to Friday 08.30 – 17.00. There is no out of hours service. When a planned discharge from the children's ward or neonatal until necessitates the involvement of the CCN Team the appropriate referral form must be completed. This may be backed up by a telephone call to the office on ext. 2519.

If the referral is urgent then a phone call may in the first instance be made to the CCN Team followed up by a written referral.

An answer machine is in operation to leave contact names but no patients details must be left.

9. For Patients Referred to District Nursing Services

Children requiring wound checks or suture removal should be referred to the District Nursing Service and the parent/carer given the time of the clinic or visit. This should be recorded in the notes.

10. Discharges to Community Midwife

The community midwives can be contacted between 9-5 pm seven days a week.

The baby's midwife should be contacted direct on her mobile from the phone number lists. Refer to the Community Midwife Off Duty to know if they are working. If they are off duty, contact with another midwife in the team must be made.

All phone contact must be followed up with the completion of the community midwifery referrals form which should be taken to Ward 12 (Postnatal Ward). If a baby is to receive follow up by a Children's Community Nurses this should be detailed on the referral form.

11. Contacting the Midwife Out of Hours

The midwife on call, (is identified by a C on the off duty), her home number is on the phone number list. This should be followed up with a referral form as detailed above.

Midwives visit up to 28 days post delivery.

Confidential information must not be left on the mobile phone answering service.

NB. Ensure that any community nursing team is informed of any infection the child may have on discharge.

12. Doctors' Discharge Letters

A discharge form (D1) is completed by the medical staff responsible for the patient's care, this outlines all essential aspects of their admission and discharge including take home medication and follow up appointments which are planned.

1 x copy in hospital records
1 x copy to pharmacy
1 x copy to be sent home with patient
1 x copy to the GP

A more detailed discharge letter is routinely sent to the GP within two weeks and a copy is kept in the patient's medical records.

13. Discharge Against Medical Advice

When a parent or carer wishes to discharge their child against medical advice, a member of the medical team responsible for the patient's care or the on call doctor must be notified and should explain to the parent or carer the risks of refusing to remain in

hospital. If the parent carer still chooses to leave the hospital they should be asked to sign a *Discharge Against Medical Advice* Form.

1 x copy should be retained in the patient's medical records.

If the patients/carer refuses to sign the form:

- A record of refusal should be made in the child's medical records.

- The child's GP should be notified by phone and a detailed letter sent by the medical staff.

- If appropriate other agencies (Police, Child Protection Team, Social Worker, Community Children's Nursing Team), should be notified by the nurse responsible for the patient's care as soon as possible.

- An IR1 incident form should be completed.

Barnsley Hospital NHS
NHS Foundation Trust

Transfer Procedure

Women's and Children's Services

Transfer of Children to Another Hospital Unit/ Ward

Transfer of Neonates to another Neonatal Unit/Ward

Guideline for Admission to the Neonatal Unit

Transfer of Children to a Regional Paediatric Intensive Care Unit

Transfer of children to another hospitals for investigation

Transfer of Children to another Hospital unit/ward

There are occasions that due to clinical need a baby/child requires transfer to another hospital unit for on going care. It is essential that this process is carried out smoothly to ensure safe care of the child.

Transfer of Neonates to another neonatal unit/ward

Guideline for clinical or non-clinical transfers when the Neonatal Unit is full to capacity.

The Neonatal Unit at BHNFT is funded, staffed and equipped for 14 cots,

2 Neonatal Intensive Care Level 1
3 High Dependency Care, Level 2
9 Special Care

When the unit is running at full capacity it is important that contingency plans are put into action to maintain the safety of the unit and maintain the highest standards of clinical care.

- Assess the levels of care of each neonate on the unit, along with available nursing staff, skill mix, available equipment and environmental conditions such as space on the unit.

- Liaise with the Ward Manager/Senior Neonatal Nurse, Consultant Paediatrician on duty and Registrar, to assess the most appropriate neonates for transfer.

- If the transfer is needed for an Intensive Care cot the Paediatric Registrar, in liaison with the Ward Manager/Senior Neonatal Nurse and Consultant will determine the neonate most appropriate for transfer.

- Contact the Bed Manager, (bleep 395) if within normal working hours. If outside of normal working hours inform the Duty Manager on Bleep 219 to ascertain the nearest intensive care cot. Also request the 219-bleep holder for assistance regarding extra staff if this is appropriate. Ensure Labour Suite, Antenatal Unit and Ward 12 is aware that the unit is full and that they should follow their protocols as necessary such as in-utero transfers as appropriate.

- Contact the Transport Team at:

- Jessop's Wing, Sheffield if within the daytime period 08.00 – 22.00.

Contact number: 0114-226-1029 or
0114-271-1900 bleep 947

- If the team is able to provide transport the neonatal unit staff will ensure all transfer forms are completed and notes are photocopied in preparation for handover when the team arrives

- If the Transport Team is unavailable the nurse in charge will delegate a member of staff to transfer the neonate. Medical support may also be required for instance if the baby requires any form of respiratory support. The consultant in charge will be contacted and provide cover for the absent doctor within the hospital for the duration of the transfer. The delegated nurse will be responsible for checking the equipment and transport incubator and make the appropriate arrangements with ambulance control and the receiving hospital.

- Any transfer of neonates should be followed by the completion of an IR1 form and inform the relevant managers; General Manager, Head of Midwifery, Labour Suite Co-Coordinator and Matron for Children's Services. Complete all relevant nursing and medical records.

- It is vital that the parents of transferring infants are informed of the transfer of their infant as soon as possible with an explanation of the current position.

- All neonates who are transferred to either ward 37 or the postnatal ward must have a completed plan of care, discharge sheet, medication instructions and any follow up appointments clearly noted. Transfer letters will accompany all babies who are transferred out to other units

- Communication between the two areas must be maintained.

- The capacity of the unit should be assessed on a regular basis and contingency plans executed as and when necessary. The senior neonatal nurse on the unit will communicate with the delivery suite and the maternity ward regarding the potential for any problematic pregnancies/labours. The Neonatal Registrar will contact the Obstetric Registrar immediately the unit becomes full to capacity and explain the need to transfer problematic pregnancies in-utero whenever possible. Obstetric and Paediatric Consultants shall be informed/involved as appropriate.

Transfer of Children to a Regional Paediatric Intensive Care Unit

As a General Hospital, Barnsley has the facility to care for children who require High Dependency Care. Those children who require Intensive care have to be transferred to a regional PICU following initial resuscitation and stabilization for further acute or long term medical management.

- Retrieval is usually from the paediatric HDU cubicle in the adult ICU. Occasionally, retrieval may be from the paediatric resuscitation bay in the Emergency Department or the paediatric ward.
- The child's condition is discussed with the regional PICU (Our lead tertiary PICU is at Sheffield Children's Hospital) to check availability of a PICU bed and to discuss any specific management issues pending the arrival of the retrieval team.
- Joint management by the Barnsley Hospital and the transport team EMBRACE should commence immediately, since successful initial resuscitation and stabilisation is crucial to the child's ultimate outcome.
- Occasionally, transport maybe undertaken by the Paediatric medical team and/or anaesthetic team.

Key information required prior to discussion with the PICU will include the following

- Child's details:
  - Name, Age, and date of birth
  - weight
- Summary of the medical problem and assessment:
  - History,
  - Examination,
  - Diagnosis
- Investigations and any available results including radiographs etc
- Clinical progress and current condition:
  - Airway,
  - Breathing,
  - Circulation,
  - Disability (neurological assessment)
- Treatment:
  - All drugs given: time and route of administration
  - Fluid chart,
  - Ventilator settings
- Parents:
  - Discussion with parents, Maternal blood (if relevant)
  - Consent form completed (if not accompanying the child)

- A copy of the child's current medical notes and a referral letter should accompany the patient. It is also important to keep a copy of the referral letter in the patient's notes and also a copy is sent to the GP. Ideally the paediatric team should also ring the GP to inform them of any child needing retrieval / transfer to tertiary centre for serious illness / diagnosis.

- If the parents do not have their own transport then this must be booked through hospital transport as there is no room in the retrieval team ambulance for any accompanying parent

Transfer of children to another hospitals for investigation

Transfer of children for investigations to other hospitals may necessitate a qualified paediatric nurse escort. (All inpatients requiring EEG investigations at the Royal Hallamshire must have a qualified paediatric nurse escort as there are no paediatric facilities on site.)

Children who require oxygen therapy or are at risk of seizure should be transported to other hospital departments in a paramedic ambulance.

Parents may accompany their child on transfers

Guideline for Admission to the Neonatal Unit		Barnsley Hospital NHS NHS Foundation Trust
Author: Sharon Rimmington	Guideline group	Reference number: 1
Issue Number 2		Authorisation : 09/09 Reviewed: 06/11 Review date: 06/14

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Introduction

Rationale

To ensure the early recognition of a sick newborn infant and a safe and timely transfer to the Neonatal Intensive Care Unit (NICU)

Scope

This document offers guidance for all staff working on the Maternity Unit and in Community for the safe and appropriate transfer of the sick neonate to the Neonatal Intensive Care Unit.

Principles

To ensure that evidence based information and best practice guidance is available for all staff involved in caring for neonates and their families.

Background

A certain proportion of newborn infants will need referral to the Neonatal Intensive Care Unit for specialist medical treatment and continuing specialist care. This cannot always be anticipated, but the risks can be reduced if robust evidence based arrangements for transfers are in place. All women and their babies will have equitable access to specialist services and can be transferred by ambulance should any complications or emergencies arise

Guideline Outline

Criteria for the transfer of a sick neonate to the Neonatal Intensive Care Unit

The Maternity Unit promotes and encourages a “rooming in” policy, whereby all healthy babies are nursed at the mother’s bedside and separation is minimal. This encourages mother / infant bonding and helps to promote breast feeding. However there are some circumstances when babies need to be transferred to a unit where they can receive specialist care from suitably trained health care professionals.

