Cazaubon Unit Operational Policy
Community Health Newham

Policy Reference Information

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Author	**Dina Carr / George Soutar**
Lead	**Veta Gordon**
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Version Control Summary

Version	Description of changes	Reason for change	Author	Date
2	Review of service specifications and provisions	Merge to intermediate care provision	Dina Carr	July 2006
3	Review of specifications and service provisions	Management and operational changes	Dina Carr Jo Dauvergne	May 2010
4	Review of specifications and service provisions	Evidence for NHSLA	Dina Carr Veta Gordon	April 2012
5	Revision of discharge standards	Compliance with most recent standards	Dina Carr / George Soutar	September 2012

CONTENT

Introduction
The East Ham Centre (EHCC) is a LIFT initiative in a modern purpose built facility providing comprehensive community health care services to Newham Residents over the age of 60 years.

This facility has brought together the Sally Sherman Nursing Home, Jack Petchey Activities Centre and the Older Peoples Services provision of Plaistow Hospital.
The Community- based facility provides Services for in- patients for NHS Continuing Care, Intermediate and respite care, an Activities Centre, and a Day Hospital and Falls Prevention Service for Older People.

The above services do not need to be provided in an acute hospital, but are beyond the scope of traditional primary care service. The Medical model is currently used although work has started to develop a more responsive and community focussed non- medical approach through the implementation of Community Led beds. The Registered Nurses provide and implement a nursing care plan supported by multi- disciplinary input, and have nursing responsibility and accountability for the patients' care according to the Nursing and Midwifery Professional Code (NMC 2008).

These services support the National Service Frameworks for Older People (2001), specifically NSFs1 (Age discrimination), 2 (Person centred care), 3 (Intermediate care), 6 (Falls), 8 (Promoting a healthy lifestyle) and the Intermediate Care Circular (HSC 2001/001 and 007). Since then, High Quality Care for All (2009) sets a new foundation for a health service that empowers staff and gives patients choice which showed that they would prefer to receive health services/ care as close to home as possible.

The In- Patient Intermediate Care Unit (Cazaubon) has 23 beds offered in single rooms with en-suite shower and toilet. The Unit can accommodate both male and female clients and retains a focus on rehabilitation.

The Intermediate Care Unit is neither a hospital nor a residential home.

Intermediate Care is a 'range of services designed to facilitate the transition from hospital to home, and from medical dependence to functional independence, where the objectives of care are not primarily medical, the patient's discharge destination is anticipated, and a clinical outcome of recovery (or restoration of health) is desired. These services will help to divert admission to an acute care setting through timely therapeutic interventions which aim to divert a physiological crisis or offer recuperative services at or near a person's own home' Kings Fund (1999).

The Cazaubon Unit currently has provision for 16 Newham Consultant Led Intermediate Care beds, up to 5 beds for short stay respite care lasting up to 4 weeks, and 2 Community Led beds. The latter are clinically managed by Primary Care (GPs) and other community based health professionals such as Community Matrons and Specialist Nurses. The services are for Newham residents who need rehabilitation /intermediate care for up to 6 weeks within the following categories:

Rehabilitation/early discharge - Those who have been discharged from a stay in hospital but require some additional rehabilitation due to their medical condition to regain confidence and skills to enable them to manage at home again, as independently as possible. This also supports timely discharge from an acute hospital bed therefore reducing delayed discharges.

Crisis intervention due to a long term condition - Those who are experiencing a crisis or deterioration in their health due to either a long term condition or an acute illness, which is temporarily disabling them to manage independently at home, but does not require the supporting technology of an acute hospital admission.

Admission avoidance - Those for whom admission to the acute hospital is unnecessary; or admission to residential or nursing home has been or is being considered and the patient would prefer or has the potential to return home with community support can prevent **premature admission** into long term residential care..

This Operational Policy covers the Cazaubon Unit only at the East Ham Care Centre (EHCC). However, it may include sections on policies and procedures that are common to the whole Centre and Community Health Newham.

1.0 Philosophy

- The Cazaubon Unit is a place of welcome, comfort and support.
- We acknowledge that our patients are individuals whose choice, rights and dignity must be respected.
- The Unit provides an effective high quality service that is patient-centred, sensitive and responsive to their individuality and requirements.
- The Unit provides slow stream rehabilitation through multi-disciplinary team assessments working in partnership with other Intermediate care provision, Voluntary and other agencies to enable a smooth transition to and from the unit.
- The Unit offers respite care, so that carers are confident and relieved to leave their loved ones temporarily for a short vacation or rest from caring responsibilities.
- Additionally the Unit facilitates and promotes client choice and independence, with a commitment to the principles of equal opportunities.
- Our philosophies respects that relatives and friends will be viewed as an integral part of the programme and are encouraged to visit and participate in activities provided at the centre, including care planning programmes.

2.0 Aims of the Unit

- To offer vulnerable patients a rehabilitation programme who fit the intermediate care criteria
- To enable patients to reach their maximum potential and live as independently as possible
- To promote an environment for intermediate therapy (i.e. health care management requiring short term in- patient admission), rehabilitation and respite care with the flexibility to develop the service provision as needs change
- To prevent unnecessary readmission to an acute hospital or premature long-term residential care, whenever possible
- To support timely hospital discharge in line with intermediate care objectives
- To support carers and families.

3.0 Objectives of the Unit

- To provide effective liaison with the acute hospital prior to admission to the Unit.
- Initiate single assessment process and facilitate patient centred rehabilitation goals.
- To promote standards of care, that considers the safety and welfare of the patients, obtains their consent, are sensitive and responsive to their needs and feelings always.
- Each patient will have their own bedroom suite, but are expected to fully participate in rehabilitation and an activity programme.
- The facility will operate based on a non-institutionalised philosophy with reasonable flexibility for client's preferences.

- To provide effective rehabilitation programmes, the Unit promotes the independence of each patient to the limits of their abilities alongside advice, social and emotional support to Older Adults in this safe environment.
- To facilitate discharge planning from the Unit, that ensures continuity of care with adequate support for clients and or families to maintain their independence and dignity on return to their home referring to other agencies as appropriate.
- All patients and carers will be treated equally regardless of age, cultural and religious beliefs, sexual orientation or disability. The aim is to ensure that no person receives less favourable treatment. Abuse or harassment or discrimination will not be tolerated in all services delivered.

4.0 Key Operations of the Service

- Patients referred for intermediate care admission to the Unit need to be medically stable and not in an acute stage of illness. Referrals are accepted from health or social care professionals in the community, hospital and primary care services.
- Initial screening of potential patients will take place via liaison with the Matron, Cazaubon Unit Manager and Senior nurses and the referrers i.e. Consultants, GPs', Community Matrons, Acute Hospital Staff.
- All potential patients must be agreed as eligible by the MDT including Cazaubon Unit / Matron, a Care of the Elderly Consultant, GP and / or Community Matron to meet the Intermediate Care criteria.
- They must agree to the suitability of patient for the Cazaubon Unit. (Refer to 5.0 & 6.0 referral process).
- Patients need to arrive at the Unit before 16.00hrs with their medical notes, x-rays, medications, any outstanding out patient appointments, their prescription chart and/ or GP/ Specialist letter.
- Within 6 hours of the patient's arrival to the Unit, the staff will ensure that a contact assessment and a comprehensive nursing assessment with their baseline clinical observations are completed and recorded electronically. These will include the Waterlow, FRASE, MUST scores and other Risk assessments (Manual Handling).
- Frequency of subsequent clinical observations will be taken, recorded and monitored depending on patient's condition but must be done at least weekly.
- However, any abnormalities in clinical observations must be reported and discussed with the Clinician responsible for the patient's care by the Nurse in charge.
- The Nursing staff must ensure that corrective actions/ treatment are implemented, monitored for effectiveness and documented accordingly, including any follow up outcomes.
- Rehabilitation assessment with a programme of goals and needs must be set within 4 days of their arrival. A minimum daily assessment of progress and other problems identified in care plans must be undertaken and documented by a Registered Nurse and/ or therapist.
- An expected date of discharge will be agreed by the team members during the weekly multi-disciplinary team meeting and communicated and discussed with the patient.
- All Rehabilitation Patients will have a minimum weekly Multi- disciplinary review led by the Care of the Elderly Consultant and discussed with the client by the responsible clinician and Cazaubon Unit staff.

