Bath and North East Somerset,
Swindon and Wiltshire Partnership
Working together for your health and care

Bath and North East Somerset, Swindon and Wiltshire (BSW) best practice framework to support health and care professionals **making decisions about admission to and discharge from acute hospitals**

Version	Date	Authors	Comment
9	19-05-2022	Harleen Kaur Johal, Natasha Wiggins, Laura Roberts, Suzy Riggs, Jill Courveur, Robin Fackrell	Ninth version for rollout in BSW. Authored on behalf of, and reviewed by, members of the BSW Ethics Advisory Group. The authors would like to acknowledge and thank the following people for reviewing and providing feedback on drafts of this framework: Jasmine Morris, Jordan A. Parsons, Marianne Tinkler, Brynn Bird, Rachel Prout, Tania Elias, Heather Cooper, Heledd Wyn.

Working Together:

Bath and North East Somerset Council, Dorothy House Hospice Care, NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group, Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, Prospect Hospice, Salisbury Hospice, Salisbury NHS Foundation Trust, Swindon Council, Wiltshire Council, and Wiltshire Health and Care

Introduction

Under significant pressure, health and care professionals have demonstrated extraordinary flexibility to continue to provide the best possible care to our patients. However, some of our current ways of working and managing risk are indirectly leading to unacceptable levels of harm for our patients, particularly for those who are frailer and more vulnerable. Building on existing work in nearby regions,[1] these decision-making frameworks aim to improve confident shared decision-making,[2] and support all health and care professionals in improving the care that we provide to the population we serve.

Through advocating for our patients and by listening to what matters most to them, we need to acknowledge that people – whose acute medical needs have been met – invariably do better in their own homes (or usual environments), as they are at significant risk of both physical and cognitive deconditioning in an acute hospital setting.[3]

By using this best practice framework, staff will be supported to take appropriate positive risk decisions, minimise collective harm, and utilise available resources to meet significant demand. In this way, we seek to avoid unnecessary or prolonged admissions and reduce any delays to discharges, by exploring all possible options to get patients back into their usual environments with enough support if it is needed.

These frameworks have been developed collaboratively with input from health and social care professionals, working in both the community and acute hospital settings, and patient representatives. While these frameworks cannot absorb the decision-making responsibility entirely, they can be used as a point of reference, to support health and care professionals when reintroducing patients into the community.

Thank you for your continued flexibility and for being open to working differently, in order to continue providing the highest quality care for our population.

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[1] Ryan K *et al* on behalf of the BNSSG Health & Care Risk Group. *Admission Reflection Tool*. Available from: https://www.clinicaltoolkit.co.uk/knowledgebase/admission-reflection-tool-art/

[2] NHS England. *Shared decision-making*. Available from: https://www.england.nhs.uk/shared-decision-making/

[3] NHS England. *Reducing length of stay.* Available from: https://www.england.nhs.uk/urgent-emergency-care/reducing-length-of-stay/

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Admission to Hospital: Decision-Making Framework

to support health and care professionals (HCPs) in *communicating* and *weighing up the risks and benefits* of admission or conveyance to hospital

1. Clinical Assessment & Information Gathering

Patient Assessment
- What are the patient's medical and psychosocial needs?
- What matters to the patient?
- Do they have capacity to decide?
- What are their immediate safety risks and vulnerabilities? Can they eat and drink? Are they continent?
- Are they nearing the end-of-life?
- Is there an existing ReSPECT form?

Functional Baseline
- Ask the patient or take a collateral history. Consider the patient's usual behaviour and daily activities, clinical frailty score, cognition, mobility, eating, bowel habits, and exercise tolerance (including stairs).
- What 'baseline', or quality of life, is acceptable to the patient?

Family, Friends & Carers
- What are their views?
- What are their concerns?
- Does anyone have Lasting Power of Attorney for Health & Welfare decisions?
- Is there a package of care in place?
- Ask how much support can friends and family provide at home.

2. Considering the Risks & Benefits of Hospital vs. Home

Admission to Hospital
- Risks: physical and cognitive deconditioning, protracted delirium. increased dependency, restricted visiting from loved ones, emotional distress. resource issues (e.g. safe levels of staffing), sleep deprivation, poor nutrition.
- Benefits: providing life-enhancing treatment, diagnostic certainty, specific medical/care needs being met.