The following conditions requiring special / intensive care would facilitate transfer to the Neonatal Intensive Care Unit:

- Extremely low birth weight babies <1500g
- Premature babies <35 weeks gestation
- Babies requiring oxygen therapy / respiratory support

- Babies requiring complex / invasive procedures i.e. Intravenous therapy, intense feeding support, lumber puncture, exchange transfusion

- Babies requiring treatment for neonatal abstinence syndrome
- Hypoglycaemia – as per neonatal hypoglycaemia policy
- Hypothermia – if not correctable at ward level
- Neonatal jaundice – if the baby requires more then double phototherapy and / or fluid management
- Neonatal infection – other than treatment for Group B Haemolytic Streptococcus in an otherwise well baby
- Poor feeding pattern – requiring supplementation via a naso - gastric tube
- Babies requiring closer monitoring than can be safely provided on the Postnatal Ward, including babies with abnormalities
- Babies requiring prolonged resuscitation
- Babies with indentified surgical and cardiac problems

<u>Arrangements for the transportation of a sick newborn to the NICU from the Labour or Postnatal Ward</u>

Transfer of a baby from the Labour Ward to the NICU

- The baby will be reviewed by the on call Paediatric doctors prior to transfer.

- The need to transfer the infant to the NICU is identified and the mother / father informed. Wherever possible the father/ birth partner will accompany the baby to the NICU

- Each infant will be assessed according to its needs and a plan of care for transfer agreed between the Paediatric and Midwifery staff

- The doctor or midwife will contact the NICU to inform them of the transfer and condition of the baby. NICU staff can then prepare to receive the baby onto the department. If the baby is severely compromised and / or unstable NICU staff may assist in the transfer.

- The baby must have identity bracelets in place. If the baby is too small or fragile to have identity bands in situ they must be placed in close proximity to the baby during the transportation process.

- The baby will be transferred on the Resuscitaire depending on the clinical condition.

- The Midwife / Paediatric Registrar will to accompany the baby to the neonatal unit and provide a full, detailed handover to the neonatal staff using the SBAR communication tool as stipulated in the Guideline for the Handover of care.

- A full and comprehensive written account will be documented in the baby notes as soon as possible. Any contemporaneous records will also be placed in the baby's notes. The baby notes will be taken to the NICU as soon as is reasonably possible. NICU staff will need a hospital number for baby as a matter of urgency. This can be obtained via main reception prior to generating delivery documentation.

- Labour Ward staff will inform the Postnatal Ward of baby's admission to the NICU prior to transferring the mother. Provisions can be made to nurse the mother in a cubical if one is available.

- The mother will be allowed to visit her baby on the NICU as soon as possible depending on her condition. Where applicable the baby's father will be allowed to visit the baby on the NICU. Each case will be assessed according to the medical needs of the mother and baby and their individual family dynamics

Transfer of a baby from the Postnatal Ward to NICU

- The need to transfer an infant from the postnatal ward to the neonatal unit may be identified by the midwife or the doctor. The Paediatric SHO will discuss the decision to transfer with the Paediatric Registrar. A transfer plan will be agreed and documented in the notes

- The need for transfer and plan of care will be discussed with the mother and her family. Wherever possible the baby's parents will accompany the baby to the NICU. If this is not possible arrangements will be made for the parents to visit as soon as the baby is stable

- The Paediatric doctor will inform the NICU of the impending transfer with a brief outline of the baby's condition.

- The baby is transferred on a Resuscitaire accompanied by the midwife and where necessary the Paediatrician and NICU team.

- The baby must have two name bracelets are in place. The security tag must be removed before leaving the ward area.

- The SCBU handover sheet will be completed by the midwife.
  The mother's case notes, baby notes, observations chart, medication chart, medication and handover sheet must accompany the baby to the NICU

- The Midwife will accompany the baby to the neonatal unit and provide a full, detailed handover to the neonatal staff, including any safeguarding issues, using the SBAR communication tool as stipulated in the Guideline for the Handover of care.

<u>Arrangements for the transportation of a sick newborn to hospital from home</u>

Local agreements are required to ensure the timely transfer of women and their babies to hospital with the appropriate personnel. In conjunction with the Yorkshire Ambulance service policies this guideline provides a standardised approach to maternal /neonatal transfers.

Rotherham NHS Foundation Trust and Barnsley Hospital Foundation Trust – The Consortium have a service agreement with Yorkshire Ambulance Services for patient transport services. The Yorkshire Ambulance Service Organisation Wide policy for the Management of the

Conveyance of Patients to a Healthcare Facility describes the services and standards to be provided in the transport of patients by ambulance into hospital from home. The transport of neonatal and obstetric patients is documented in the Yorkshire Ambulance Service Inter-facility Transfer Policy. The parameters for transfer are outlined in the Yorkshire Ambulance service procedure for the Management of Obstetric and Gynaecological Emergencies

Process for Transfer:

The Community Midwife will request an ambulance by dialling 999 in an emergency situation. The ambulance crew will assess the baby and consult with the midwife to determine if transfer is required.

- The midwife would confer with the Labour Ward Shift Leader and determine the optimum destination for the baby (i.e.) NICU, Labour Ward.
- The Labour Ward Shift Leader will contact the on call Paediatrician and NICU team to arrange a reception point for the baby (i.e.) Main Reception, Emergency Department, or Labour Ward. The healthcare professionals needed to assess and deliver care would be assembled at this point.
- The Community Midwife will accompany the mother and baby to hospital and assist in the care of the baby during transfer
- The Community Midwife will provide a detailed handover to the receiving midwifery and paediatric staff and record a comprehensive account of events on the partogram and in the baby records.
- The Paramedic / Technician crew will give a verbal handover to the receiving member of staff where appropriate. This will be followed by a written Yorkshire Ambulance Patient Report Form (PRF) including all relevant clinical and assessment information.
- The hospital staff will file this record in the notes and document all the information given to them by the ambulance crew in the records.

<u>Process for sharing information between the maternity and neonatal units regarding daily activity</u>

The Labour Ward shift leader will liaise with staff on NICU on a daily basis or when indicated to:

- Ascertain the available number of cots (intensive or otherwise) and capacity to accept new admissions
- Communicate high risk pregnancies on the maternity unit and potential admissions
- Inform of imminent pre term deliveries where neonatal staff may be required to attend
- Discuss the potential transfer of women in pre term labour from other hospitals
- Inform staff of any impeding closure of the maternity unit

The NICU staff will inform the staff on the Labour Ward of:

- Any impending closure of the unit

The NICU staff will inform the Postnatal Ward of:

- Any transfers back to the ward area
- Any transfers to another hospital
- Any discharges from the unit home

Process for reporting and learning lessons from anticipated admissions to NICU / SCBU

All admissions to the NICU will generate the completion of the Trust's Accident / Incident (IR1) reporting form. An investigation / case review is undertaken to investigate if the correct management of the woman and her baby has been undertaken following the Maternity Unit's evidence based guidelines and protocols. Where errors have occurred the systems of work are reviewed and changes made to policies and procedures, as appropriate by the lead practitioner for the area where the errors occurred. This is monitored via the case review action plans that are completed by the ward managers on a monthly basis. Cases are discussed at the weekly and monthly risk management meetings to address issues arising quickly. The trend analysis for each area is reported on a quarterly basis to the Women's and Paediatric Governance Meetings.

Roles and Responsibilities

Midwives have a responsibility to:

- Be aware of the parameters for wellbeing and normal behaviour in a newborn infant
- Diligently carry out assessments of newborn infants and report any deviations from the norm to the paediatric doctors
- Carry out emergency procedures on a sick newborn infant and request support from paediatric staff
- Jointly develop a plan of transfer for a sick infant to the NICU
- Communicate with all other healthcare professionals to ensure the smooth and timely transfer of the infant
- Offer support and advice to the parents and facilitate visiting to NICU at the earliest possible time
- Provide a verbal and written handover of care

- Maintain competencies in Neonatal Resuscitation and attend any training regarding newborn wellbeing

Paediatric Doctors have a responsibility to:

- Respond in a timely fashion when asked to review a sick newborn infant
- Carry out emergency procedures on a sick newborn and arrange transfer to NICU once stable
- Communicate with all other healthcare professionals to ensure the smooth and timely transfer of the infant
- Offer support and advice to parents
- Undertake any training appropriate to the post

NICU staff have a responsibility to:

- Prepare for the admission of a sick newborn infant
- Be in attendance at a delivery of a compromised baby or attend the resuscitation of a compromised baby
- Communicate with all other healthcare professionals to ensure the smooth and timely transfer of the infant
- Offer support and advice to parents
- Undertake any training appropriate to the post and maintain competencies required

Health care Assistants / Auxiliary nurses have a responsibility to:

- Report any concerns they may have regarding a baby's wellbeing to midwifery staff
- Provide support to the resuscitation team during the resuscitation of a compromised infant. This can include; calling for assistance; scribing; fetching equipment; reassuring parents
- Ensure all doors are open and lifts available to facilitate the smooth transfer of the infant to the NICU
- Attending appropriate training in neonatal resuscitation

Equality Impact Assessment

Women's and Children's Services are committed to ensure that both current and potential service users and their families will not be discriminated against on the grounds of religion, gender, race, sexuality, age, disability, ethnic origin, social circumstance or background. The principles of tolerance, understanding and respect for others is central to what we believe and central to all care provided.