- Detailed rehabilitation programmes and care plans will be led by the Unit's Physiotherapist and Occupational Therapist, implemented by the Cazaubon Rehabilitation Support Workers.
- Other primary care/ community specialist admissions to Intermediate Care will have a minimum weekly review of care plans, discussed with the patient and the Cazaubon Unit staff.

- All patient interventions must be documented contemporaneously on RiO.
- Daily nursing progress notes must be documented at least twice a day by the Cazaubon Staff.
- If there is deterioration in the patient's condition, the Clinician responsible will provide clinical / medical advice and treatment, including out of hours (Refer to 6.8 & 9.8), or patient transfer to A&E is facilitated using the 9-999 Emergency Ambulance Service.
- As patients are admitted for rehabilitation and not in an acute episode of illness, an early warning system is not in use.
- Where a patient has to attend any health service outside of EHCC e.g. Out patients / Diagnostics, A&E, they are accompanied by a nurse escort if required and their medical/ clinical notes/ prescription chart / medicines. A nurse to nurse transfer form is also completed if the transfer is expected to result in an admission.
- Family / next of kin are also informed of the transfer as soon as this known and invited to accompany the patient if they wish.
- Patients consent to share their information and relevant documentation with other professionals must be sought, before any referrals can be made.
- Nursing care will be provided by Registered Nurses, Rehabilitation Assistants and Support Workers. Nursing care plans are formed according to patient's nursing needs, supporting their rehabilitation goals.
- The Unit complements Borough wide intermediate care services and will work in partnership with other community and hospital based services in order to meet patients' and their carers' needs.
- A home assessment may be undertaken by the occupational therapist, with or on behalf of the patient to ascertain home environmental conditions. Advice and/or equipment may be recommended to assist with client's achievement of independent of living.
- A referral to a Social worker will be made if Social Services are required.
- The Social worker will ensure that updated information on care packages and care provision in the community are also given to the patient/ family on discharge.
- The discharging nurse will ensure that a discharge letter outlining the outcomes of rehabilitation, their destination, medicines and any referrals made/ appointments expected is sent to the GP and/ or referring professional. A copy of the letter is also given to the patient. (refer to appendices 3 & 6)

5.0 Eligibility Criteria

The Intermediate Care Unit will operate as a 'step up' unit for clients registered with a Newham GP from the community, and as a 'step down' unit for clients from acute hospital wards, including from out of borough.

5.1 Intermediate Care referrals criteria

- Eligible patients will be adults over the age of 60 years, who have recovered from the acute medical stage of illness and meet the following criteria (eligibility checklist):
    - medically stable for at least 48 hours.
    - patient able to participate in rehabilitation on admission.
    - no significant changes in medical management anticipated.
    - Patient could potentially benefit from active nursing /rehabilitation intervention in one or more of the following – education / psychological care / mobilisation / symptom control / nutrition / feeding / wound care / nurturing.
    - routine investigations results (bloods and ECG) are available and, where any abnormalities are present, a clinical course of action has been agreed and documented.
    - discharge destination has been identified
    - a maximum stay of 6 weeks is envisaged
    - patient understands and consents to rehabilitation in the Unit
    - resident in Newham and registered with a Newham GP.

- The Hospital Consultant and the MDT have assessed the patient and agreed they have completed the acute episode of their care/ do not require acute hospitalisation, is appropriate to be managed in the Cazaubon and be under the care of the MDT in the Unit.
- Patients demonstrate an understanding of the contribution they will need to make towards their rehabilitation, they consent and are willing and able to participate in the rehabilitation, activity or enabling processes eg. have some standing balance, cognitive ability to follow instructions, etc.
- A rehabilitation programme for a week to six weeks will improve their independence and to which their family and/or carers agree to.
- Are assessed as able to benefit from rehabilitation in a ward setting and not primarily waiting to go to a residential / nursing home, unless a transitional admission is proposed, ie prevention of premature admission to long term care by reinforcing a rehabilitative programme in a step down facility instead of an acute hospital setting.

5.2 Referral Screening

All referrals to the Cazaubon need to be made via an initial contact / or Cazaubon referral form. Their suitability will be checked against the criteria as above and the check list completed by a Cazaubon/ EHCC Senior Nurse following their own physical assessment of the client.
Any accepted client must be transferred or admitted to the East Ham Care Centre between 10.00-16.00hrs Monday to Friday. Out of hours admissions may occasionally be considered if the patient is known to the Cazaubon MDT and/ or the Community Matron and the GP, has seen the patient within the last 24 hours.

6.0 Referral Process

Clients and carer/s must agree to the referral and possible admission to the Unit. All referrals must be faxed to the Cazaubon Unit, unless previously arranged, e.g. Rolling respite.

6.1 Intermediate Care

- Referrals to the Unit can be made by telephone, fax, or letter or using the Cazaubon referral form (refer to appendix 1)
- Referrals should contain a comprehensive medical history, identifying any complex needs, potential ability for rehabilitation and state an expected outcome. All medical notes and other relevant documentation should accompany the patient on admission.
- On receipt of a referral, the Cazaubon senior nurse must undertake an assessment of the referral documentation received within 4 hours, complete the eligibility checklist and manage the referral process.
- If accepted, Client transfer will be agreed or client will be put on a waiting list. The Cazaubon Senior nurse will inform referrer of outcome within two working days of referral.
- Clients can be referred at any time but completion of admission process will be within a maximum of two working days following receipt of referral, unless there are changes e.g. to the client's condition or in the case of a beds crisis escalation.
- All referrals must be categorised into the intermediate care remit of - early discharge / rehabilitation, crisis intervention, admission avoidance, long term conditions / frequent flyer or transitional.

6.2 Social services respite

- Social Services Clients must have had a review proved on SAP/ Overview documentation and meet London Borough of Newham's Fair Access to Care Services (FACS) eligibility criteria as assessed by their care co-ordinator (usually their Social Worker.)
- The documentation must be sent to Cazaubon alongside the client's yellow SAP folder and other relevant documentation.
- Referrals for these beds are only accepted via the Social Services Department Brokerage, Assessment and Review Team (SSD- BART).

6.3 Social services respite / Community led bed clients

- All referrals must be accompanied by a recent GP/ Community Specialist medical history including a list of current prescribed medication. There must be clear documentation that acute hospital intervention is not required at the time of referral.
- Consent must also be obtained from the GP/ Community Specialist/ (Matron) to provide medical / clinical cover including Out of Hours, while patient is in the Unit.
- A letter will be sent to the GP/ Community Specialist within 24 hours of admission to inform them of admission and also of their medical responsibility towards client while in EHCC.
- A discharge date must be agreed with both the client and their carers prior to admission (refer appendices 3 & 6)

6.3.1 Not more than 5 beds on the unit should be used at any time for Social Services respite clients and not more than two for Community led bed admissions.

6.3.2 Not more than 2 beds on the unit should be used at any time for Community led bed admissions.

6.4 Emergency Placements to Cazaubon Unit from the Community

- Emergency/ short notice placements can be considered providing that the Cazaubon Nurse-in-charge is satisfied that the criteria for admission to the Unit is met i.e. client does not require an acute hospital admission (refer to 5.0) and there is a bed available.
- The client has agreed to the admission to the Cazaubon Unit and is aware of reason for admission (medical summary including test results if any, reasons for referral, medications, and clinician agrees to provide clinical cover while client is in the Cazaubon).
- The Social Worker and clinician in charge (GP / Community Specialist / Community Matron) agrees to carry out a review within 72 hours of placement. S/he will liaise accordingly with the Cazaubon Unit staff, and jointly make a decision as to appropriateness of continuing the placement or referring to the Care of the Elderly team or an alternative placement.

