

To:
Community Hospital Matrons
Dr Andrew Seymour (LMC representative)
Dr Ian Donald
Dr Christine Haseler
Mr Paul Wilson
Dr Kyra Neubauer
Jill Crook, John Ford
General Managers
Mary Morgan, Stuart Sedgwick-Taylor, Karen Butler
Sarah Hughes
Capacity team

Cotswold Locality Office
Cirencester Hospital
Cirencester
Gloucestershire
GL7 1UY

Telephone: 08454 222738
Fax: 08454 222792

julie.goodenough@glos.nhs.uk

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Ref:

Dear Colleague

Re: Gloucestershire Community Hospitals – Guidelines for the admission/transfer of patients to medical inpatient beds

Please find attached the final version of the above document. This has been developed with input from key stakeholders including GP colleagues, and has now been signed off by the medical leads for Care Services (Dr Ian Donald, Dr Christine Haseler and Dr Paul Wilson) and senior operational managers including the Community Hospital Matrons and the capacity team lead.

These guidelines will be operational from 1st September 2008. Please remove any existing guidelines and replace them with the attached document.

A formal review of the guidelines will be undertaken in March 2009. In order to assist the formal evaluation, I would be grateful if IR1 forms could be completed if any transfers and/or admissions are found to be outside the guidelines. Please send these to Veronica Hourston (Capacity team lead) at Cirencester Hospital.

In the meantime, should you have any concerns regarding the use of these guidelines, please do not hesitate to contact me. These guidelines may be subject to change before the formal evaluation if significant problems are identified

Please do not hesitate to contact me if you have any questions.

Yours sincerely,

Julie Goodenough
Head of Community Hospital Services
Gloucestershire PCT

Gloucestershire Community Hospitals

Guidelines for the admission/transfer of patients to medical inpatient beds

Background

The following are guidelines to aid referrers in their selection of patients for admission/transfer to Community Hospital beds. The guidelines are not rigid and admission at the margins of the criteria may be appropriate, for instance patients with severe COPD but who are being managed palliatively would be suitable for a community hospital. The resuscitation status of the patient should be considered in determining whether appropriate for a community hospital or not. Any admissions around the margins of the guidelines should always be discussed with the bed management team and/or the nursing or medical staff covering the individual unit.

Community Hospitals provide inpatient care for adults only. In particular community hospitals specialise in care of the elderly, care of medically ill patients who do not require consultant input or high dependency nursing, palliative care, end of life care and rehabilitation

Admission/Transfer Process

Direct admissions

Patients may be admitted directly to a community hospital bed by a referring GP via the PCT bed management team¹ and/or discussion with the GP/consultant providing medical cover to the community hospital and/or discussion with the senior nurse on duty. The bed management team must be informed of all admissions in order to update the bed state. If a bed is not available at the community hospital of choice, the referring practitioner should contact the bed management team who may be able to identify an available bed in a suitable alternative community hospital

Directly admitted patients should normally be seen and fully assessed & clerked by a doctor either prior to admission or on admission (preferably within 4 hours of admission).

Transfers

All transfers into community hospital beds will be referred by the in-reach team via the PCT bed management team. The bed management team will liaise with the senior nurse on duty and/or the accepting doctor in the community hospital before accepting transfers.

Prior to transfer from the acute Trust, patients must have been assessed by a doctor to ensure transfer is still appropriate, there must be a ward to ward telephone handover, a clear management plan should be documented within the medical notes, drugs must be prescribed, there must be enough space left on the drug chart to last at least 3 days, and the transfer checklist must be completed.

Medical and nursing notes, drugs and any clinical equipment not immediately available on site (e.g. infusion pumps, VAC pumps/dressings etc) must be sent to the community hospital with the patient and the patient should not arrive after 6pm unless specifically agreed with the accepting community hospital.

Once transferred to the community hospital patients must be seen and assessed by a doctor within 24 hours of admission.

Note ¹: The bed management team can be contacted on 01285 655 711 between the hours of 8am and 6pm Monday to Friday and 8am-4pm on Saturday

If arranging admission or transfer out of hours the referring doctor/organisation should contact the accepting doctor or the senior nurse in the community hospital to discuss and arrange admission or transfer.

The contact details for the community hospitals are shown below.

Community Hospital Contact Details:

Berkeley Hospital
Tel: 01453 562000

Cirencester Hospital
Tel: 01285 655711

Dilke Memorial Hospital
Tel: 01594 598100

Lydney District Hospital
Tel: 01594 598220

Moore Cottage Hospital
Tel: 01451 820228

Note: Intermediate Care Beds only

Moreton District Hospital
Tel: 01608 650456

Stroud General Hospital
Tel: 01453 562200

Tewkesbury Hospital
Tel: 01684 293303

Winchcombe Hospital
Tel: 01242 602341

Exclusion Criteria

The following are guidelines

Community Hospital inpatient facilities admit adults only (>18 years).