Audit / Monitoring

Admissions to NICU / SCBU will be audited on an annual basis. The results will be reviewed and presented to the multidisciplinary audit meeting. Any deficiencies will be actioned via the audit action plan to try and improve safety and learn from previous mistakes. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

Any adverse incidents relating to antenatal screening will be monitored via the incident reporting system. Any problems will be actioned via the case review and Root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety

Consultation Process

Those listed have been consulted and comments / actions incorporated as required.

B Glymond - Ward Manager (postnatal)
S. Rimmington – Midwife (postnatal ward)
G. Jepson - Practice Facilitator Midwife
Judith Sands – Sister in Charge (NICU)
A Ward – Matron for Labour Ward and Inpatient Services
BHNFT Maternity Services Guideline Group

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Training

Training will be given as documented in the Maternity Training Needs Analysis. This is updated on an annual basis.

Dissemination and Access

A hard copy of this guideline is available on the Postnatal Ward, Labour Ward and in Community. An electronic copy of the guideline is available on the Maternity Intranet or via the Practice Facilitator Midwife

Review Process

This guideline will be reviewed in 3 years from the date of issue by the Maternity Services Guideline Group. It will be reviewed within this period if there are any new reports, evidence or external guidance to suggest a change in practice.

Glossary of Terms

BHNFT	Barnsley Hospital NHS Foundation trust
NHS	National health Service
NICU	Neonatal Intensive Care Unit

PRF	Patient Report Form
SHO	Senior House Officer

Obstetric Guideline Checklist

Guideline for Admission to the Neonatal Unit	**Lead Professional** Sharon Rimmington / Gill Jepson	**Review Date** 2014

Formatting	Included/attached
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Delivered		

Audit/ Monitoring	Method	Date Commenced	Date Completed
Audit Process			
Monitoring process			

Appendix 4

Transfer Procedure

Women's and Children's Services

Guideline for In-utero transfer

Guideline for the Transfer of women by ambulance / maternal transfer to HDU/ITU

IN-UTERO TRANSFER GUIDELINE		Barnsley Hospital NHS NHS Foundation Trust	
Author:	Guideline group		
Issue Number	3	Authorisation date: Reviewed: Next review date:	11/04 12/09 12/12

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Introduction

Rationale

- To ensure the efficient in-utero transfer to another hospital
- To ensure that the decision to transfer is made by the appropriate Healthcare Professional to the appropriate receiving Healthcare Professional using conference calls

Scope

This guidance applies to all Healthcare Professionals working on the Maternity Unit at BHNFT who are required to arrange an in-utero transfer for the following reasons:

- Clinical Transfer – one that occurs due to the prematurity or condition of the fetus requiring specialised care at another hospital. (Our Neonatal Intensive Care Unit can accommodate infants of 26 weeks gestation and above.)
- Non-clinical transfer – one that occurs due to shortage of cots or staff

Principles

Staff working on the Maternity Unit at BHNFT adopt a consistent approach to in-utero transfers which is in line with best practice recommendations.

Background

"Embrace" (Yorkshire and Humber infant and Children's Transport Service) has been designed to provide neonatal and paediatric transfers for Yorkshire and the Humber. In addition it will function as a perinatal and paediatric bed / cot bureau.

Guideline Outline

The decision for in-utero transfer will be made by the Consultant Obstetrician in conjunction with the Consultant Paediatrician.

Arrangements for transfer

- The Labour Ward Registrar will consult the Labour Ward Shift Leader and the Obstetric Consultant on call for Labour Ward. The Consultant must be involved in the referral process
- When a decision has been made for an in-utero transfer (in accordance with the BAPM document "Management of acute in – utero transfers: a framework for practice") the Shift Leader will contact the Yorkshire and Humber Infant and Children's Transport Service (Embrace) on 0845 147 247 2
- Embrace will inform the Shift Leader of the nearest available cot / bed
- Embrace will arrange a conference call between clinicians (preferably Consultant to Consultant) to exchange information
- The Shift Leader is responsible for arranging appropriate transport and escort for the woman to the agreed unit
- The Registrar will complete a transfer letter giving detailed obstetric history and rationale for transfer
- The Midwife / Registrar will explain the reason for transfer and arrangements with the woman
- The Midwife will arrange for the relevant records to be photocopied to accompany the woman
- Before transfer the referring doctor should be sure there is minimal risk of delivery or maternal or fetal compromise in the ambulance

Transfer Management

- The referring unit is responsible for safe, efficient and rapid transfer
- Cervical assessment should be performed immediately prior to transfer if the woman is in labour (digitally or by transvaginal ultrasound)
- Tocolysis will usually be used for the duration of the transfer to delay delivery and ensure safe transfer. The efficicacy of the tocolysis should be assessed prior to transfer i.e. evidence of complete cessation of uterine activity for at least an hour with no cervical changes over this time
- The midwife will arrange transport and midwifery / obstetric escort for the patient **(If an obstetric escort is required then the Obstetric Consultant should be involved in the**

decision to transfer process. It may be necessary to delay the transfer until the woman is stable)

- No Paediatric presence is indicated. If delivery is that likely then transfer would be inappropriate
- The midwife will collect a Sonicaid / Pinnard to auscultate the fetal heart rate at intervals during the transfer. Any recordings must be documented in the midwifery records
- The midwife will take the emergency delivery bag

Communication

- 216 / 219 bleep holder must be informed

At the earliest opportunity during working hours:

- An IRI form must be completed
- The Head of Midwifery and General Manager must be informed
- The Shift Leader must communicate on a daily basis regarding the status of the woman / delivery and update the IRI form

NB. In - utero transfer INTO the unit should be reported to the Labour Ward Co-ordinator / Matron and an IRI form completed.

Equality Impact Assessment statement

Women's and Children's Services are committed to ensure that both current and potential service users and their families will not be discriminated against on the grounds of religion, gender, race, sexuality, age, disability, ethnic origin, social circumstance or background. The principles of tolerance, understanding and respect for others are central to what we believe and central to all care provided.

Roles and Responsibilities

All staff working on the maternity unit at Barnsley Hospital are responsible for ensuring this guideline is followed

Dissemination and Access

This guideline is available as part of the Labour Ward Handbook. A hard copy can be found on Labour Ward. An electronic copy can be found on the Intranet or via the Practice Facilitator Midwife

Review

This guideline will be reviewed within three years of authorization. It may be reviewed within this period if there are any reports, new evidence, guidelines or external standards suggesting that a guideline review is required

References

Embrace. Yorkshire and Humber infant and Children's Transport Service. Unit 7, Capitol Close. Capitol Business Park. Barnsley. S75 3 UB

British Association of Perinatal Medicine. Management of acute in-utero transfers: a framework for practice. A Fenton, D Peebles, J Ahulwalia. June 2008

Glossary of Terms

BAPM – British Association of Perinatal Medicine
BHNFT – Barnsley Hospital NHS Foundation Trust
IR1 – Trust Incident / Accident reporting form
NHS – National Health Service

Transfer Procedure

Women's and Children's Services

Guideline for the Transfer of Women by Ambulance/Maternal Transfer to HDU/ITU

Guideline for maternal transfer by ambulance		Barnsley Hospital NHS NHS Foundation Trust	
Author: J. Rear-Barton	Guideline group Maternity Guideline Group	Reference number:	1
Issue Number 2		Authorisation date: Reviewed: Next review date:	08/011 08/11 08/14

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Guideline Outline:

- A consistent approach to the documentation of the transfer of care.
- Local agreements with ambulance service in emergencies or when transfer is required.
- Documentation requirements of each staff group when transferring women to labour Ward HDU / ITU
- Documentation requirements of each staff group when transferring women into hospital during the antenatal and postnatal period.
- Documentation requirements of each staff group when transferring during the intrapartum period.

Audit/ Monitoring

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Guideline Checklist.

Introduction

Rationale

This guideline describes the process for ensuring that there is an effective system in place for the safe transfer of women by ambulance.

Scope**.**

This guideline applies to all staff working within Barnsley Hospital who are involved in the transfer of Obstetric patients to Labour Ward HDU or ITU.

Background

A clear organisational structure for midwives and medical staff is crucial to the effectiveness of the multidisciplinary team. Explicit and transparent lines of communication are crucial, to ensure the optimum care for women and their babies during the transfer into hospital or to the Labour Ward HDU / ITU.

Guideline Outline

Local agreements with ambulance service in emergencies or when transfer is required.

Local agreements are required to ensure the timely transfer of women with the appropriate personnel. In conjunction with the Yorkshire Ambulance service policies this guideline provides a standardised approach to maternal transfers.

Rotherham NHS Foundation Trust and Barnsley Hospital Foundation Trust – The Consortium have a service agreement with Yorkshire Ambulance Services for Non-emergency patient transport services. This document describes the services and standards to be provided in the transport of patients by ambulance into hospital from home and between hospitals.

Yorkshire Ambulance Services have been consulted in the formation of this guideline. The documentation will work in conjunction with the Yorkshire Ambulance Service Guidelines:

- Inter-facility Transfer Policy (2008)
- Management of the conveyance of patients to a healthcare facility (2009)
- The Organisation Policy on Obstetric Care (2009).

All medical directors of acute trusts in Yorkshire were involved in the formulation of theYorkshire Ambulance Service policies mentioned above.

Other departments within the hospital e.g. the Emergency Department have been consulted in the formulation of this guideline

A consistent approach to the documentation of the transfer of care.

Breakdowns in verbal and written communication between healthcare providers are a major concern in the delivery of care. Suboptimal communication is not only a common occurrence but is also associated with untoward events. The Unit has adopted the SBAR communication tool to try and address these issues with a systematic approach.

SBAR can be applied to both written and verbal communication. The following SBAR steps will be used to communicate issues, problems or opportunities for improvement to co-workers, managers or medical staff:

Situation – State what is happening at the present time that has warranted the communication.