6.5 Emergency Transfers to A&E from EHCC in Case of Clinical Emergency

- A decision to transfer to acute care will remain the responsibility of the Clinician in charge of the client, i.e. Care of the Elderly team, GP , Community Matron or their Specialist representative except in the case of a life threatening acute emergency (e.g. Cardiac Arrest, Respiratory Distress/ Arrest, Excessive bleeding) where the Nurse in Charge can arrange the transfer through 9-999.
- Basic Life Support should be carried out in all cases (CPR and Assisted oxygenation), unless there is written documentation advising otherwise, e.g. DNAR form signed by the Consultant/ Clinician responsible for the client's care.
- The Cazaubon Nurse- in- Charge will notify the Clinician responsible as soon as possible, if any of these actions are taken.

6.6 Requirements for all potential Respite/ Community Led Bed Clients

- All clients must have an FP10 or a signed doctor's prescription and letter accompanied by a recent medical history clearly stating the patient is medically stable.
- Prescribed medications need to be transcribed by a prescriber (incl NMP) on to the EHCC Medicine Administration Chart, if not already done so, or as soon as the client is admitted.
- The Single Assessment contact and overview documentation must be e-mailed/ faxed to the nurse-in- charge. The Nurse- in- charge must agree that the placement is suitable according to criteria and eligibility. (pp8-9)
- Upon admission to the Cazaubon Unit, the respite bed medical cover will be the responsibility of the Client's GP or nominated representative, e.g. Specialist/ Community Matron.
- Clients occupying respite beds must bring appropriate and sufficient supply of walking aids, clothing, toiletries, medication and continence pads – for the duration of their stay.
- Respite Care will be chargeable and arranged through the Brokerage and Review Team who will apply Local Authority policies including Individual Budgets through the Social Worker.
- Social respite clients who occupy Cazaubon unit will not access multi-disciplinary professions such as physiotherapy or occupational therapy unless referred to and accepted by the Care of the Elderly Team. This can be agreed on a temporary basis and can revert to a Community led bed admission as the client's condition improves.
- Appointments or follow-up visits for out-patients etc. will need to be informed to the Unit immediately this is known, especially if assistance is required eg for escorts or other preparations need to be made prior to the appointment.
- Rolling respite can be requested and arranged via referrer and Social Worker, as appropriate.

6.7 Escalation Procedures for Admission to EHCC from NUHT in Case of Beds Crisis

- EHCC Senior Manager (SM) must be notified of a Beds Crisis alert in NUHT. SM will liaise with Matron and Cazaubon Nurse in Charge to confirm beds availability/ status. Patient safety must remain paramount during the escalation and transfer process.
- NUHT must send referral by fax on: 020 8475 2122 marked **URGENT FAO:** Matron EHCC
- Matron will liaise with NUHT Discharge coordinator and confirm outcome, including agreed patients to transfer, based on:
    - Patient and family have agreed to the transfer to the Cazaubon Unit.
    - Documented evidence shows patient is known to and assessed as medically stable by Care of the Elderly Team and recommended fit for transfer.
- Cazaubon Nurse in Charge must ensure admission procedure adhered to according to Key Operations of Service.

7.0 Provision/Quality Indicators

The Unit uses monthly scorecards to measure service delivery, performance and achievement against business plan objectives.

- A professional, holistic assessment of medical, rehabilitation and care needs, in conjunction with the ward and community based health professions, social services, family and carers is performed usually within the first week of admission using SAP and electronic clinical recording (RiO, Care First and Electronic Patients' Records). Care Planning Meetings are arranged for clients who have complex discharge planning needs, therefore facilitating timely discharge and reducing Length of Stay.
- Incidence of HCAIs, e.g. all admissions screened for MRSA and C difficile if previously symptomatic. All admissions are isolated for 48 hours following admission to EHCC.
- Regular/ minimum weekly consultation with all aspects of rehabilitation and care/support to promote maximum independence in activities of daily living.
- Weekly multidisciplinary team review of all aspects of care and rehabilitation with adjustments made as independence is reached and as agreed with client.
- Intermediate Care performance indicators e.g., i.e. remained in the Community 91 days post discharge, any readmission to acute hospital within 28 days of discharge due to a related condition.
- NHS Vital signs indicators e.g. Numbers of respite offered to carers
- Governance reporting and actions e.g. Sickness absence, Training, Safety Alerts, Incidents, Complaints and Compliments, Bench Marking , implementation of NICE guidelines to promote clinical effectiveness, work with Community Specialist and other allied health teams, local authority.
- Annual audits of record keeping, Infection Control, Medicines Administration including use of CDs, quarterly Tissue viability audits are also undertaken to monitor performance.
- Home Care Support arrangements can be made for the provision of social and voluntary care services if appropriate. Relevant documentation will be given to clients before their discharge involving clients fully in their care. (Refer to appendices 3 & 6)
- 24 hour medical cover will be available to all patients in the East Ham Care Centre, either through the Care of the Elderly Consultants Team or the GP (CooP) out of hour's service.
- Discharge reports with details of clients' progress, medication, outcomes and referrals to other agencies, will be written within 5 days of discharge from the Unit ensuring continuity and consistency of care.

- Discharge questionnaires and quarterly Listening Days are also in place for past and present users.
- Monitoring of maintenance of independence in the community 28 and 91 days post discharge (National Indicator 125).
- Monitoring of planned care provision in the community 48 hours post discharge(Refer to appendix 6)

8.0 Cazaubon Unit Multi-Disciplinary Team

The multi-disciplinary team consists of:

- Matron
- Cazaubon Registered Nursing Staff
- Cazaubon Rehabilitation Support Workers
- Housekeeper
- Community Allied Health Professionals:
  - Physiotherapist
  - Occupational Therapist
  - Speech and Language
  - Podiatry
- Care of the Elderly Consultants, Associate Specialists, NUHT OP wards, Discharge Coordinators, Pharmacy
- Community professional/ GP
- Social Worker/ BART

8.1 Cazaubon Unit

Cazaubon Unit, East Ham Care Centre, Shrewsbury Road, Forest Gate E7 8QP
Telephone: 0208 475 2029 / 2150 Fax: 0208 475 2031

8.1.1 Visiting Hours

- Monday – Friday : 15.00hrs - 17.00hrs and 18.00hrs - 20.00hrs
- Weekends and Bank Holidays - 10.00hrs-12.00hrs, 13.00hrs -17.00hrs and 18.00hrs - 20.00hrs

8.2 Roles of Staff

All staff must endeavour

- To help maintain effective communications between the Unit, the client, the relatives and other professionals
- To ensure that cohesive and seamless care is provided which creates a positive experience for clients and their families.
- To maintain and work towards continuously developing their own skills and competencies to meet required standards of service.
- To continuously promote the enabling, flexible and supportive philosophy of Intermediate Care and rehabilitation services.

8.2.1 House Keeper

- To work as a member of the multi- disciplinary team, ensuring regular, efficient standards of cleaning is carried out every day on the Unit.
- To be responsible for reporting any maintenance problem directly to Estates & Facilities department, monitor and follow-up any actions undertaken.
- To ensure spillage kits are available for dealing with blood and bodily fluids cleaning are available for use on the Unit.
- To carry out regular monitoring of furniture and fittings and to ensure good state of repair

- To be actively involved in the promotion of good housekeeping and networking with other housekeepers across the Trust.
- To make sure that all clients choose their meals from a menu on a daily basis and to liaise with nursing, nutritional and catering staff to ensure clients receive any special meals and/or meals of their choice.
- To order and offer light bites i.e. fruit, yogurts, biscuits, cakes and fruit drinks according to clients' needs.