The following categories of patients should not be admitted directly to a community hospital bed.

1. Diagnostic Category

a) Cardiology

- Acute, sudden onset of chest pain likely to be cardiac in origin
- Myocardial infarction where thrombolysis is indicated
- Cardiogenic shock
- Cardiac dysrhythmias with haemodynamic disturbance
- Acute heart failure

b) Respiratory Medicine

- Severe* asthma

- Severe* exacerbations of COPD
- Severe* community acquired pneumonia
- Acute respiratory failure

*the admitting doctor will assess the severity of the chest problems and judge whether appropriate to admit or not

c) Diabetes and Endocrinology

- Diabetic ketoacidosis

d) Gastroenterology

- Any gastrointestinal bleeding
- Acute abdominal pain
- Any exacerbation of Inflammatory Bowel Disease – refer to gastro team
- Undiagnosed jaundice
- Undiagnosed and diagnosed infective D+/orV (unless able to isolate in a side room)

e) Renal

- Acute renal failure
- Acute on chronic renal failure
- Acute haematuria

f) Neurology

- Stroke (less than 48 hours) unless there is documented clinician/patient decision that dictates otherwise (e.g. advance directive)
- TIA – refer to rapid access clinic
- Status epilepticus
- Any suspected brain haemorrhage, i.e. sudden onset of severe headache
- Acute meningitis
- Abrupt onset of neurological symptoms (such as suspected spinal cord compression or Guillain-Barre)
- Acute Head Injuries

g) Haematology

- Neutropaenia
- Labile INR
- Undiagnosed anaemia

h) Poisoning

- Overdose of any toxic substance
- Patients under the influence of alcohol

i) Mental Health

- Patients with an acute psychiatric disorder including elderly patients who are agitated and likely to wander and would be more appropriately managed in a specialist unit
- Patients retained under the Mental Health Act
- Self poisoning, self harm, ongoing suicide risk
- Aggressive or potentially violent patients

j) Other diagnostic categories

- Acute gynaecology and obstetric patients

k) Diagnostic Facilities

- Patients who require urgent diagnostic facilities not immediately available at the community hospital facility
- Patients who require urgent surgical or orthopaedic assessment and/or possible surgical intervention

2. Non-diagnostic category

Many patients, especially the elderly, may present in a non-specific manner, e.g. confusion, "off legs", when the diagnosis may not be immediately obvious. Such patients require a thorough and comprehensive history, examination and investigation to establish a diagnosis or diagnoses (most elderly requiring admission have multiple problems). These patients can be considered for direct admission to a Community Hospital bed, provided none of the physiological parameters below are present:-

Physiological parameters

If any of the physiological parameters below are met, indicating a severely unwell patient, this patient should **not** be admitted to a Community Hospital Bed unless after consideration there is a clear reason to do so, e.g. the patient is terminally ill and for palliative care:-

- Respiratory rate <10
>30
- Heart rate <50 beats per minute (unless pharmacology induced)
>130
- Oxygen saturation <92% on oxygen
- Blood sugar <4
- Conscious level <15 GCS
- Temperature <34⁰
>40⁰

3. Ambulance Admissions via MIU

Patients in these categories should **NOT** be taken to community hospital MIU departments for resuscitation and/or treatment

1. Head Injuries

- Penetrating injury or depressed skull fracture
- Open injury with or without CSF leak
- Glasgow Coma Scale <15 or a deterioration in the score
- Lateralising signs

2. Trauma Cases

- Spinal cord injury
- Patients involved in a significant accident with a high probability of serious injury (which may not be apparent).
- Patients involved in a high energy impact with the potential for serious injury. This includes:
 - a) High speed accident
 - b) Ejection of patient
 - c) Roll over of vehicle
 - d) Death of another occupant in the same vehicle

3. Eye Injuries

- Penetrating injury

- Bilateral eye injury

4. Chest Injuries

- Penetrating injuries
- Crush fractures including flail chest and multiple rib fractures
- With respiratory embarrassment

5. Fractures

- Femur - with the exception of surgically treated fractured **neck of femur**.
- Tibia
- Any compound fracture
- Hip and ankle dislocations
- Neurovascular compromise

6. Burns

- More than 10%.

7. Traumatic amputations

- Other than tips of toes and fingers.

8. Poisoning

- Complicated drug overdose.