Principles for ensuring safe and effective discharges from hospitals to care homes.

NHS ENGLAND AND IMPROVEMENT – MIDLANDS REGION

Version	1.0
Status	FINAL
Publication date	21 January 2022
Approval	Regional IPC Operational Group

Adapted from “Principles for Ensuring the safe and effective discharge of individuals to care homes from hospital”, North West Regional Guidance for use in the Midlands Region

Version Control

Version	Date	Changes
0.1		Draft version for comment

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Principles for ensuring safe and effective discharges from hospitals to care homes

1.0 Background

Following recent concerns surrounding the safe and timely discharge of patients from hospital settings into care homes, this document aims to present the key principles around safe and effective discharge.

There are a number of factors to consider in relation to this, including:

- Escalating and sustained high community transmission rates across the region
- The number of care home outbreaks that have been identified
- The risk to patients who are unable to access the care that they require within the hospital inpatient setting.
- Improving relationships between providers and registered manager to ensure that care home managers feel confident to accept admissions and know how and where to access advice and support where they do feel confident.

The current delay in discharging patients results in:

- Delayed discharge will increase risk of functional decline, physical decline through muscle wasting, and risk of contracting a transmissible/avoidable infection amongst individuals
- Prolonged stays in hospital and the consequent isolation from familiar routine and surroundings will impact on a person's mental health and wellbeing.
- If a hospital is nearing capacity due to people being in hospital unnecessarily, other people will experience longer waiting times for admission and treatment delays.

It is fully recognised that:

- Care homes have the right to refuse to accept a person they do not feel they can deliver safe care to, whether that be due to the complexity of their condition or COVID-19 status.
- Care Homes need to satisfy their insurance companies, in order to do this, they must abide by both UKHSA and government guidance.

This document is consistent with the national guidance (as of 20.01.2022), which is in place and does not seek to take the place of national guidance or agreed local organisational policy or procedures. This is a set of principles developed by the region to support the delivery and interpretation of the guidance across multi-agency partners within each system.

2.0 Scope

This document outlines principles to support safe discharges into care homes. These are overarching principles, outlining key aspects of current national guidance to support collaborative decision-making within systems.

3.0 Context

In response to continued and sustained pressure across the region, this document has been prepared to offer support into the system. This document supports the UKHSA technical guidance and the relevant national guidance.

Across East and West Midlands, the Health Protection teams are dealing with significant numbers of care home outbreaks. It is estimated that in January 2022 over 60% of homes are affected.

4.0 National Guidance

The full suite of national guidance can be found on the GOV.UK website, links to the key documents relating to these principles can be found below:

- Coronavirus (COVID-19): adult social care guidance - GOV.UK (www.gov.uk)
- Coronavirus (COVID-19): admission and care of people in care homes - GOV.UK (www.gov.uk)
- Designated settings for people discharged to a care home - GOV.UK (www.gov.uk)
- Coronavirus (COVID-19) testing in adult care homes - GOV.UK (www.gov.uk)

5.0 Key Principles

1. Across the Midlands region, we need to work together to prevent the transmission of infection within care homes and prevent care home and hospice outbreaks.

2. There is evidence to support that the best place for a person to recover is within their own home. Where needed this can be supported by short term reablement or rehabilitation and/or through the use of virtual wards.

3. For care home residents who are fit for discharge, and where there is agreement for the most appropriate place for the patient to be discharged to,

every effort should be made to ensure that they are transferred as soon as practically possible.

4. Assessment for long term care provision should not be undertaken in a hospital setting. These assessments should take place in the person's own home, unless this would not be appropriate to meet the person's needs. Where this is not appropriate consideration should be given to an alternative setting, such as care home or intermediate care setting. It is recognised that there may be exceptional circumstances where these assessments may be completed in the hospital setting.