8.2.2 Support Workers

- To act as the co-worker and liaise with Registered nurses, Occupational therapist and Physiotherapists
- To provide direct individual care to clients, enabling and promoting their eventual independence and achieving individual rehabilitation goals as assessed by the therapists, incorporating this philosophy within all aspects of clients' daily living activities.
- To report both verbally and in writing patient's progress of care according to prescribed care plan at least daily.
- To participate actively in all aspects of the work of the multi-disciplinary team towards patients' care.

8.2.3 Rehabilitation Assistants

- To act as key workers for clients, liaise with RNs', Physio and Occupational therapists.
- To carryout exercise programmes as demonstrated by the Physiotherapist or Occupational therapist with individual clients and in groups.
- To provide support to clients and professional coordinators to carry out individual care plans to achieve rehabilitation goals
- To conduct follow-up home visits as necessary

8.2.4 Registered Nurses, including Deputy Unit Manager

- To assist the Unit Manager with the daily operations of the Unit.
- To conduct regular nursing assessments for all clients, to co-ordinate nursing care plans with a view to resolving health problems and ensure care documentation guidelines are met.
- To identify any deterioration to client's condition and seek timely and appropriate help.
- To ensure effective shift handover which informs all staff of clients' progress/ rehabilitation and care plans. To ensure effective communication within the team, with carers and outside agencies
- To Line-manage, monitor and mentor registered and non- registered staff including students on placement and support their personal and professional development.
- To ensure that care agreed with clients is delivered by all staff according to professional and NCHCS guidelines.
- To follow up referrals made to other services including AHPs/ agencies, according to client's needs avoiding any gaps in the Care Planning and discharge process.

8.2.5 Physiotherapist

- To assess, set achievable goals with the patient and form a physiotherapy care plan, including a risk assessment, and maintain full documentation.
- To provide relevant reports and assessments of patients' functional abilities.
- To help patients regain function and mobility, by working towards set goals.
- To communicate progress with the multi-disciplinary team and community agencies, participate in care planning reviews, ward rounds and home visits.

- To educate clients about their condition and their role in achieving and maintaining rehabilitation goals.
- To supervise the Rehabilitation Assistants (RA) working in this role, update and liaise with the RA and the Unit Manager on progress or ways to support practice improvement.
- To provide training and advice to formal and informal carers as required.

8.2.6 Occupational Therapist

- To provide occupational therapy interventions on the Unit and participate in multi-disciplinary patient reviews.
- To write-up risk assessment and rehabilitation care plans in the SAP notes prioritise programmes which encourage maximum independence and other relevant reports, as required.
- To supervise the Rehabilitation Assistants working in this role, update and liaise with the RA and the Unit Manager on progress or ways to support practice improvement.
- Undertake home assessment for functional ability, safety and adaptations where necessary. Request and obtain the adaptation equipment as relevant.
- Provide advice to patients, carers and other agencies as required.
- Monitor effective and safe use of equipment.

8.2.7 Social Worker

- To provide the overview assessment of the SAP, interview both clients and their carers to identify discharge and carer's support needs.
- To set up and facilitate care planning meetings as required, including any Safeguarding Adults processes.
- To set up and regularly review clients' care packages in partnership with patients and their carers for patients returning home.
- To suggest and provide timely information on suitable residential and nursing home placements for patients where required.
- To cooperate and participate fully in the multi- disciplinary team's objectives and keeping clients, carers and the multi-disciplinary team informed of progress of discharge planning.

8.2.8 Care of the Elderly Consultant/ Associate Specialist team

- To ensure the referral (Appendix 1) is completed within 24 hours of planned transfer.
- To assess a client's suitability for transfer to Cazaubon Unit and retain clinical/ medical responsibility for the episode of care in the Cazaubon Unit.
- To carry out weekly MDT ward rounds, discuss patient progress with the Cazaubon Unit Team and to support medical continuity after care.
- To ensure an appropriate plan of clinical management for each client and be available for liaison with relatives concerns, via appointment.
- To ensure that at discharge, patients have achieved their defined goals as far as possible.
- Provide advice and respond to reassessment of reported changes to patient's condition and/ or clinical emergencies in the event of any deterioration of patient's condition.
- Please refer to ELFT Resuscitation Policy.
- All other unplanned transfers to acute hospital care will be discussed and agreed with the Clinician responsible for the client.

8.2.8a Availability of Care of the Elderly Consultant in EHCC: Day Hospital: Mon, Tue, Wed and Friday mornings or (NUHT: 0207 476 4000 Bleep 628 within 9-5) or the Associate Specialist for Care of the Elderly / Stroke: 07889113461 (24 hours)

8.2.8b IN A LIFE- THREATENING CLINICAL EMERGENCY

and in the absence of immediate medical advice nor of a DNAR (Do Not Attempt to Resuscitate) , the Registered Nurse in charge of the shift will make the decision to arrange transfer to Accident and Emergency Dept via 9- 999, and carry out Basic Life Support until ambulance arrives.

8.2.9 Unit Manager

- To act as gatekeeper to the Unit, ensuring all referrals and admissions processes are followed and are appropriate.
- To lead on supporting the strategic development of the Unit ensuring services are always patient centred.
- To Line manage the staff of the Cazaubon Unit, ensure that all staff within the Unit are efficient and effective in performing and carrying out their roles, staff competencies and skills are appropriate and maintained, and professional teams are working in a cohesive and collaborative manner.
- To ensure sufficient and appropriate staffing ratios are available in all the shifts in the Unit.
- Provide managerial responsibility and operational leadership for the Unit by ensuring effective channels of communications are present and sustain continuous improvement of services as identified.
- To manage the budget and ensure contracted activity is maintained.
- To ensure smooth professional running of the Unit in line with policies, procedures and risk management ensuring adherence to clinical governance framework.
- To agree the Unit's policies and standards and to review them annually.
- To ensure appropriate and relevant data are available which evidences the Unit's performance and achievement of objectives.
- To carry out regular patients' satisfaction surveys (at discharge), arrange regular Listening Days (3 monthly) and utilise the information for future development and improvement of Cazaubon and Intermediate Care services.
- To analyse questionnaires, investigate complaints and acknowledge compliments forming an action plan to inform developments of the service.
- To ensure continuity and consistency of care eg follow up discharge reports with details of clients' progress, medication, outcomes and referrals to other agencies, are written within 5 days of discharge from the Unit to ensure.

8.2.10 Matron

- To ensure documentation are complete and patients are suitable for East Ham Care Centre provision
- To support the Intermediate Care Ward ensuring coordination of communications with patient/ family/ NUHT and EHCC staff to ensure the transfer process happens smoothly.
- To support the Senior Nurses to ensure that the referrals and admissions processes in EHCC are adhered to and each professional carries out their roles and responsibilities.
- To provide clinical leadership to staff within In- Patient wards and ensure professional standards are maintained.
- To ensure the Clinical Governance framework is implemented and adhered to.

9.0 Documentation / Record Keeping

- Clients that are transferred from Newham / Bartshealth are expected to have their hospital records with them on transfer to EHCC, including an accurate and updated medications and prescription chart.
- Nursing documentation must be maintained according to local record keeping policy, and the Nursing Midwifery Council Record Keeping Guidance for Nurses and Midwives (2009) to improve accountability, show how decisions related to patient care were made, support the delivery of services, among other things. This must be done either electronically (on RiO) or on paper (if RiO unavailable).
- All patient records are stored confidentially and must adhere to DPA (1998) and ELF Information Governance requirements. Patients can have access to their records on written request (Access to Health Records and DPA)
- Patient contacts and multi-disciplinary care plans are to be placed in their bedrooms for ease of availability to them. This ensures good communication between the disciplines and can avoid duplication.
- All relevant staff must be aware of and act on relevant information contained within the client's clinical records appropriately, e.g. Personal details, Discharge instructions, Resuscitation status, etc.
- Allied health professionals must maintain individual patient progress notes and must ensure clear and effective communication to support patient- centred care.