Management at Home
- Risks: medical/care needs not adequately met, clinical deterioration, impact on carers, worsening healthcare inequities, medicines-related harm.
- Benefits: continuation of package of care, familiar environment, greater input from friends and family, reduced exposure to nosocomial infections, other patients can access urgent care.

Further Considerations
- What positive benefits of hospital admission are expected, which likely outweigh the significant risks?
- Could the patient be managed in a hospice, community hospital, or with a Hospital@Home service?
- Do you need to discuss the case with a colleague (e.g., elderly care, palliative care, MDT)?

3. Making a Decision with the Patient (and their Family)

Patient-Centred Discussion
- What would the patient prefer?
- If the patient lacks capacity and a best interests decision must be made, you should still involve the patient as much as possible.
- Are the right people present for the discussion (e.g., family or friends)?
- Do you need an interpreter?

Clear & Honest Communication
- Discuss the risks and benefits of each option, and, if relevant, resource pressures.
- Be transparent about the safety risks of each option.
- Does everyone present understand the risks and benefits?
- Address any concerns honestly.

Careful Documentation
- Note the views of: the patient (both now and those previously expressed), HCPs and family/friends.
- Document the risks and benefits of each option that was discussed.
- Explain the rationale for the decision that has been made, and how much it aligns with the patient's preferences.

4. Planning & Safety-Netting

Admission to Hospital
- Set the estimated discharge date.
- Assess rehabilitation need rapidly, and keep needs under regular review.
- Make early referrals (e.g. PT/OT, palliative care, dieticians).
- Optimise the patient's medications.
- Aim to return patient to their usual situation in their own home as soon as possible.

Management at Home
- Aim to discharge early in the day.
- Consider anticipatory medications, and optimise existing medications.
- Aim to call the day after discharge to check-in with patient, identify potential issues, and offer advice.
- Complete the discharge summary and inform the patient's GP within 24 hours.
- Provide crisis advice (e.g. calling 111, or local clinical advice line if available).

Managing Risk & Moral Distress
- Be prepared for readmission, as this will be inevitable in some of these patients, but aim to readmit to the same team.
- Provide written and verbal advice to patients and their friends and family, as leaflets and/or on the discharge summary.
- Reflect on the decision, alone and/or with a colleague.

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Discharge from Hospital: Decision-Making Framework

to support health and care professionals (HCPs) in discharging *medically stable patients with the best available package of support*

1. Clinical Assessment & Information Gathering

Patient Assessment
- What are the patient's medical and psychosocial needs?
- What matters to the patient?
- Do they have capacity to decide?
- What are their immediate safety risks and vulnerabilities? Can they eat and drink? Are they continent?
- Are they nearing the end-of-life?
- Is there an existing ReSPECT form?

Ongoing Care Needs
- Can any treatments be continued at home?
- Can the patient manage their own medications?
- Can mobility aids or telemedical devices be provided to reduce falls risk and care needs?
- Can therapy assessments be done in the patient's home? Could follow-up in falls clinic, or community PT/OT, be arranged?

Support Network
- If awaiting a package of care, ask friends and family how much support they could provide to facilitate a timely discharge.
- What are their views? What are their concerns?
- Could someone stay overnight on day of discharge for extra support?
- What alternatives can be arranged (e.g., private carers, Age UK)?

2. Considering the Risks & Benefits of Different Options

Continued Admission in Hospital
- Risks: physical and cognitive deconditioning, protracted delirium. increased dependency, restricted visiting from loved ones, emotional distress. resource issues (e.g., safe levels of staffing), sleep deprivation, poor nutrition.
- Benefits: providing life-enhancing treatment, diagnostic certainty, specific medical/care needs being met.

Discharge to Usual Environment
- Risks: care needs not adequately met, clinical deterioration, impact on carers, worsening healthcare inequities, medicines-related harm.
- Benefits: continuation of package of care, familiar environment, greater input from friends and family, reduced exposure to nosocomial infections, other patients can access urgent care.

Further Considerations
- What would stop this patient from going back home, or to their usual environment?
- If the patient's *medical* needs have been met, could their bed be given to someone in greater *medical* need?
- Do you need to discuss the case with a colleague (e.g., elderly care, palliative care, MDT)?

