Admissions of a service user to a hospital/immediate Care Policy

Revised March 2013

Intermediate Care

Care home name: Wellbeing Residential Group

Background

Intermediate care is a term used to describe a range of services made available to older people who are leaving hospital and to older people who are at risk of hospital admission. The emphasis of intermediate care is on promoting independence through active recovery as it aims to help to move a service user from medical dependence to being more independent by providing a supported pathway between social, primary and acute care. The ultimate aim is to avoid unnecessary or inappropriate hospitalisation.

Such care can be provided in a wide range of different settings, ranging from hospitals to care homes to peoplesôown homes and intermediate care is only appropriate where older people are medically stable and no longer need specialist medical support on hand. This provides the major difference between intermediate care and traditional rehabilitation services in that rehabilitation services usually have specialist clinical support on site.

Policy Statement

Wellbeing Residential Group fully adheres to the new outcomes essential standards of quality and safety which consist of 28 regulations and its associated outcomes. They are set out by the Health and Social Corporation Act 2008 for regulated activities.

Aim of the Policy

This policy is intended to set out the values, principles and policies underpinning this Wellbeing Residential homes approach to quality. It seeks to:

- establish clarity of roles and expectations between the home and intermediate care purchasers
- ensure that all homes provide a high quality, safe and appropriate service with areas of risk addressed
- provide the basis for a sound contractual agreement which delivers value for money.

The Home’s Definition of Residential Intermediate Care

Wellbeing Residential accepts the definition of intermediate residential care contained within the DH document: *Contract Guide — Residential Intermediate Care*. In this document intermediate residential care is defined as describing services that meet all the following criteria as care which

- is targeted at older people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long-term residential care, or continuing NHS in-patient care

- is provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery
- has a planned outcome of maximizing independence and typically enabling service user/users to resume living at home
- is time-limited (normally no longer than six weeks and frequently as little as one to two weeks or less)
- involves cross-professional working, with a unified assessment framework, single professional records and shared protocols.

The Home's Intermediate Care Policy

The objective of intermediate residential care at the home is to facilitate the transition from hospital care or to reduce the likelihood of hospital care to functional independence so that an individual service user may return to his or her usual place of residence within a pre-defined period of time and so:

- avoid unnecessary admission to hospital
- support the transition from hospital to home
- avoid preventable or premature admission to long-term residential or nursing home care.

It is Wellbeing Residential Groups policy and view that residential intermediate care is intended to be built around active rehabilitation but is not appropriate for people with longer-term rehabilitation or continuing care needs.

The Home's Admission Criteria

Clearly it is important that those admitted into intermediate care at the home are likely to derive significant benefit and in this respect the process of assessment, appropriate patient/user selection and clear care planning are vital.

In particular the Wellbeing insists that in each case of proposed admission for intermediate residential care there must always be clear clinical and managerial accountability for each new service user.

Prioritisation of the service will be determined by the needs of the service user, in accordance with admission criteria, and this home will only allow placements for service users whose need for health care meets all of the criteria set out below.

1. All contracts for intermediate residential care should be time limited and that time should be specified at the entering of an agreement.
2. The service user must be registered with a GP.
3. No significant acute changes in medical management should be anticipated within the contracted period of intermediate care provision.
4. The assessed requirement for care must indicate that the service user's care can be safely and effectively provided outside of an acute hospital.
5. The assessed requirement for care should indicate that maximum independence is most likely and can be safely achieved in a residential/inpatient setting, with ready access to care staff for assistance or reassurance.
6. The service user should initially be assessed as being likely to return home within six weeks of admission, unless exceptional circumstances apply.

Intermediate Care Assessment

DH guidelines state that an agreed assessment approach is crucial to the success of the contracting process for intermediate care and that whatever assessment process is used should be agreed between all parties. Wellbeing has agreed to use local social services assessment tools. The *National Service Framework for Older People* outlines the principles of a single assessment process for the health and social care needs of older people, implemented from April 2002, and this is expected to replace these local guidelines.

Intermediate Care Procedures

This home will:

1. Ensure that a named, clinical practitioner is responsible for the operational management of its intermediate care rehabilitation services.
2. Confirm that employment checks have been carried out on all members of staff, to a standard that mirrors at least the standards required of NHS and local authority providers, and that if necessary, prompt and appropriate action will be taken to ensure that there is no risk to service user care.
3. Ensure that staffing arrangements reflect the ethos of a therapy led service and that staff have relevant experience of a rehabilitative care environment.
4. Be responsible for ensuring that agreed, adequate levels of appropriately qualified staff are maintained at all times, that staff competencies are maintained through regular training and review and that all qualified staff have extant registration with the relevant professional registration bodies.
5. Ensure that the physical environment of the home reflects the purpose of care and the distinctive needs of service users admitted to the level of residential intermediate care and in particular to:
    a. provide intermediate care facilities which are separate from long stay, standard accommodation so as not to cause disruption to permanent service users
    b. provide dedicated accommodation for residential intermediate care users together with specialised facilities, equipment and staff, to deliver short-term intensive rehabilitation and enable service users to return home at the end of their stay
    c. ensure that as far as is practicable, the décor and furniture is of a domestic style in those areas to be used for residential intermediate care
    d. tailor any general nursing and personal care as appropriate to care plans prepared by a case manager for individual service users
    e. ensure that therapists and other specialist clinicians are at all times provided with adequate facilities and support to undertake their clinical work
    f. ensure that home staff are qualified and/or are trained and appropriately supervised to use techniques for rehabilitation including treatment and recovery programmes, promotion of mobility, continence and self-care
    g. ensure that staff are deployed, and specialist services from relevant professions including occupational and physiotherapists are provided or secured in sufficient numbers and with sufficient competence and skills, to meet the assessed needs of service users admitted for residential intermediate care
    h. ensure that individual service user progress is reviewed on a daily basis
    i. notify the case manager where a service user is making better progress than anticipated so that an early review of suitability for discharge can be

undertaken, thus optimising the service user's opportunity for early and successful discharge

j. make suitable and immediate arrangements, where, in the judgment of the home staff, a service user requires emergency treatment or admission to hospital

k. immediately notify the case manager or intermediate care coordinator in the event of a significant deterioration in a service user's health status

l. arrange admission/readmission to acute care if necessary through a locally agreed acute admission/readmission policy.

The home lead for dealing with intermediate care issues and enquiries is the manager.

Signed: _____

Date: _____

Policy review date: _____