10.0 Training and Staff Development

- New staff will receive an induction and preceptorship and an in-house programme to support their role in the Unit. Key induction areas include contact with both in patients and other Community Health Newham and ELFT related services.
- In addition, training around clinical recordings and recognising their meanings in patients' conditions, the use of clinical equipment and other medical devices in use will be ongoing and provided as necessary.
- Rehabilitation Assistants and Support Workers will be actively encouraged to attain relevant National Vocational Qualifications (NVQs) and Foundation Degrees.
- All professional staff are encouraged to access post-registration training as part of their Continuing Professional development.
- All Staff will have an annual Individual Performance Review including a personal development plan, reflecting present and future training needs required for their Professional development and the Unit's and Service Objectives.

11.0 Management Arrangements

- The Cazaubon Unit is part of the Specialist Nursing Services (Adults Services, Community Health Newham, and ELFT) under the overall responsibility of the Associate Director for Nursing.

- Day to day out of hour's responsibility for the Unit is delegated via rota to a Senior Manager within Adult Services**.** Contact can be made at any time via their individual mobile numbers. An updated Senior Manager on call rota is available in the Bleep Holders folder.

Appendix 1

CAZAUBON UNIT REFERRAL

TELEPHONE: 0208 475 2029 0r 2150 FAX: 020 8 475 2031

NAME:		AGE & D.O.B:
		HOSPITAL / NHS NO:
ADDRESS:		
DATE OF REFERRAL:		**Sign & print name:**
DATE OF ASSESSMENT VISIT:		**Sign & print name:**
DATE OF ADMISSION:		**Sign & print name:**
REFERRING WARD: DIAGNOSIS ON ADMISSION:		
REFERRING CONSULTANT/ HOSPITAL BASE:		
REASON FOR REFERRAL TO CAZAUBON UNIT:		
REHABILITATION GOALS IDENTIFIED:		
PRESENTING DIAGNOSIS:		
PREVIOUS MEDICAL HISTORY:		
MEDICATION:		
ANY ALLERGIES?		
IS PATIENT AWARE OF REFERRAL AND HAS CONSENTED?		

ADMISSION CRITERIA CHECKLIST: (please Tick √)	YES	NO
Patient is over 60?	☐	☐
Patient is Newham Resident?	☐	☐
Plan is for discharge home?	☐	☐
Are there any concerns about patient returning home? If yes, pls state.	☐	☐

Patient is medically fit/stable? *If out of borough Hosp referral – ie WX or RLH - please send medical and discharge summary from Consultant, PHYSIO & OT assessment and others as relevant*	☐	☐
Patient requires isolation due to ? MRSA positive or C-difficile toxins Patient had diarrhoea since admission? If not, WHEN DID THE CLIENT HAVE DIARRHOEA DATE……. Specimen sent for test? Date…… Name and designation of person providing information ……..	☐ ☐ ☐	☐ ☐ ☐
Medical investigations completed? (If medical investigations pending in next week, pls specify date of review appointment) Date_____	☐	☐
Is pain well controlled? If pain poorly controlled, book review appointment: Date	☐	☐
Drug chart included?	☐	☐
Has patient received Cazaubon Information Leaflet?	☐	☐
Does patient/family understand admission is 2-6 weeks only?	☐	☐

Continence status	
Current mobility including any physio input	
Previous Mobility	
Current Transfers	
Previous Transfers	
Previous functional ability Including any OT input	
Current assistance required in washing & dressing	

Details of any memory difficulties		
Able to follow instructions & learn new information?	YES ☐	NO ☐
Is the patient awaiting residential unit yes or no What does patient want to achieve from admission to Cazaubon Unit?		
Patient willing to participate in rehabilitation and consents to transfer to Cazaubon?	YES ☐	NO ☐

REFERRAL ACCEPTED / DECLINED / Review Assessment Required?

Date of Review:

IF BED NOT AVAILABLE, DATE PLACED ON WAITING LIST:

OUTCOME OF ASSESSMENT DOCUMENTED IN MEDICAL NOTES?

OUTCOME OF ASSESSMENT FED BACK TO STAFF/ REFERRER (Name)?

Name of assessor: Signature:

Designation: Date & time:

Appendix 2

HOW TO C5

CONTACT THE DOCTOR IN AND OUT OF HOURS

The Care of the Elderly Consultants lead a weekly Multi disciplinary review of all Intermediate Care in- patients and three monthly review of all Continuing Care In-Patients.

There is a doctor in EHCC, Day Hospital on Monday- Wednesday and Friday mornings. They can be requested to 'Clark' new patients that have arrived to the Unit, and to attend to any emergencies/ unexpected changes to patients' condition while on site.

When leaving a message please state:

1. Patient name, date of birth
2. Name of ward
3. Contact number and your name
4. Urgency of consultation

Possible reasons to contact the on call Doctor or Consultant would be:-

1. Sudden/ unexpected deterioration in patient's condition
2. Excessive Vomiting
3. Acute Urinary Retention
4. High Temperature
5. Abnormal Raised or Low Blood Pressure or Blood Sugar
6. Loss of appetite/ inability to eat or drink, possible dehydration
7. Acute Pain, including Chest Pain (Not cardiogenic shock)
8. Acute Abdominal Distention
9. Respiratory Problems
10. Loss of consciousness
11. Accidents/ incident
12. Allergic reaction (Not anaphylactic shock)

Please request doctor to speak to the family/ relatives to discuss plans and outcomes expected, if any deterioration in patient's condition occurs.

TO CONTACT A DOCTOR OUTSIDE OF DAY HOSPITAL AVAILABILITY:

Doctor on Call (Associate Specialist for OP and Stroke): 07889113461 or
Newham University Hospital Switchboard: 02074764000 **Bleep 628**.

IN A LIFE- THREATENING CLINICAL EMERGENCY
and in the absence of immediate medical advice nor of a DNAR (Do Not Attempt to Resuscitate) , the Registered Nurse in charge of the shift will make the decision to arrange transfer to Accident and Emergency Dept via 9- 999, and carry out Basic Life Support until ambulance arrives.

Appendix 3

HOW TO T1

TRANSFER A PATIENT TO ANOTHER HOSPITAL

The Nurse in Charge must ensure that any patient transferring out of EHCC is dressed appropriately to preserve their dignity, comfort and privacy to travel in an ambulance. Consideration must be given as to patient's general condition and also whether travelling in a chair or in a stretcher.

PLANNED TRANSFER

Transport to be booked through the ward clerk on Ext. 2034 and the nurse escort arranged through the senior nurse/ bleepholder.

Nurse in charge must ensure relatives are aware of the transfer. Invite relative to accompany patient.

Nurse to nurse and inter- health transfer forms to be completed and to accompany the patient with the medical notes, X-rays, drug chart, nursing notes, property, and property list.

EMERGENCY TRANSFER (SEE ABOVE)

Basic Principles and good practice in discharge planning

- The discharge checklist should always be completed (appendix 7)
- Where transfer or discharge is being considered, the patient's level of need should be assessed and referrals made to other services in a timely manner as appropriate. This will include social care and community nursing teams.
- Assessment and planning associated with transfer or discharge should always incorporate thorough risk assessment and planning. Consideration should be given as to the risks involved in escorting patients as part of a transfer and the necessary level of skill mix required, if any, to escort patients.
- It is important that patients are involved in the planning and decision-making about the transfer or discharge of their care and that this should take account of any preferences the patient may have and also ascertain whether they have mental capacity to make informed decisions/choices about their care
- Patients should be given adequate notice, where possible, about transfer and discharge arrangements and given clear information about support options available following transfer or discharge, in order that joint and informed choices can be made.
- Patients and carers should be provided with clear information about how they can access the service again, if arrangements following transfer or discharge do not work out or things deteriorate.
- Patients and carers should have clear information provided about the referral pathways and processes for any services they are being discharged from or transferred to (this should include information about possible waiting times, assessment process, intervention type, time-scale of intervention).