5. Good communication is key, sharing information between the hospital and the care home using plain language, such as patient tested positive on 01/01/2022 and has been stepped down in line with the national guidance, rather than using internal colours to describe patient COVID-19 status. It is noted that the use of colours within inpatient settings such as "red" or "blue" is not consistent, therefore utilising plain language, or the categories as set out in the risk assessment at appendix two, will support with care home managers being able to risk assess effectively.

6. The best interest of the person must be considered as part of the risk assessment process. Where a person does not have capacity, the views of their advocate must be sought.

7. During times of intense community transmission and nosocomial (hospital acquired) infection, staff and residents may be exposed to COVID-19 even when there is no known exposure documented.

8. Risk assessments must be carried out to balance the risk of introducing COVID-19 into a care home against the risk of extended hospital stays and the wider risk to patients being unable to access the healthcare they require.

9. Risk assessments need to be person centred and consider all aspects of the patients' health and wellbeing, including their physical care provision and mental health.

10. Evaluation is required to ascertain where the greatest risk lies in relation to COVID-19 and the other health and wellbeing impacts.

11. A blanket approach is not recommended during outbreaks, risk assessment should consider if the individual can be cared for safely in the home, including through isolation. **This may mean that discharges back to care homes of usual residence can be facilitated during an outbreak if it is safe to do so.**

12. Care home managers are responsible for risk assessments for their settings, staff and residents and they will be making their decisions on this basis. In the

current challenging situation additional support from DsPH, local CCG IPC teams, local public health and adult social care teams may be required to support these discussions.

13. A RAG matrix (Appendix 2) has been developed (adapted from North West) to assist with these decisions and to consider the preferred option for new admissions to potential care homes, based on person-specific and setting-specific factors. The aim is for a collaborative approach to support the care home manager with the process; considering issues including the care home's staffing capacity and ability to isolate residents. Local areas may have their own pathways which reflect local operationalisation of the principles below and these should be followed by local partners.

14. A care home is generally considered to have an active outbreak for at least 14 days since the onset of the infection in the last case and outbreak measures should continue to be implemented during this time. It is understood that this may change in line with the national review that is underway, current national guidance should be followed.

15. Due to the impact of community transmission on staffing, local areas may be exploring ways to ensure PCR results are fast tracked for health and care staff to ensure a timely return to work for identified COVID-19 contacts and timely declaration of a care home outbreak being over. The removal of the requirement for confirmatory PCR from 11 January 2022, following a positive Lateral Flow test, will improve the timeliness of results.

16. UKHSA have outlined the essential elements of a risk assessment for discharging residents back to care homes with outbreaks (see Appendix 1)

17. Settings may have other compelling reasons not to accept discharges that are unrelated to infection prevention and control or COVID status. For example, care homes may be operating a lower bed level in response to greater levels of stress and fatigue amongst care workers.

18. Some operators will be concerned about the liability issues and frequent changes to guidance can cause confusion especially when it is not clear if there is specific guidance for health and care that is different to that for members of the public and other sectors.

19. Consistent application of principles and risk assessment approach across the Midlands systems will give the measure of reassurance that the health and social care system is responding collectively to the shared challenges. By following the principles outlined, consistency of approach across the Midlands may be maintained.

20. PCR testing and vaccination checks should be completed in line with current national guidance for the setting.

Appendix 1 – Risk Assessment Framework

The risk assessment framework (adapted from the NW Guidance) is developed to support effective and consistent risk assessment process to:

- ensure that each outbreak is risk assessed, based on the specific situation in the care home including staffing, suitable accommodation and the optimal placement for the resident; and
- avoid the need to keep an individual in hospital for 14 days whilst waiting for an outbreak to be declared over (if safe to do so).

The responsibility for this risk assessment sits with the care home manager, however, this can be used by discharge and care planers to explore the feasibility of discharges.