Background – Explain the circumstances leading up to the situation. Put the situation into context for the reader / listener.

Assessment – What do you think the problem is?

Recommendations – What do you do to correct the problem?

A system of clear verbal and written communication should be adopted which reflects the SBAR method of communication.

Documentation requirements of each staff group when transferring women to HDU / ITU

The high dependency care unit is situated on the labour ward within the maternity unit of a district hospital. The ITU is situated within the hospital therefore the majority of transfers are internal transfers. Referrals of Obstetric women to HDU / ITU are via the labour ward or the Emergency Department.

When maternal transfers to a Unit in another hospital are required, the ambulance crew will assist with the transfer and they will complete a standard Patient Report Form detailing the transfer. However the main documentation in this instance would be completed by the midwives and medical staff in the patient's records. Photocopies of the full records would be made to take with the woman to the external unit.

All documentation must follow the Trust Standards for Record keeping and the Maternity Records Management guideline. The requirements for each staff group are as follows

Midwives / ED Nurse:

- To complete the early warning score chart or appropriate observations to detect deterioration in the woman's condition appropriately and highlight when referral is needed.
- To document what has triggered the need for transfer in the records.
- To document in the woman's records (the ED chart or case notes) `the background information, the problem occurring at the time and why medical referral is required.
- To document the date and time medical staff are contacted to review the woman.
- To document in the records the action / plan of care to be taken after medical review.
- To ensure that all results of investigations are documented in the records.
- To ensure that all medication has been signed for in the drug chart.

Medical Staff (Obstetricians, Anaesthetists and ED Consultants):

- To document in the records the previous history, any underlying problems and background information
- To document what has triggered the referral.
- To document the assessment of the woman.
- To document what the diagnosis is.
- To document the date and time that Consultant discussions / referral to Consultant care occurred.
- To document in the records the plan of care
- To document any investigations or tests required and the date and time results have been reviewed.
- To document in the records what treatment / medication has been prescribed.
- To document any multidisciplinary reviews and the outcomes that take place.

Documentation requirements of each staff group when transferring women into hospital during the antenatal period and postnatal period.

Women can be transferred into hospital via ambulance through two routes:

a. By contacting labour ward with a problem and asking for an ambulance to bring them into hospital. The staff on labour ward would then arrange ambulance transfer into labour ward. Based on the information given a community midwife may be sent out to the woman in addition to a paramedic / technician crew. For example if it is thought that the woman will deliver shortly.

b. By dialing 999 in an emergency situation. The ambulance crew will assess the woman and determine if transfer is required. They would contact labour ward and inform them of their impending arrival. In a situation such as a road traffic accident they would transfer the woman to the Emergency Department. They would follow the guideline for referral for a woman admitted via the ED.

Ambulance Crew

The paramedic / technician crew will document the date and time of arrival at the scene and undertake set of standard observations and gain any previous maternal history. The crew will give a verbal handover to the receiving member of staff. This will be followed by a written Yorkshire Ambulance Patient Report Form (PRF) including all relevant clinical and assessment information.

The hospital staff will file this record in the notes and document all the information given to them by the ambulance crew in the records.

Community Midwives

The community midwife, if sent out, will undertake an assessment of the woman documenting:

- Details of the incident which requires admission
- The background history, the current situation and a clinical assessment.
- This may include a full set of clinical observations, estimation of blood loss, uterine tenderness, fundal height, vaginal examination and estimation of any neurological signs such as headaches or blurred vision.
- She must document the date and time she was called out
- Date and time of arrival on the scene.
- If transfer is required the community midwife will escort the woman in the ambulance and inform labour ward of the transfer. She will document the date and time of departure from the scene.
- Any actions taken during transfer
- Date and time of arrival into hospital.

She will record all her findings on a history sheet as a contemporaneous record of events. This will be filed in the woman's notes on admission to labour ward. A full verbal handover will be given incorporating SBAR.

Emergency Department staff will complete their ED admission form and document the situation, previous history and background, the clinical assessment and diagnosis. They will document referral to obstetric and other medical / surgical teams. A plan of care will be documented including any action to be taken prior to the woman being transferred to the appropriate ward. A full verbal handover will be given incorporating SBAR.

If the woman is transferred from one hospital to another the midwife transferring will record the following:

- Details of the incident which requires transfer
- The background history, the current situation and a clinical assessment.
- This may include a full set of clinical observations, estimation of blood loss, uterine tenderness, fundal height, vaginal examination and estimation of any neurological signs such as headaches or blurred vision
- Date and time of arrival of ambulance and time set off.
- Any actions taken during transfer
- Date and time of arrival into hospital.

Documentation requirements of each staff group when transferring during the intrapartum period.

The Midwifery Led Care unit is situated on the end of the consultant led labour ward within the hospital. Therefore external transfer by ambulance during labour is not required if they are in labour on this area. Women are transferred by walking across the corridor or they are pushed in a trolley / wheelchair to the labour ward area.

Intrapartum transfers by ambulance are needed if complications occur during a home confinement, or if the woman requires further pain relief. The community midwife will escort the woman into hospital in the ambulance.

The community midwife will record in the partogram – the date and time she was called out to the home delivery and the time she arrived to take over care; the progress in labour and clinical observations, analgesia given and events occurring during the home confinement as per our maternity documentation standards. She must also document:

- The plan of care and background information.
- The reason for transfer into hospital.
- The date and time she contacted the labour ward shift leader to inform them of the problem and impending transfer.
- The date and time ambulance control was contacted to arrange transfer.
- The date and time the ambulance crew arrived and any other preparations for transfer.
- Date and time of departure from the scene.
- Any actions taken during transfer
- Date and time of arrival into hospital.

The community midwife will give a verbal handover also incorporating SBAR.

The partogram will be maintained by the hospital staff once the woman arrives on labour ward for assessment and further management plan.

Audit/ Monitoring

Maternal transfer by ambulance will be audited on an annual basis. The results will be reviewed and presented to the multidisciplinary audit meeting. Any deficiencies will be actioned via the audit action plan to try and improve safety and learn from previous mistakes. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

Any adverse incidents relating to antenatal screening will be monitored via the incident reporting system. Any problems will be actioned via the case review and Root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

Dissemination and Access

This guideline will form part of the labour ward and community handbooks. Copies can be found in each ward area and the community office. It can be accessed via the intranet or Practice facilitator.

Training

Training will be given as documented in the Maternity Training Needs Analysis. This is updated on an annual basis.

Review

This guideline will be reviewed in three years of authorisation. It may be reviewed before that time if there are any untoward incidents occurring, reports, new evidence or external standards suggesting that a review is required.

References

Advanced Life Support Group, and the Royal College of Obstetricians and Gynaecologists (2007). *Managing Obstetric Emergencies and Trauma*. London: RCOG Press.

Confidential Enquiry into Maternity and Child Health. (2004). *Why Mothers Die 2000-2002.* London: RCOG Press.

Maternity Care Working Party. (2006). *Modernising Maternity Care - A Commissioning Toolkit for England (2nd Edition)*. London: The National Childbirth Trust, The Royal College of Midwives, The Royal College of Obstetricians and Gynaecologists

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. London: RCOG Press.

The Institute for Healthcare Improvement and NHS Institute for Innovation and Improvement (2006). *Situation Background Assessment and Recommendation (SBAR).* London: IHI and NHS Institute for Innovation and Improvement.

SBAR: A shared medical model improving communication between clinicians. 2006. Joint commission on Accreditation of Healthcare Organisations. Journal on Quality and Patient Safety.

Glossary of Terms

ED – Emergency Department
HDU – High Dependency Unit
ITU – Intensive Therapy Unit
NHS – National Health Service
PRF – Patient Report Form

Equality Impact assessment

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to all care provided.

Appendices

Appendix 1 – Obstetric Guideline Outline

Appendix -1
Obstetric Guideline Outline

Guideline	**Lead Professional**	**Review Date**
Maternal transfer by ambulance	J. Rear-Barton	08/2014

Formatting	Included/attached
Headings	07/07/09
Quality Impact Statement	07/07/09

References	07/07/09

Consultation Process	Date Disseminated/Presented	Relevant information
Initial circulation to Guideline Group and relevant parties (draft 1)		
Amended draft sent to development lead		
Final Draft presented to Guideline Group for ratification	05/07/11	Ratified 05/07/11
Amended/final Draft presented to Women's Governance group for Ratification	01/08/11	Date ratified: 01/08/11

Archiving	Date of distribution	Date of Archiving
Distribution and Retrieval	01/08/11	01/08/11

Training Package devised	Date	
Training Package Delivered	Date	

Audit/ Monitoring	Method	Date Commenced	Date Completed
Audit Process			
Monitoring process			

Guideline for Admission to Labour Ward High dependency Unit/ transfer to Intensive Care Unit		Barnsley Hospital NHS NHS Foundation Trust	
Author: G Jepson	Guideline group	Reference number:	
Issue Number 3	Maternity	Authorisation date: Reviewed: Next review date:	08/2009 05/2011 05/2014

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- Roles and Responsibilities
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- Inclusion Criteria for Admission to High Dependency Unit
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- Guidance for staff when to involve clinicians outside maternity
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Appendix one – Flow chart for admission to HDU
Appendix 2 – Obstetric Guideline Checklist

Introduction

Rationale

The purpose of this guideline is to ensure that women receive High Dependency Care (HDU) or Intensive Care (ICU) in the environment most suited to their condition, following assessment by a multi-disciplinary team.

Scope

This guidance applies to all members of the multi-disciplinary team responsible for the assessment, planning, and implementation of the woman's care.

Principles

- To ensure that all women requiring HDU / ICU admission receive care in the appropriate environment.
- To ensure that care is delivered by appropriately trained staff
- To ensure that the care delivered is of a consistent standard which is evidence based and follows best practice guidelines.