- It should be acknowledged with patients, that discharges and transfers are often an anxiety provoking time. Patients should be provided with support through this process, having the opportunities to discuss concerns as well as other issues. Withdrawal or ending of treatment and transition from one service to another may evoke strong emotions and reactions and staff should ensure that such changes are discussed carefully with the patient beforehand and are structured and phased.
- Family and carers should have the opportunity (with the agreement of the service user) to be involved in the planning of transfers or discharge, where appropriate.
- Involved family and carers should be notified before the service user is transferred or discharged.
- Planning with regards to transfer and discharge should be fully and accurately documented in order that all parties relevant to the transfer or discharge can clearly understand the arrangements and refer to these when needed.
- Clinical staff should engage with and communicate effectively and timely with others involved in the transfer and discharge process. This will include Trust staff, staff from other agencies i.e. social care or NHS bodies, patients, their family and/or carers.
  Key information should be given to those who become responsible for treatment and care following transfer or discharge.
- If a patient is discharged home in receipt of other services the ward nursing staff will contact the patient/carer 48 hrs post discharge to ascertain that these services have commenced. If the patient or carer is not contactable then the nurses will contact the relevant agency to ensure that the services have been initiated.
- In many circumstances, transfer and discharge will follow similar procedures and general principles will apply to each activity.

- **If the patient is/will be in receipt of care from the extended primary care team , e.g. community OT, District Nursing, a member of the relevant team should be invited to the discharge planning meeting**

6 Transfer

- This protocol applies to patients being transferred to other inpatient or outpatient services while the ‘bed’ is kept open for the patient’s return .
- The planning of all transfers to and from an acute hospital should incorporate detailed planning of both mental and physical health care needs and treatment and a detailed plan of care should always accompany the patient at the point of handing over the patient to the receiving care providers.
- Documentation to accompany the patient on transfer
  As a minimum the following records should accompany any internal or external transfer:
  - RIO summary and if being transferred to NUHT the NUHT notes if available
  - Drug charts
  - Care plan
  - X-rays or other diagnostic records as appropriate
- Out of hours transfer arrangements
  Transfer of patients out of hours is sometimes necessary but where possible transfer should happen during normal office hours. Any out of hours transfers should pay special regards to safe escort arrangements, prior risk assessment and adequate supporting documentation to accompany the transfer.

Appendix4

PROTOCOL FOR VIRTUAL WARD ADMISSIONS TO EAST HAM CARE CENTRE

1. 0 Terms of reference:

1a The service will support the Intermediate Care agenda by preventing unnecessary acute hospital admissions and providing a Step up approach to care in the community, closer to home.

1b Referrals will be considered for patients who are deemed medically stable by the VW/ GP, but require short term (maximum 7 days) in- patient admission for supportive or monitoring purposes in order to help them manage their long term condition in the community. If extension or additional days are required, this will be discussed and agreed with either the Unit Manager or Matron and reviewed on a regular basis.

1c Referrals will be considered from the Community through the Community Matrons working within the Extended Primary Care Services.

1d The medical responsibility will remain with the individual's GP/ Community Matron, including the provision of out of hours medical services. This must be made clear and evidenced by the referrer (if not the GP) as having been agreed prior to the admission.

1e Nursing and other supportive services will be provided by the Specialist Nursing Team and EHCC Therapies.

1f There will be an average of two beds allocated for this purpose and acceptance will be subject to availability within the contracted beds.

1g The service will be based in the East Ham Care Centre, and will normally be available for referrals Monday to Friday only, to coincide with Extended Primary Care Teams' (EPCT) working times. Out of hours referrals will be considered through the Community Matrons' (CM) during their working hours.

2.0 Procedure:

Referral:

2a The EPCT (referrer) will send a referral and discuss with Matron or Cazaubon Senior staff using the EMIS/ eSAP front sheet specifying the purpose/ reasons for referral. The referral will include personal and medical details eg. diagnoses and medications list/ history.

2b A response to the referrer will be made within six hours of receipt of above. If referral accepted, availability of a bed is confirmed at the time.

2c The documentation must include a recent (maximum 24 hours) medical/ clinical assessment/ review indicating that an acute admission is not required at the point the referral is made.

2d The patient (or next of kin) must consent to come to a GP Community- led admission/ bed and this must be evident in the referral. AVW Information leaflet explaining the admission will be given to the patient by the referrer once the admission is agreed.

2e All assessments, medical history and care plan will be formed and completed by the CM and Cazaubon staff and be available to the EHCC Staff before or when the patient arrives. The CM will also complete the Medicines Administration Chart

2f The patient must also have sufficient amounts of medications (including dressings, continence pads, etc) to provide cover for the initial periods of the admission (at least 72 hours). Top up/ changes and supply of medicines and other surgical supplies will remain the responsibility of the Community prescriber by FP10.

2g Clinical responsibility and accountability remains with the patient's GP/ Community Matron during the Community led episode.

3.0 Admission:

3a The Referrer will arrange the transport to transfer the patient to EHCC. The arrival time must be confirmed and aimed for the patient to arrive before 4 pm Mon- Fri.

3b The referrer will also be responsible for ensuring notification to other community providers and services of the admission eg Extended Primary Care, Social Worker, home care agencies.

3c On admission, any discrepancies in the information provided to EHCC and the actual condition of the patient will be notified to the Referrer. The Referrer must correct/ rectify them in agreement with the EHCC Nursing Staff.

3d Transfer to acute hospital/ A/E will also be considered if the EHCC staffs determine the patient's needs as being unable to be met while in EHCC, after discussion with the referrer or OOH cover.

3e Discharge planning will remain the responsibility of the referrer and is expected to be notified to EHCC staff within seventy two hours of admission, or earlier if a shorter period of in- patient care is required.

3f Unless agreed with the Cazaubon Unit staff, the referrer will continue to provide specialist advice and carry out diagnostic or other tests/ treatments, including referrals and monitoring, as if the patient was in the community. This will include treatment or tests following hospital and/ or other appointments.

3g The referrer will be expected to monitor and maintain progress notes alongside local (EHCC) documentation procedures and liaise with the EHCC staff regularly (minimum of every two days) in order that care planning, expected outcomes, and expectations are clearly evaluated in a timely manner..

3h The referrer will feedback any changes from M-D meetings, as required.

3i EHCC staff will provide nursing and other specialist care as relevant and appropriate, according to identified and agreed needs and admission outcomes.

3j A referral to Accident and Emergency, (in the case of a sudden deterioration in the patient's condition, e.g. via 999) will be decided at the time by EHCC staff. The referrer will be notified of this in any case.

Discharge:

The referrer will be responsible for:

4a Ensuring the patient, GP and carers are aware of the discharge by completing the discharge letter and telephone follow up. A copy will be given to the patient on discharge.

4b Booking all transport, medicines, (including dressings) and cost of other supplies.

4c Reinstating care packages and other community services and ensuring these are available to the patient on discharge.

5.0 Governance:

5a The patient's registered GP remains clinically accountable and responsible for the patient during the VW admission, as if the patient was in the community.

5b Other clinical governance and quality assurance will remain the responsibility of the EHCC staff during the admission, according to ELFT policies and procedures. These will include Data protection, Information sharing, Incident reporting, Management of Complaints etc.

6.0 Review:
The Service will be reviewed quarterly according to CHN/ ELFT requirements.

Examples of indicators: Referral to admission timing; numbers of patients referred/ accepted/ discharged on time; user satisfaction score; ease of access into service; remained independent in the Community after 3 months.