3. Making a Decision with the Patient (and their Family)

Patient-Centred Discussion
- What would the patient prefer?
- If the patient lacks capacity and a best interests decision must be made, you should still involve the patient as much as possible.
- Are the right people present for the discussion (e.g., senior HCP, family, social care, PT/OT)?

Clear & Honest Communication
- Discuss the risks and benefits of each option, and, if relevant, resource pressures.
- Be transparent about the safety risks of each option.
- Does everyone present understand the risks and benefits?
- Address any concerns honestly.

Careful Documentation
- Note the views of: the patient (both now and those previously expressed), HCPs and family/friends.
- Document the risks and benefits of each option that was discussed.
- Explain the rationale for the decision that has been made, and how much it aligns with the patient's preferences.

4. Planning & Safety-Netting

Continued Admission in Hospital
- Explore alternatives e.g., (out-of-area) residential/nursing home, community hospital, hospice.
- Aim to perform PT/OT assessments in patient's own environment, as soon as possible.
- Consider updating ReSPECT form if appropriate.
- Optimise the patient's medications.

Discharge Home
- Aim to discharge early in the day.
- Consider anticipatory medications, and optimise existing medications.
- Aim to call the day after discharge to check-in with patient, identify potential issues, and offer advice.
- Complete the discharge summary and inform the patient's GP within 24 hours.
- Provide crisis advice (e.g., calling 111, or local clinical advice line if available).

Managing Risk & Moral Distress
- Be prepared for readmission, as this will be inevitable in some of these patients, but aim to readmit to the same team.
- Provide written and verbal advice to patients and their friends and family, as leaflets and/or on the discharge summary.
- Reflect on the decision, alone and/or with a colleague.

Example Scenario

Mrs A is assessed as needing support around meal-times and support in the morning and evening with getting changed and washed. In terms of meeting her eligible needs Mrs A will require support – morning, lunch time, evening – three calls a day ('TDS') through a Package of Care (PoC).

Options to discuss:

- Direct payment (DP) to pay a private Personal Assistant (PA). This may include a friend, neighbour, or someone not residing in the same house. This would rely on family/friends stepping forward to support Mrs A, with the understanding that this being used as a temporary solution.
- A potential DP (via an exception) to pay Mrs A's husband, or a family member who lives with Mrs A, to act as a PA to support discharge, if there is no PoC available. This can only be done with clear directive that this is a temporary measure, while there are no commissioned services available, and that once a commissioned service is available, then care provision would revert to external care provision.
- Mixing a PoC with informal support, if Mrs A is mobile. Her formal PoC could be decreased to AM and PM only, for personal care. She could have additional support from a neighbour/friend at lunch time, or make an arrangement with other local services such as Age UK.
- A family member providing unpaid support on an interim basis, if Mrs A is in agreement with this plan following a discussion which weighs up the risks and benefits of continued hospital admission, until an ongoing PoC is sourced.
- Consideration of flexibility in the application of the Care Act 2014. Mrs A could use her DP (via an exception) to support a family member, who does not live with her, to pay for childcare so that they can spend time supporting her on an interim basis.
- Consideration of DP (via an exception) if Mrs A is not be able to access a PoC, which could result in a placement in a nursing/residential home. This would have a greater impact on Mrs A, both in terms of her right to 'respect for private and family' life (*Article 8, Human Rights Act 1998*) and facilitating the least restrictive option, but it may be a more preferable option to her and her family than continued hospital admission.

- Consideration of telecare provision (e.g., during the day), so Mrs A is able to converse and have support from a distance with a nominated friend/family member/neighbour, who has agreed to be point of contact and responder.
- Use of telemedical devices, which recognise if Mrs A has fallen in her home, and can directly contact an ambulance.

Anticipating potential issues:

- *People who have mobility issues*. Local authorities occupational therapists (OTs) are able to review PoCs with equipment, that enables PoCs to decrease to single-handed support with the right equipment. This could be considered at point of discharge, as opposed to once people are back at home.
- *Review of continence needs*. This will also greatly impact in terms of people abilities to sustain at home.
- *Exacerbating gender inequalities*. If friends and family offer to support Mrs A in meeting her care needs to facilitate a timely discharge from hospital, be aware of how gender inequalities may be exacerbated if the caring responsibility primarily falls on females, and try to offer support (e.g., through DPs).