Background

Life threatening obstetric emergencies happen infrequently. High Dependency Care should be available on or near the Labour Ward and managed by appropriately trained staff. If this is not feasible women should be transferred to the unit most suited to meeting her needs. In order to manage care appropriately there must be a robust system in place for the assessment and referral to either HDU or ICU. The decision of how and where to care for the woman must involve a multi-disciplinary team, including Obstetric, Anaesthetic, Midwifery and Nursing Staff.

Guideline Outline

Levels of Care

'Comprehensive Critical Care' recommended a new classification of critical care patients according to clinical need as follows:

Level 0 - Patients whose needs can be met through normal ward care in an acute hospital.

Level 1 - Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care whose needs can be met on an acute ward with additional advice and support from the critical care team.

Level 2 - Patients requiring more detailed observation or intervention including support for a single failing organ system or postoperative care, and those stepping down from higher levels of care.

Level 3 - Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.

The Labour Ward has the capacity and equipment to care for one High Dependency patient, offering primarily Level One care. The room next to the Emergency Obstetric Theatre is used in most cases but any of the larger delivery rooms may be utilized to accommodate a high dependency patient.

The Intensive Care Unit is situated within the same hospital as the labour ward. It has the capacity to care for any Obstetric patient, either in a cubicle or in the main ICU department with input from a multi-disciplinary team. The unit can offer Level Two and Level Three care.

The condition of the women requiring High Dependency/ Intensive Therapy care will change and must be subject to continuous assessment. As a result the woman's level of care may fluctuate between the different levels. It will be the responsibility of the multi-disciplinary team to decide the most appropriate place for the woman to be. They will have to consider: the woman's needs, staffing levels, staff competencies, workload and skill mix on each unit.

Equipment

All equipment used to monitor a patient requiring high dependency care has been assessed as fit for purpose and is governed by the Trust's Policy on Medical Device management and/or any recommendations made by the Medicines and Healthcare Products Regulatory Agency. Equipment, such as ECG and Invasive Haemodynamic monitors are standardised between HDU, ICU and Theatre Recovery.

The following equipment is available for use in HDU and for intra-unit transfer in accordance with OAA 92005) guidelines are:

- Non-invasive blood pressure monitor
- ECG monitor
- O2 saturation monitor
- Invasive haemodynamic monitor
- Temperature monitor
- Oxygen and suction
- Boyles machine
- Defibrillator
- Blood warmer
- Warm air blankets (theatre recovery)
- Portable ECG with the facility to perform invasive haemodynamic monitoring (theatre recovery)

The equipment is checked on a daily basis to ensure that it is available and working by the labour ward staff & recovery staff respectively and signed for on the check sheets in each area.

Roles and Responsibilities

The Multi-disciplinary Team will consist of:

- The Obstetric Consultant, Registrar, and SHO
- The Anaesthetic Consultant, Registrar, ODA on call for Labour Ward, recovery staff.
- Midwives
- Intensive Care Staff, including the Outreach Nurses
- Any other persons whose input / assessment will have a positive impact on the woman's recovery

Key Responsibilities (Midwives)

- To monitor normal pregnancies
- To recognise the warning signs of abnormality and deterioration following approved documentation and initiate referrals to the obstetric team
- To contribute to the care planning of a woman requiring HDU/ICU care
- To care for women in the High Dependency Unit
- To contribute to the care of women in the Intensive Care Unit
- To ensure clear lines of communication between midwifery, obstetric, anaesthetic, and nursing staff
- To maintain contemporaneous records in the case notes and facilitate an effective handover of care
- To develop and maintain their own competencies in High Dependency Care, by: attending Mandatory Training , where feasible completing high Dependency Care Competency Programme, and attending any other training pertinent to High Dependency Care

Key Responsibilities (Obstetric Medical Staff)

- To recognise deviations from the norm and be aware of abnormal signs and symptoms
- To instigate appropriate investigations/ treatment
- To diagnose conditions and plan further management
- To ensure that the woman is assessed by an obstetrician of suitable seniority and experience in a timely fashion
- To ensure clear lines of communication between obstetric, anaesthetic, midwifery and nursing staff
- To maintain contemporaneous records in the case notes and facilitate an effective handover of care
- To contribute to the care planning of women requiring HDU/ITU care
- To follow guidance and procedures for conditions requiring referral to other medical specialties
- To maintain clinical competencies by: attending Mandatory Training and attending any other training pertinent to High dependency Care

Key Responsibilities (Anaesthetic Medical Staff)

- To diagnose conditions and plan further management of care as part of a multi-disciplinary team
- To instigate appropriate investigations
- To be vigilant for signs of deterioration in the woman's condition indicating a transition from level one to level two or three and act accordingly

- To work in conjunction with the labour ward ODA in helping / instructing midwives in equipment or procedures that are not routinely encountered
- To ensure clear pathways are available for referral to the anaesthetic team
- To ensure clear lines of communication between, anaesthetic, medical, midwifery and nursing staff
- To maintain contemporaneous records in the case notes and facilitate an effective handover of care
- To maintain clinical competencies by attending appropriate training

Key Responsibilities (Intensive care staff)

- To care for a woman in the Intensive care Unit
- To develop and maintain a multi-disciplinary care plan for a woman being cared for on the Intensive Care Unit
- To offer support and advise to staff caring for a woman on the High Dependency Unit
- To ensure clear lines of communication between midwifery, obstetric, anaesthetic, and nursing staff
- To maintain contemporaneous records in the case notes and facilitate an effective handover of care
- To develop and maintain their own competencies by attending appropriate training

In cases of serious maternal or fetal compromise a Supervisor of Midwives can be utilised to act as a liaison between staff and families.

<u>Requirements of each staff group when transferring women to high dependency unit / ITU and documentation requirements.</u>

Medical Staff:

- Ensure that the woman fulfils the criteria for transfer to HDU / ITU and the reason is clearly documented in the notes.
- Ensure that the woman is referred to a senior medical person – Obstetric Registrar / Consultant, Anaesthetist covering the HDU/ ITU on that day. Fully document the referral in the patient records. Complete the medical handover of care books on labour ward.
- Ensure that all medical documentation is completed in full in the records and ensure that all blood results tests are filed in the notes.
- Ensure that the senior medical person reviews the woman and that an individual management plan is clearly documented in the HDU / ITU chart.
- Clearly document in the HDU / ITU chart when further review is to take place.
- Inform the on call anaesthetist of the admission to HDU. Obtain an anaesthetic review if appropriate. Ensure that this is documented in the records**.**
- If the skills or opinions of clinicians outside of the maternity services are required. The medical staff should clearly document in the records which clinician the woman has been referred to.
- Ensure that the woman is seen by the appropriate external clinician and a management plan is documented in the records.
- Ensure that the woman's Obstetric Consultant is informed of her deterioration in condition and transfer to HDU ITU.

Midwifery Staff:

- Communicate with the Shift leader on labour ward / Sister on ITU to decide on a time for transfer. Document the date and time of transfer in the records.
- Ensure that all the patient's records are complete including MEOWS score chart. Document the reason for transfer to HDU / ITU care.
- Assess the woman's condition and determine if any equipment is required to transfer the woman safely to HDU / ITU e.g. portable oxygen, ECG machine. Document in the records if any equipment is obtained.
- Assess staffing levels to determine if further help is required to transfer the woman safely to HDU – this may mean re-deploying staff from within the unit or obtaining help from portering staff. This may include medical escort to transfer the woman.
- A full handover of care MUST be given to the staff taking over care in HDU. This MUST be recorded in the records.

Inclusion Criteria for admission to HDU

The conditions managed on the HDU are primarily, although not exclusively obstetric by nature and may include:

- Eclampsia, severe pre- eclampsia or any hypertensive patient whose condition is deteriorating
- Diagnosed HELLP syndrome
- Diagnosed DIC
- Haemorrhage causing maternal compromise
- Pre-existing maternal disease requiring close monitoring
- Signs of shock or anaphylaxis
- Acute Fatty Liver

Management of care

- The woman will receive one to one care by an appropriately trained member of staff whilst on HDU (appropriately trained staff being a midwife who has completed the competency based training programme in HDU care or is supervised by the senior midwife on labour ward whilst they undertake this training).
- The appropriate High Dependency Chart should be used.
- Effective communication is essential at all times. Documentation should follow the guidelines for Record Keeping, Handover of Care and NMC standards.
- Any assessment and treatment plans must be clearly documented in the case notes by all members of the multi-disciplinary team contributing to the care
- The ICU outreach nurses can be consulted where necessary and may be involved in the assessment process to decide the best place to provide the optimal level of care for the woman in question

Specific additional monitoring may include:

- O2 saturation and ECG.

- CVP and Arterial lines may be considered **ONLY** if staffing levels and competencies support the use. In these circumstances midwives will need extra support / advise from ITU, Anaesthetic staff

Discharge from HDU care

The decision to transfer from HDU care to generic care must be made by the multi-disciplinary team and the care plan clearly documented in the case notes.
The decision will take into consideration:

- The woman's needs
- Staffing levels and skill mix
- Activity levels on the ward area's

The discharge summary must be completed and a comprehensive handover must be given following guidelines for the Handover of Care. The HDU summary sheet and an IR1 form must be completed

Inclusion criteria for transfer to Intensive Care Unit

- The woman requires advanced respiratory support
- The woman requires circulatory monitoring and support
- The woman requires neurological monitoring and support
- The woman requires renal support
- The woman requires more intensive management and observation than can be provided on HDU

Guidance for staff on when to involve clinicians outside of the Maternity Services

There may be some rare instances where the skills or opinions of clinicians outside of the maternity services are required. Staff should consider obtaining an opinion from clinicians outside the maternity service when the womans condition deteriorates due to :
:

- Pulmonary Embolism
- Haemorrhagic shock
- Septecaemic shock
- Eclamptic convulsions leading to coma
- Cerebral vascular accident
- Disseminated Intra-vascular Coagulation
- Hypo/hyperglycaemia
- Acute heart failure
- Pulmonary aspiration of gastric contents
- Anaphylatic or toxic reaction to drugs or allergies
- Amniotic fluid embolism
- Air embolism

Cardiac arrest resulting from

- A continued deterioration in the woman's condition from any of the above

- Hypoxia
- Hypovolaemia
- Hypo/hyperkalaemia
- Hypermagnesaemia
- Hypocalcaemia
- Trauma
- Tension pneumothax
- Cardiac tamponade

OR the deterioration in the woman's condition results in the requirement for Level 2 or more care.