Appendix 5
Community Led Beds/ Virtual Ward Referral Form

1. PERSONAL DETAILS			
NHS Number		**Clinical records Number**	
***First Name**		***Last Name**	
Title		**Would like to be known as**	
***Current Address**			
Telephone Number			
Lives alone	☐	**Lives with:**	
***Date Of Birth**		**Age**	
***Gender**		**Preferred Language**	
Ethnic Origin		**Religion**	
Patient consent to referral	☐ **Yes** ☐ **No**	**Name and title of referrer**	
***Communication Needs**			
Advocate required	**(please tick)**	**Yes** ☐	**No** ☐

*GP DETAILS			
GP Name		**Telephone number**	
Practice address		**Fax number**	
Postcode		**Email address**	
* **MEDICAL DIAGNOSIS AND RELEVANT MEDICAL / MENTAL HEALTH HISTORY** e.g. details of recent hospitalisation, frequent hospital admissions, current or recent health concerns/investigations, relevant past history **PLEASE INCLUDE ALLERGIES**			
Is the person aware of the diagnosis?	**(please tick)**	**Yes** ☐	**No** ☐

DRUG THERAPIES/CURRENT MEDICATIONS (INCLUDING NON-PRESCRIBED) AND HOW / WHEN THEY ARE ADMINISTERED

e.g. Oxygen user, self administered, by registered nurse, by social care worker using dosette, blister pack etc., timings. Difficulties in getting a regular supply; managing labels/ containers; swallowing, taking or using. Taking as prescribed? Medication effective?

Name of medication	Dosage	Form	Frequency/time of day

Comments:

***REASON/S FOR REFERRAL**

NEXT OF KIN/ CARER/ CONTACT DETAILS

Name	**Relationship(s)** (Next of kin, main carer, advocate, emergency contact, friend, family, neighbour, other)	**Address (if not the same as above)**	**Telephone Number(s)**

6. ANY OTHER RELEVANT INFORMATION

PLS FAX COMPLETED REFERRAL FORM FAO:
EAST HAM CARE CENTRE MATRON: 02084752122

Appendix 6

CAZAUBON - DISCHARGE CHECKLIST

Please make brief comment in the boxes

DISTRICT NURSE REFERRAL **Date Sent ……..** **Confirmation Date…….** **Reasons for referral** **Wound Care Continence** **1) Bed and pressure relieving Mattress** **2) Cot- sides** **3) Medications –Insulin** **Other Please State**	**Time and date the DN has been informed that the patient has left the ward.** **DATE…….** **Time……..**
Does the patient have the capacity to make informed decisions and choices? **Has a formal assessment of mental capacity been undertaken** **Are wound care dressing and dressing packs been supplied for the patient to take home?** ***Minimum of three days supply***	**YES/NO** **If NO what advocacy arrangements are in place?** **YES/NO** **If yes when.** **If no why.** **YES / I f No state reason**
Continence needs Yes No **If Yes Has continence assessment been completed and forwarded to continence advisor? Yes No** **If No why?**	**How many pads have been given to the Patient to take home** **……**
Social Care Package in place **Yes No**	**Does patient know when to expect their first visit? Yes No**
Equipment in place ***- check with Occupational Therapist.***	**YES / NO**
MEDICATION **Blister packs or Containers**	**Explained and understood by the patient or carer . Yes No**
Next of Kin/Family/ Carers aware of the discharge	**YES/NO**
Mobility Walking Stick or Frame et	**Ensure patient takes this home.**

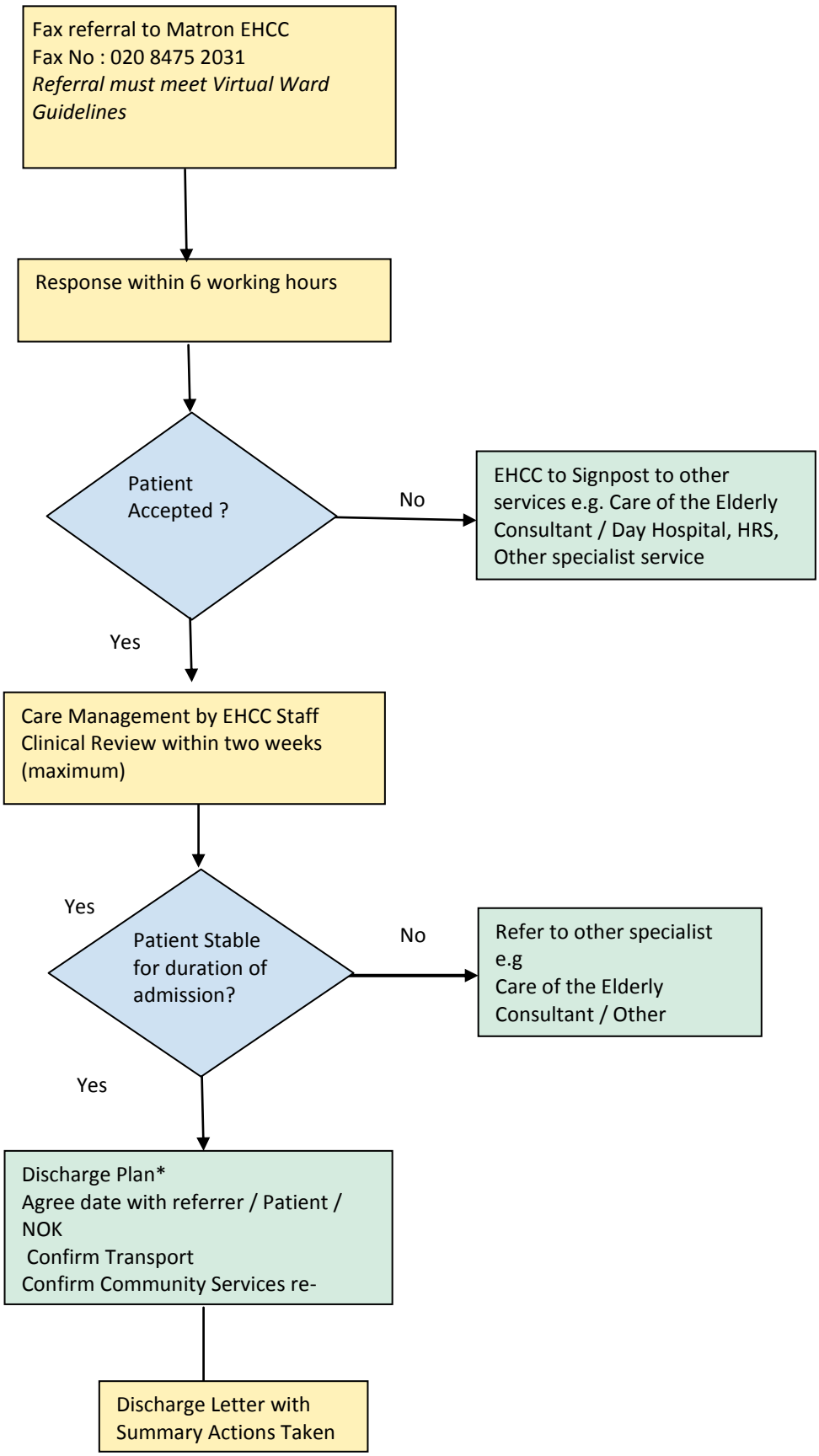
Keys – How will the patient access the home?? i.e family member, friend neighbour	**Check that the patient will be able to gain entry to their home.**
TTA Discharge Letter x 4 copies 1 Original to GP 2 Patient 3 Notes 4 Cazaubon Folder (for VW patients only)	
Transport booked	**Inform transport dept. when the patient is ready for discharge.**
All PROPERTY INCLUDING MONEY RETURNED TO PATIENT.	**ENSURE MONEYS RETURNED ARE SIGNED FOR IN THE APPROPRIATE PROPERTY BOOK**
Community Physio referral	**YES / NO**
Community Matron referral	**YES/NO**

Signature ……..… Date ……Name ……..