Decisions involving resident discharge back to a care home known to have a COVID-19 outbreak should be based on an individual and dynamic risk assessment which encompasses a wide range of issues, including but not limited to:

The resident

- their COVID-19 vaccination status (primary course and booster)
- their ability to isolate on re-admission
- their individual needs and how these would be impacted by outbreak control measures or by alternative accommodation
- their personal preferences (importantly, residents and their families should be made aware of the situation and given the opportunity to highlight any concerns and make alternative arrangements where necessary)

The Outbreak status

- the stage of the outbreak e.g. emerging versus recovery
- any evidence of ongoing transmission (informed by testing data), this should include staff and patient cases for consideration.
- incubation periods/infectious periods and number/proportion of residents likely to be infectious (and their ability to self-isolate)

The care home

- the proportion of residents and staff that have received vaccination booster doses
- Access to sufficient and appropriate PPE.
- the ability for IPC advice to be followed within the home including zoning of resident and cohorting of staff type of care home and the residents that live there (which may in turn impact on ability to follow outbreak prevention and control actions).

Appendix 2 - Risk Assessment Matrix

This matrix (adapted from the North West Guidance) is to assist with decision on discharge or admissions to care homes.

- Where it is safe to do so patients/residents should return to their usual care home of residence.
- COVID-19 positive patients should be discharged to designated settings

The responsibility for this risk assessment sits with the care home manager, however, this can be used by discharge and care planers to explore the feasibility of discharges. Support to complete these assessments is available from the DsPH, local CCG/ICS IPC teams or local health protection teams.

Please read the KEY below to interpret this chart

	RED COVID OUTBREAK HOME	AMBER COVID HOME - WATCH	GREEN NON-COVID HOME
RED Positive case	1st preference (if staffing adequate, if patient can be isolated effectively, barrier nursed)	2nd preference - risk assess (if patient can be isolated effectively, barrier nursed) Not appropriate for who are wandering/walking with purpose.	**NO**
AMBER EXPOSED /INCUBATING	Only under public health advice or returning to their own home. Not appropriate for residents who are wandering/walking with purpose.	1st preference if returning to own care home. 1st preference if it is a new admission, do a risk assessment.	1st preference if returning to own care home. 2nd preference if it is a new admission, do a risk assessment.
GREEN RECOVERED CASE AND/OR NO KNOWN EXPOSURE	Only if recently infected in the last 90 days and recovered.	2nd preference – risk assess, can they be kept safe.	1st preference

Key to the criteria in the risk assessment matrix:

Patients:

RED POSITIVE CASE	• Confirmed symptomatic coronavirus – within 14 days of onset of symptoms OR Still symptomatic • Asymptomatic positive case (new infection or re-infection after 90 days of previous PCR). • A positive case can go back to a red home before 14 days isolation is over, based on a risk assessment. • Patients who are suspected coronavirus must not be discharged until test results are known.
AMBER EXPOSED/INCUBATING	• Asymptomatic (not had COVID-19 in last 90 days) but has been exposed in a setting and/or they are a close contact. • Asymptomatic been in hospital and test negative (isolate 14 days on admission).
GREEN RECOVERED CASE AND/OR NO KNOWN EXPOSURE	• Asymptomatic not known to have exposure e.g. from green care home or from their own residence to care home • Confirmed recovery from coronavirus (at least 14 days after onset, asymptomatic now and tests negative) • COVID vaccines/booster status must be considered

Homes:

RED COVID OUTBREAK HOME	**Live outbreak - Evidence of transmission in the care home is most likely.** Examples: • 2 or more cases in staff or residents symptomatic / asymptomatic **linked** in the last 14 days • Care homes in outbreaks may have critical numbers of staff affected which could result in significant business continuity issue.
AMBER COVID HOME - WATCH	**Evidence of transmission in the care home unclear or care home emerging from outbreak.** Examples: • 1 or more cases in staff or residents symptomatic / asymptomatic **not clear that they are linked** • Last outbreak round of testing revealed no cases (counting down to 14 days clear)
GREEN NON-COVID HOME	**COVID free / evidence of transmission outside the home** Examples: • No current active cases in the last 14 days. • 1 or more cases in staff **with clear transmission outside the home**