The appropriate clinicians can be contacted by dialing the following numbers:

- The cardiac arrest team - 2222
- Anaesthetic - 3333 and stating which obstetric service you require in an emergency. Or using the Baton bleep 366 at other times.
- Theatre staff - 3333 in an emergency. Or using the baton bleep 246
- ODP – 3333 in an emergency or the baton bleep 108.
- Anaesthetic outreach nurses can be contacted by bleeping 273 (between 0800 – 1800hrs.)

Any other clinicians can be contacted via switchboard

The decision to transfer to another unit

This must be made by the multi-disciplinary team consisting of an Obstetric Consultant, Anaesthetic Consultant and senior labour ward staff. A Consultant to Consultant referral is required prior to transfer.

Preparations for transfer:

- A risk assessment of the transfer process must be made with appropriate action plan.
- Relevant staff must be informed..
- The woman or the woman's relatives must be informed. They must be given details of the woman's destination if they are not allowed to co-travel.
- All documentation must be completed.
- Arrangements made for medical / anaesthetic cover during the transfer and on the unit.

If the transfer is to a unit outside of the hospital then transport and escort arrangements must reflect the level of care required by the woman. Documentation must be completed and case notes photocopied for transfer

An IR1 form must be completed.

References

Confidential Enquiry into Maternal and Child Health UK Why Mothers Die 2000-2002 (chapter 17)

Report of the National confidential Enquiry into Peri-operative Death (NCEPOD) 2005 report/recommendations

Intensive Care Society Guidelines for the Introduction of Outreach Services 2002

Clinical Negligence Scheme for Trust's. Maternity Clinical Risk Standards 2009/10. NHSLA. Standard 2 Criterion 9

Glossary of Terms

CVP – Central Venous Pressure
DIC – Disseminated Intravascular Coagulation
ECG - Electrocardiogragh
HDU – High Dependency Unit
HELLP – Haemolysis, Elevated Liver enzymes, Low Platelets
ICU – Intensive Care Unit
MEWS – Maternity Early Warning Score
NHSLA – National Health Service Litigation Authority
ODA – Operating Department Assisstant

Equality Impact Assessment

Women's and Children's Services are committed to ensure that both current and potential service users and their families will not be discriminated against on the grounds of religion, gender, race, sexuality, age, disability, ethnic origin, social circumstance or background. The principles of tolerance, understanding and respect for others is central to what we believe and central to all care provided.

Dissemination and Access

This guideline will be available as part of the Labour Ward Handbook. A hard copy will be kept in each area and on Labour Ward

An electronic copy will be available on the Maternity Intranet and via the Practice Facilitator Midwife

Training

Training will be given as documented in the Maternity Training Needs Analysis. This is updated on an annual basis.

Audit and Monitoring

High dependency care will be audited on an annual basis. The results will be reviewed and presented to the multidisciplinary audit meeting. Any deficiencies will be actioned via the audit action plan to try and improve safety and learn from previous mistakes. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

Any adverse incidents relating to high dependency care will be monitored via the Incident reporting system. Any problems will be actioned via the case review and Root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

Review

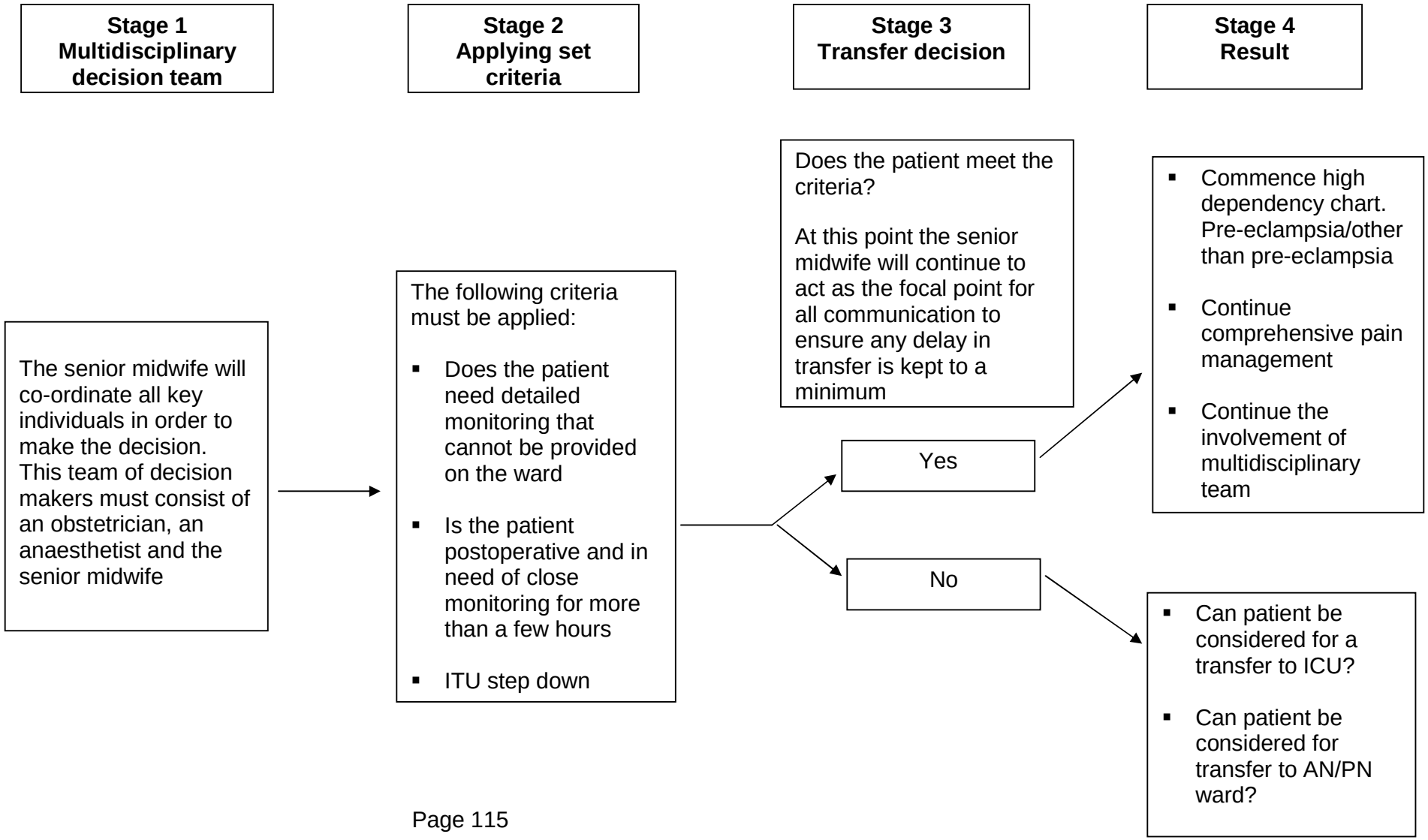
This guideline will be reviewed in three years of authorisation. It may be reviewed within this period if there are any reports, new evidence, guidelines or external standards suggesting that a guideline review is required.

Appendices

Appendix one - Flow chart for admission to High Dependency Unit

Appendix One

Flow chart for admission to obstetric high dependency unit



Appendix Two

Obstetric Guideline Checklist

Guideline	**Lead Professional**	**Review Date**
Admission to HDU	Gill Jepson	05/2014

Formatting	Included/attached
Headings	Attached
Quality Impact Statement	Attached
References	Attached

Consultation Process	Date Disseminated/Presented	Relevant information
Initial circulation to Guideline Group and relevant parties (draft 1)		
Amended draft sent to development lead		
Final Draft presented to Guideline Group for ratification	31/07/09 Reviewed 04/11	Ratified 18/04/11
Amended/final Draft presented to Women's Governance group for Ratification	03/08/09 Reviewed 09/05/11	Date ratified: 03/08/09 Ratified 09/05/11

Archiving	Date of distribution	Date of Archiving
Distribution and Retrieval	09/05/11	09/05/11

Training Package devised	Date	
Training Package Delivered	Date	

Audit/ Monitoring	Method	Date Commenced	Date Completed
Audit Process			
Monitoring process			

PROCEDURE FOR ALL PATIENT TRANSFERS BETWEEN CLINICAL AREAS/DEPARTMENTS IN THE HOSPITAL

INTRODUCTION

The guidelines are intended to create a quality standard for the safe and timely transfer of patients throughout the Trust and to reduce the risk of adverse incidents relating to the transfer of patients.

COMMUNICATION

Effective and accurate communication is essential to ensure the safe transfer of patients throughout the Trust. The Bed Manager/219 bleep holder will liase between the referring and accepting ward, giving details of the patient's name, gender, diagnosis and whether a side-room is required.