48hours after the Patient discharge. **Telephone Patient to ensure services as above are being received appropriately. If patient not available contact care provider** **Service start confirmed yes/ no**	**RN Name** **……** **Dated** **……** **Please note below & update RIO any necessary actions you have taken.** ***Ie Ask district nursing service when they will visit the patient.***

File this form when completed in the **BURGANDY** Discharge Check List Folder

Appendix 7 Referral Flowchart



Appendix 8

CONTINENCE ADVISORY SERVICE GUIDELINES FOR ASSESSMENT AND ORDERING OF CONTAINMENT PRODUCTS FOR ELFT STAFF

Access to the Service

The Continence Advisory Service has an open and direct access for advice and evidence based information. The service will undertake secondary assessment and specialized treatment.
The service can be contacted on 02084752012

Procedure for sending completed assessments and obtaining products

- The Continence Advisory Service operates Monday to Friday 09.00- 1700hrs excluding bank Holidays. The office also provides telephone enquires service from 09.00- 17.00 hrs.
  Assessments should be faxed to 02084752063
  In an urgent situation emergency supplies can be obtained out of hours form the reception at East Ham Care Centre following completion of the emergency requisition form available on the wards and at team bases.

- Assessments will be checked within 1 working day following receipt by a continence nurse and if the assessment is correctly completed containment products will be authorized and sent to NHS logistics. The client should then be contacted by NHS logistics and be in receipt of products within 5-7 days

- Urgent referrals will be assessed within 2working days of the referral

Assessment

The primary aim of a level 1 continence assessment is to:

- Promote continence by addressing physical, emotional, environmental, social and developmental needs
- Identify the underlying cause of incontinence
- Formulate a plan of management by setting realistic goals with defined outcome measures
- Initiate appropriate treatment and where necessary refer for specialist investigation
- Where these measures have been tried and are unsuccessful / inappropriate, incontinence aids / appliances / products may be prescribed

Assessment Process

- Assessments will be undertaken by a practitioner who has been trained in the promotion of continence and management of incontinence

- Assessments will be undertaken using the level 1 continence assessment form

- All clients presenting with incontinence problems (bladder or bowel) or a potential problem must be assessed using the level 1 form

- Following assessment the needs of the patient are identified and these are discussed with patient and family and a care plan formulated and agreed upon.
- Involve where appropriate family, carers and significant others in the care

Review and Reassessment

All patients should have a periodic review of their initial assessment to:

a) Monitor the effectiveness of their treatment/ management plan
b) To ensure there is adequate clinical improvement
C) For clients receiving disposable products
- Adults reassessed yearly
- Children every six months

d) Ongoing reassessments will be documented using the appropriate documentation
f) If there is a change in the client's clinical need within the year of receiving products the client, carer or family is to contact the initial assessor for a reassessment
g} If products are still required after a year a new referral will be required for the needs to be assessed again

PROCESS FOR THE PROVISION OF DISPOSABLE PADS

ELIGIBILITY TO RECEIVE DISPOSABLE INCONTINENT PADS

- The Continence Advisory Service has overall responsibility for the provision and supply of continence products, following a continence assessment/reassessment by health care professionals.

- Continence Products "are an essential component of the management of incontinence that should normally only be issued after an initial assessment or when the management plan has been completed and reviewed. Offering pads prematurely can lead to psychological dependence upon them and reluctance to attempt curative treatment". Department of Health (2000)

Provision Criteria:

- Incontinence can be managed by a comprehensive range of products and pads should only be supplied in accordance with the Continence Advisory Service continence formulary which is available on the wards/within the department.

- Products are only provided after a comprehensive level 1assessment has been made (except when the need is short- lived, e.g. end of life.)

ADULTS

- Adults whose incontinence has proved intractable to treatment. e.g. End of life, terminally ill

- Incontinence due to severe physical or mental disability

14.2 AVAILABILITY OF DISPOSABLE CONTINENCE PRODUCTS

- Products are provided by NHS logistics in line with the contract for provision and Trust containment formulary
- Products are delivered through the Home delivery service to the client's home or Residential care home.
- Disposable products may be provided where clinical need requires the use of a minimum of two to a maximum of 4 products in 24 hours. As the containment products provided are technologically advanced and highly absorbent, this is usually more than sufficient if used appropriately.
- "Products will be provided on a named client basis to meet their total requirement over a 24hour period and the amount required will be determined by the assessor who makes a selection from the Trust formulary.
- Net pants will only be supplied for use with the shaped body worn pads without a sticky back strip. Clients will be issued initially with 5pairs and thereafter 5pairs every 6months as these are washable, highly durable and to be used to hold the pads firmly in place.
- Clients with light urinary incontinence will be advised to purchase their own pads or may be offered washable reusable pants as an alternative. Up to three pairs will be provided initially and three pairs every year thereafter, upon assessment.
- Incontinence pads are not designed for vaginal bleeding and wound exudates
- Clients with faecal incontinence **ONLY,** would be supplied with Tena Comfort Normal with net pants

Appendix 9

NURSE TO NURSE FORM

(For transfer of patients from ward to ward or to other hospitals)

Transfer from
Patients name
Address

To
Age
Date of birth
Religion
NHS No

Next of kin
Address

* relatives informed of transfer/not informed

Telephone No
Date of admission
Diagnosis

Consultant

Date of operation
Dressings required
(Please indicate frequency and special lotions, etc)

* sutures removed/not removed
* wound satisfactory/not satisfactory

Medication (please list drugs – for information only)

1. 3.
2. 4.

Assessment of patient (please tick as appropriate)

Mobility	Bedfast	Chair	Walks with aids	Walks alone
Toilet	Incontinent	Commode	Managers with help	Manages alone
Diet	Fluid	Light	Full	Special – state
Fluids	Restricted	Ad.Lib	Fluid Balance chart	

Condition of pressure areas

Site	Condition	Treatment
Sacrum		
Hips		
Heels		
Elbows		
Shoulders		

PROPERTY (please tick as appropriate)

Accompanying patient	Not accompanying patient – state location
Checked and correct	Not checked
Checked and incorrect	List attached/ not attached

Date: …….

Signature:……

(Ward sister/ Charge nurse)

Contact No: …… ..

*May include Continued Community Rehab / Social Services Care Package

Appendix 10

East Ham Care Centre
East London NHS Foundation Trust

Inter-Healthcare Infection Control Transfer Form

Patient / Client details: (insert label if available) Name: Address: NHS Number: Date of birth:	**Consultant:** **GP:** **Current patient/ client location:** Transferring facility – hospital, ward, care home, other: Contact no: Is the ICT aware of transfer Yes / No
Receiving facility – hospital, ward, care home, district nurse **Contact no:** Is the ICT/ ambulance service aware of transfer? Yes / No	Is this patient/ client an infection risk? ***Please tick most appropriate box and give confirmed or suspected organism*** ☐ Confirmed risk Organism: ☐ Confirmed risk Organism: ☐ Suspected risk Organism: ☐ No known risk Patient/ client exposed to others with infection e.g. D&V Yes / No

If patient/ client has diarrhoeal illness, please indicate bowel history for last week:
(based on Bristol stool form scale)

Is the diarrhoea thought to be of an infectious nature? Yes/ No

Relevant specimen results (including admission screens – MRSA, glycopeptides-resistant enterococcus SPP, *C. difficile*, multi-resistant Acinetobacter SPP) and treatment information, including antimicrobial therapy:

Specimen:				
Date:				
Result:				

Treatment information:

Other Information:

Is the patient/ client aware of their diagnosis/ risk infection Yes/No

Does the patient/ client require isolation? Yes/No

Should the patient/ client require isolation, please phone the receiving unit in advance.

Name of staff member completing form: ……

Print name:

Contact:

For further advice, please contact your Infection Control Team / Advisor