It is the transferring wards responsibility to give a thorough handover to the receiving ward, including the following patient information:

- Name
- Date of birth
- Diagnosis
- Consultant
- Early Warning Score (EWS) status
- Safety issues (safeguarding concerns, confusion, falls risk, pressure sores etc.)
- Infection status
- Medical plan of care
- Nutritional status
- Elimination/hygiene needs
- Mobility status
- Investigations undergone/planned/pending
- Discharge plans
- Social circumstances

It is the referring wards responsibility to inform the patient and their next of kin of the reason and details of the transfer, ensuring that this is done in a manner that assures them that the continuity and quality of their care will be maintained.

Main reception should be informed of the transfer by the ward clerk from the hours of 0800-1600, and by the nurse in charge of the transfer outside these hours.

TRANSFER ARRANGEMENTS

It is the referring wards responsibility to ensure the transfer occurs in a timely manner.
If the patient is transferring care from one consultant speciality to a different one, it is the referring wards responsibility to ensure a member of the medical team has accepted the patient on the receiving ward.

The nurse in charge of the transferring ward must assess the support that the individual patient may require during the transfer process and identify the appropriate grade Health Care Worker to escort the patient during transfer. The appropriate mode of transport must be ascertained, whether it is bed, trolley or wheelchair. If a wheelchair is deemed appropriate a nurse may transfer the patient without a porter. For any other mode of transport a porter should accompany the patient and nurse in accordance with Trust procedure for the movement and escorting of patients (July 2007)

If any adverse incident occurs in the transfer of patients, the Health Care Worker accompanying the patient must complete an IR1. The area receiving the patient must be informed of the incident.

Staff on the receiving ward must acknowledge the patients arrival in a professional and welcoming manner.

It is the referring wards responsibility to ensure that all the patient's personal belongings are safely transferred with the patient and a property form accurately completed. All patient's medications must also be sent in a safe and secure manner when transferring to another ward.

OUT OF HOURS
The process for out of hours transfers is that contained within this procedure apart from noted exceptions.

DOCUMENTATION
It is the responsibility of the transferring ward to ensure that the following documentation is sent with the patient on transfer:

- Interhealth transfer checklist
- Clinical/medical notes
- All nursing documentation, including care plans, EWS chart, fluid balance charts and any other nursing assessment charts.
- Treatment sheet
- Investigation/ blood requests

All the above must arrive on the receiving ward in an accurate, legible and complete form and transported in a safe and confidential manner.

PRIVACY AND DIGNITY

All staff involved in the transfer must respect and maintain the patient's privacy, dignity and modesty at all times and be aware of, and respect any cultural, ethnic and religious diversities.

APPENDIX 6

GUIDELINES FOR THE TRANSFER OF ADULT PATIENTS BETWEEN HOSPITALS

INTRODUCTION

Significant risks to patients can occur when there is poor communication of information between trusts when transferring the care of a patient.

The principle concern must be to maintain patient well being, provide optimal care during the transfer period, and deliver the patient safely to the receiving hospital.

The Trust remains responsible for the provision of care until the patient arrives and is accepted by the receiving hospital.

Before transport is ordered the Consultants team transferring the patient must have made arrangements for transfer and acceptance with the receiving Consultants team.

Agreement of the patient to transfer should be documented. In emergency situations when a patient is unable to agree transfer, where possible, the next of kin should be informed of the decision to transfer. The responsibility for transfer rests with the consultant in charge of the patients care and the consent of the relatives is not always required.

Relatives should be made aware of the transfer decision as soon as is practicable, where appropriate.

Infection status must be communicated in advance of the patients transfer.

All patient records and information transferred between organizations must be treated confidentially as governed by the Data Protection Act 1998. Disclosure of information should justify the purpose and everyone should be aware of their responsibility.

PRINCIPLES

During a transfer a patient should be treated and cared for in such a way as to maintain:

- Patient safety
- Necessary treatment and care
- Contact with appropriate staff
- Dignity and modesty
- Respect of individual needs

PROFESSIONAL ROLES

Medical staff are responsible for:

- Discussing the situation with the consultant team at the referring hospital
- Making the decision to transfer following consultation with the team and patient

- Informing the next of kin of the decision and reasons for transfer, as appropriate, with the consent of the patient
- Liaising with staff at the receiving unit and agreeing transfer arrangements and expected time of arrival
- Ensuring the receiving unit has full details of the patients' condition and requirements
- Ensuring all relevant medical documentation is fully completed and up to date i.e. The patient's medical case notes and treatment sheet
- Nominating appropriately trained staff to accompany the patient during transfer, if required
- Identifying the urgency of the transfer
- Ensuring the patient is prepared appropriately and that their condition is as stable as possible
- If inotropes or other vasoactive drugs are required to optimize haemodynamic status, patients should be stabilized on these prior to transfer.
- Every effort should be made to correct and stabilize hypovolaemia prior to transfer.

Nursing staff are responsible for:

- Discussing the transfer arrangements with nursing staff in the receiving hospital
- Contacting ambulance control with relevant information in order to ensure appropriate ambulance for transfer and requesting transport. Tel. number 24 hours 08451219992
- Obtaining a time for transfer
- Identifying appropriate nursing staff required to accompany the patient if necessary
- Identifying the appropriate grade of nurse who is competent and safe to escort the patient
- Ensuring a full explanation is given to the patient and /or relative with, where practice the consent of the patient
- Being available to provide nursing support
- Assisting in preparing the patient for transfer
- Any equipment used to assist in the transfer of the patient must be fit for purpose and the escort trained in its use.
- Ensuring all appropriate nursing documentation is completed.
- Ensure arrangements are made for the transfer of patients' valuables and property

Nurse accompanying patient is responsible for:

- Ensuring the necessary equipment and medication is available for use during transfer
- Ensuring appropriate documentation accompanies the patient
- Monitoring and recording patient condition during transfer
- Ensuring that full and accurate details of patients condition and treatment are given to the receiving unit

OUT OF HOURS

The process for out of hours transfers is that contained within this procedure apart from noted exceptions.

DOCUMENTATION TO BE TRANSFERRED WITH PATIENT

- A **copy** of the patients medical case notes and pathology results.
- Copies of all nursing documentation, nursing record, care plans, treatment sheet, observation charts and any other charts in use.
- A completed Inter-health transfer check list-incorporating infection control, carbon copy to be filed in original Medical case notes.
- The transfer of X-ray images will be on an encrypted CD. During office hours contact the General X-ray Office on ext 2550. Out of the hours the Radiographer-on-call will arrange the CD's Bleep 265.

CONFIRMATION OF PATIENT IDENTITY

The nurse co-ordinating the patients transfer to another hospital should ensure that the correct information is transferred with the patient. In order to ensure transfer of correct information relating to a particular patient, the nurse should ensure that the following checks are carried out:

- The patients identification name bracelet records the patients first and surname, date of birth, unit number and NHS number. This information should correspond with the information recorded in the patients medical case notes, nursing documentation and X-rays being transferred with the patient.

PATIENTS REQUIRING A SURGICAL ESCORT

- Patients with blunt/penetrating chest trauma and a chest drain transferring to the Cardiothoracic Unit.

PATIENTS REQUIRING A MEDICAL ESCORT

- Patient with large spontaneous pneumothoraces being transferred to the Cardiothoracic Unit

PATIENTS REQUIRING A NURSE ESCORT

- Cardiac patients with a temporary pacing wire or vasoactive/inotrope infusions in situ.
- Patients with upper GI haemorrhage who are cardiovascularly stable.

PATIENTS WHO CAN BE TRANSFERRED BY PARAMEDICS WITHOUT MEDICAL/NURSING ESCORT

1. Patients in need of vascular surgery, e.g. Leaking abdominal aortic aneurysm.
2. Stable patients with blunt abdominal trauma, e.g. Hepatic injury
3. Patients with chest trauma and no chest drain in situ, e.g. Thoracic aortic injury.
4. Patient with upper limb/tendon injury transferring to the Plastic Surgery Unit who do not require circulatory support.
5. Patients with spinal injury/pelvis fracture/lower limb injury who do not require airway/circulatory support.
6. Patients with acute coronary syndrome (without temporary pacing)
7. Patients with neurological deficit not requiring intubation/ventilatory/ circulatory support.
8. Patients requiring haemodialysis being transferred to the Renal Unit.

Barnsley Hospital NHS
NHS Foundation Trust

Appendix 7

INFECTION CONTROL MANAGEMENT FOR THE ADMISSION, TRANSFER AND DISCHARGE OF INFECTED PATIENTS

INFECTION CONTROL MANAGEMENT FOR THE

ADMISSION, TRANSFER AND DISCHARGE OF INFECTED PATIENTS

CONTENTS

Admission- Acute and Emergency Dept **Page 3**

Medical Emergency Unit **Page 4**

Elective Admissions **Page 4**

Internal transfers **Page 4**

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Movement between departments **Page 5**

Discharges **Page 5**

APPENDICES

Inter-health care infection control transfer form **Appendix One**

Department of Medical Imaging infection control procedure **Appendix Two**

INFECTION CONTROL MANAGEMENT FOR THE ADMISSION, TRANSFER AND DISCHARGE OF INFECTED PATIENTS

PURPOSE

To provide clear guidelines on admission, transfer and discharge management, to all staff involved in the active management of these processes.

AIM

To ensure that having been admitted to hospital that the patient has the right to expect that they will receive appropriate care in an environment designed to prevent or minimise the transmission of infection.

Should internal or external transfer be required, the patient's movement should be planned and co-ordinated to ensure that their infection control needs are met.

On discharge the patients ongoing health care needs should be examined and appropriate measures taken to ensure a safe and effective discharge.

ADMISSION

Admission to hospital may be acute or elective. It is essential that immediately on arrival that a full and detailed assessment of the patient and their possible infective status is undertaken.

ACUTE

If the admission is acute the patient will, in most cases, be assessed either in ED or on the Medical Emergency Unit.

Emergency Dept

Once the patient has been booked into the Emergency Dept the staff should be alerted to any previous MRSA status by using the PAS system. Patients who are previously MRSA positive must be cared for by following the MRSA policy and using appropriate P.P.E, obtaining appropriate swabs, effective hand decontamination and thorough cleaning of the cubicle/area and all equipment, when the patient is moved from the department.

Patients presenting with diarrhoea, rashes or unexplained pyrexia must be nursed in isolation as appropriate, ensuring the use of standard (universal) precautions to prevent the transmission of infection within the department.

MEDICAL EMERGENCY UNIT (M.E.U)

Patients with a known or suspected infection must be nursed in isolation within the unit. If the unit is unable to provide suitable isolation, please advise the bed managers for prompt action. It is essential to follow Standard (Universal) Precautions. Specific questions should be asked to ascertain any infective illnesses e.g.

- Has the patient had unexplained diarrhoea/vomiting in the last 48 hours.
- Does the patient have an infectious disease, rash or a pyrexia of unknown origin
- Has the patient been previously MRSA positive

Where a patient is admitted with diarrhoea, rapid isolation of the symptomatic/positive patient Is essential with thorough adherence to the basic principles of infection control, effective hand decontamination, cleaning of the equipment and the environment. The Infection Prevention and Control should be informed.

Specific advice can be sought from the Infection Control team, on extension 2825, Bleeps 371 , 411 or 472, 809 and 810. Please refer to the Infection Prevention and Control Intranet site and policies for subject specific advice e.g. MRSA and GRE Policy, Clostridium Difficile Policy

ELECTIVE

If the patient is previously MRSA positive, appropriate swabs will be taken and decolonisation prescribed (if still positive) prior to admission.

ACUTE

All acute admissions will be swabbed on admission to MEU, otherwise they must be swabbed on admission to the ward

Close liaison is necessary between the Infection Prevention and Control Team and the bed management team to ensure that all patients with an infection or possible infection are appropriately placed within each ward.

INTERNAL TRANSFERS

The Infection Prevention and Control team will support and provide information to staff where patients with a known or possible infection are to be transferred or discharged. When transferring patients to other wards or departments within the hospital it is vital to inform the receiving area if the patient has, or is suspected to have an infection. This will ensure that the patient is allocated a side room and appropriate infection control precautions are taken. Liaison is essential between the ward staff, Infection Prevention and Control team and the bed management team.

EXTERNAL TRANSFERS

If patients with known or suspected infections are to be transferred to another hospital or healthcare setting the receiving healthcare provider must be given as much information as possible.

- Type of infection
- Precautions in place
- Swab or specimen results
- Current treatment

Patients with diarrhoea should be 48 hours symptom free and have passed a normal stool before transfer.

If the patient is to be transferred by ambulance, the ambulance personnel should be advised of any necessary precautions.

See Appendix One for the Inter-healthcare Infection Control transfer form.

MOVEMENT BETWEEN DEPARTMENTS

Visits to other departments may be limited, dependent on the infectivity of the patient.

Patients with uncontrolled diarrhoea should not be sent to other departments unless the treatment or investigation is essential.

Infective patients should be seen at the end of a working session and should not be left in a waiting area with other patients.

Personal Protective Equipment must be worn e.g. aprons and gloves when in direct contact with a patient.

Patients may be transported by trolley or wheelchair, after returning the patient to the ward the trolley/chair must be thoroughly cleaned before re use. Porters and other transport staff must be advised to wash and dry their hands/ use alcohol gel between patients and follow all infection control requirements.

For specific advice for the department of Medical Imaging see Appendix Two

DISCHARGES

Discharge to Home

If the patient is to be discharged to their own home with an infection it is essential that they and their carers/family are given information regarding their infection and any subsequent precautions necessary to prevent transmission.

The Infection Prevention and Control team are available to give any support or advice required. Ext 2826/2825 or Bleep 371, 411 or 472.

Discharge to another Hospital or Healthcare provider

Prior to discharge the receiving clinical teams, hospitals, nursing home or PCT hospital must be notified of patients known to be requiring any infection control precautions. See appropriate policy.

Discharge to Mount Vernon Hospital

If the patient has had infective diarrhoea or CDT they must have either a negative stool sample or be 48 hours symptom free and have passed a normal stool prior to discharge.

- Patients who are MRSA positive must have been swabbed within 7 days prior to discharge to MVH, unless still receiving decolonisation treatment
- Swab all wounds that are not healed and require a dressing
- Any wounds that are dry and healed do not require swabbing UNLESS the patient has previously been MRSA positive.
- Fresh trauma wounds e.g. in the A&E do not require swabbing. Wounds do not require swabbing until 48 hours after they have occurred.

For queries re discharges to Kendray, Keresforth and Locality centres please contact the Infection Prevention and Control team on Ext 2825 or Bleep 371, 411 or 472

Inter-health transfer check list – Incorporating Infection Control. **Appendix One**

Complete in all cases and in black ink
The carbon copy to be filed original to be sent with patient

General details

Name	Unit Number			
Address				
Allergy				
DOB				
Consultant				
GP				
Next of Kin				
Contact number for Next of kin				
Date of transfer				
Time of transfer				
Current location				
Moving to:				
Contact number for destination				
Details	**Yes**	**No**	**N/A**	**Sign**
Patient aware of transfer				
Patient has communication difficulties				
Relatives aware of transfer				
ID band in place				
Allergy status known				
Observations required				
Escort required				
Medications correct / green pharmacy bag				
Property with patient				
Property with relatives				
Medical Aids / adaptations				
Last food taken				
Last drink taken				
Case notes and all charts present				
Pain score				

Infection Prevention and Control

This section is mandatory Infection Control contact number _____.

Details	Yes	No	N/A	Sign
Is this patient an infection risk?				
Conformed risk				
Suspected risk				
No known risk				
Are the IC aware of transfer?				
Is the patient aware of their diagnosis/ risk of infection?				
Does the patient require isolating?				
Is the receiving department aware of need to isolate?				
Are the ambulance team aware of infection status?				
Has the patient been exposed to others with an known infection/ (eg D&V)				

Patients with Diarrhoea

Details	Yes	No	N/A	Sign
Is the diarrhoea thought to be infectious?				
Indicate bowel history for last week if diarrhoea present. *(Please use Bristol stool chart)*				

Relevant specimen results
(including admission screens – MRSA, Glycopeptide-reistant enterococcus SPP, C Difficile , multi-resistant Acinetobacter SPP) and treatment information including antimicrobial therapy:

Specimen	Date	Result	Sign

Treatment information

Other information

Print Name _____ Sign _____.

Date _____.

Appendix Two

Department of Medical Imaging

Departmental Infection Control Procedure

Introduction

This procedure is supplementary to the Trust's Infection Control manual and should be used in conjunction with it. The aim of this supplementary policy is to clarify issues surrounding the transporting of patients to the medical imaging department and the procedures that should be followed whilst the patient is in the department. All staff are reminded to follow Standard (Universal) Infection Control Precautions at all times

The carrying out of the investigation should not be compromised because a patient has an infective disease or positive for Clostridium Difficile/MRSA, by following the correct protocols it will be possible to transport the patient to the department for their investigation. Mobile investigations should only be performed where the clinical risk of transporting the patient to medical imaging department outways the radiation protection risk. Any mobile request must be within departmental Ionising Radiation (Medical Exposure) Regulations 2000 guidelines.

Aim

To ensure the patient receives the required treatment /investigation whilst protecting the patients, visitors, and staff in the medical imaging department by preventing the spread of pathogenic microorganisms

Transporting of Infections Patients

Patients should only be sent to the medical imaging department after consultation with the department. The request card must clearly state that there is an infection risk the department will then contact the referrer who will be responsible for ensuring the department is informed of the appropriate precautions to be taken to prevent the spread of infection. If there is any clarification required then the infection control manual should be consulted and if necessary the advice of the infection control nurse.

The department will ensure that the patient is kept in the department for the minimum amount of time required to complete the investigation. Patients should be seen at the end of a list they should not be sent for until the department is ready for them and must not be left waiting with other patients. Preferably these patients should be taken directly into the examination room. At

the end of the investigation the patient should be returned immediately to the ward it is therefore important to organise that a support assistant and escort, if required, are available. Gloves and aprons are not required when transporting patients only when direct contact is required. Alcohol hand rub is available on every ward

It is essential that the medical imagining department is notified in advance of patients who may be an infection risk so that appropriate precautions can be taken to prevent the spread of infection. Failure to do so may affect the patient's treatment.

If a patient arrives in the department without prior notice wherever possible complete the treatment following Standard (universal) Infection Control Precautions, if in doubt contact the infection control team.

Procedures in department

Protective clothing to be worn if appropriate this will include gloves and aprons
Handwashing is important both before and after every investigation, alcohol dispensers as a supplement to hand washing, are sited in all clinical areas

Equipment

Equipment should be routinely cleaned as part of good hygienic practice. Routine cleaning of equipment should include the following: -

- X-ray tables, tube heads, and ultrasound couches should be wiped daily with detergent wipes
- Ultrasound Transducers must be wiped after each patient using the agreed procedure
- X-ray cassettes should be wiped daily with detergent wipes

<u>After Procedure Involving Infectious Patient</u>

- All single use equipment must be disposed of appropriately in clinical waste bags and sharp containers
- All equipment to be cleaned using alcohol spray or wipes or Chlorine solution 1000ppm esp. Clostridium Difficile
- Wheelchair or trolley to be cleaned using alcohol spray or wipes or Chlorine solution 1000ppm esp. Clostridium Difficile
- It may be necessary to clean the floor

Dave Houghton
Denise Potter
May 2006