NICE National Institute for Health and Care Excellence

NICE Pathways

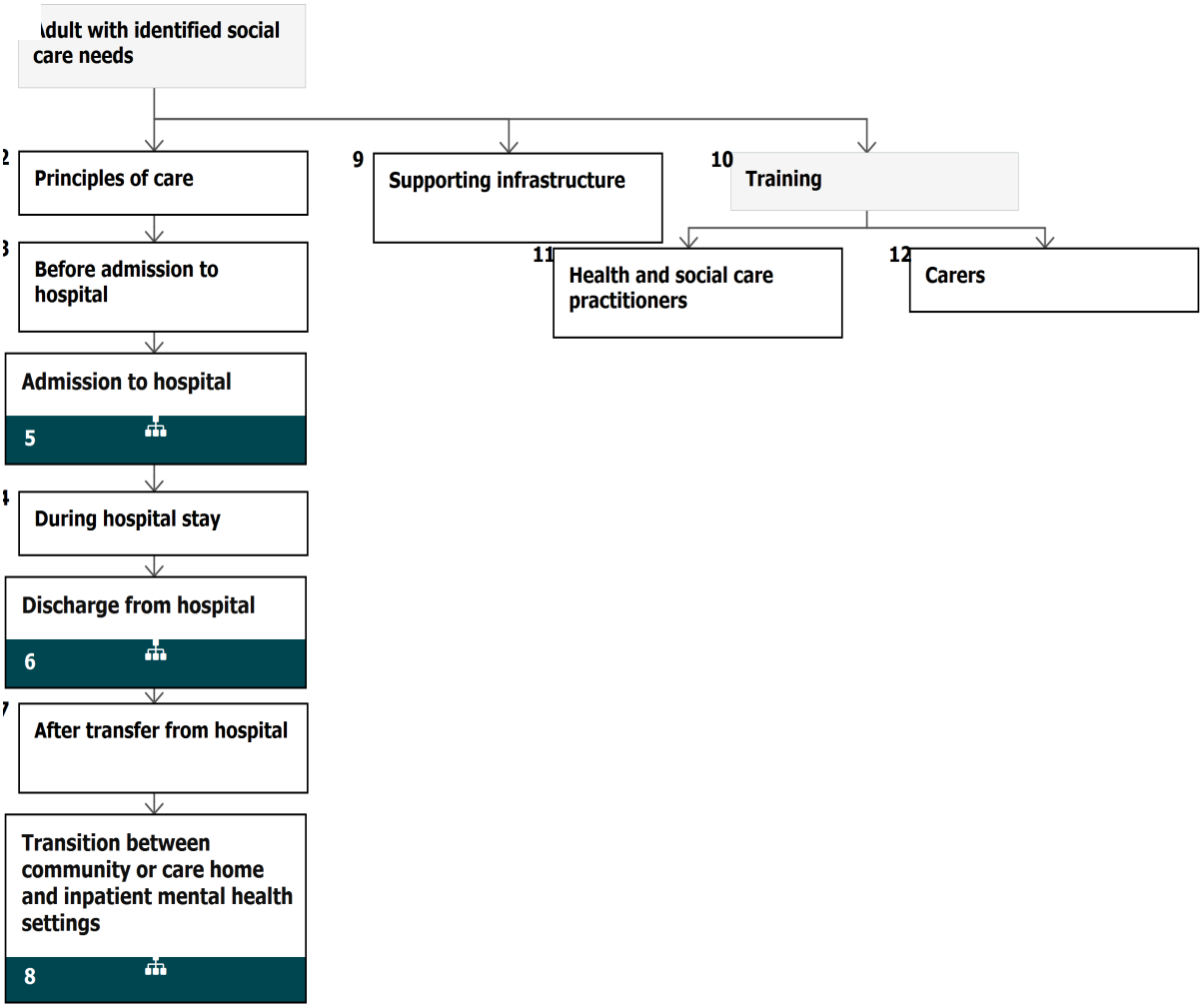
Transition between inpatient hospital settings and community or care home settings for adults with social care needs overview

NICE Pathways bring together all NICE guidance, quality standards and other NICE information on a specific topic.

NICE Pathways are interactive and designed to be used online. They are updated regularly as new NICE guidance is published. To view the latest version of this pathway see:

http://pathways.nice.org.uk/pathways/transition-between-inpatient-hospital-settings-and-community-or-care-home-settings-for-adults-with-social-care-needs
Pathway last updated: June 2017

This document contains a single pathway diagram and uses numbering to link the boxes to the associated recommendations.



1 Adult with identified social care needs

No additional information

2 Principles of care

Person-centred care

See everyone receiving care as an individual and an equal partner who can make choices about their own care. They should be treated with dignity and respect throughout their transition.

Identify and support people at risk of less favourable treatment or with less access to services for example, people with communication difficulties or who misuse drugs or alcohol. Support may include help to access advocacy.

Involve families and carers in discussions about the care being given or proposed if the person gives their consent. If there is doubt about the person's capacity to consent, the principles of the Mental Capacity Act must be followed.

Communication and information sharing

Ensure that the person, their carers and all health and social care practitioners involved in someone's move between hospital and home are in regular contact with each other. This is to ensure the transition is coordinated and all arrangements are in place. For more on medicines-related communication and medicines reconciliation during transitions, see what NICE says on medicines optimisation and managing medicines in care homes.

Give people information about their diagnoses and treatment and a complete list of their medicines when they transfer between hospital and home (including their care home). If appropriate, also give this to their family and carers.

Offer information in a range of formats, for example:

- verbally and in written format (in plain English)
- in other formats that are easy for the person to understand such as braille, Easy Read or translated material (see the Accessible Information Standard).

NICE has produced recommendations on social care of older people with multiple long-term conditions.

3 Before admission to hospital

Health and social care practitioners should develop a care plan with adults who have identified social care needs and who are at risk of being admitted to hospital. Include contingency planning for all aspects of the person's life. If they are admitted to hospital, refer to this plan.

If a community-based multidisciplinary team [See page 9] is involved in a person's care that team should give the hospital-based multidisciplinary team a contact name. Also give the named contact to the person and their family or carer.

Health and social care practitioners and advocates should explain to the person what type of care they might receive (see tailoring healthcare services for each patient and enabling patients to actively participate in their care in NICE's recommendations on patient experience). Discussions might cover:

- place of care
- religion, culture and spirituality
- daily routines (including the use of medicines and equipment)
- managing risk
- how, when and where they receive information and advice
- the use of an advocate to support them when communicating their needs and preferences
- advance care plans
- contingency planning
- end-of-life care.

4 During hospital stay

Record multidisciplinary assessments, prescribed and non-prescribed medicines and individual preferences in an electronic data system. Make it accessible to both the hospital- and community-based multidisciplinary team [See page 9]s, subject to information governance protocols.

At each shift handover and ward round, members of the hospital-based multidisciplinary team should review and update the person's progress towards hospital discharge.

Hospital-based practitioners should keep people regularly updated about any changes to their plans for transfer from hospital. (See information in NICE's recommendations on patient experience.)

Provide care for older people with complex needs in a specialist, geriatrician-led unit or on a specialist geriatrician-led ward.

Treat people admitted to hospital after a stroke in a stroke unit and offer them early supported discharge. (See planning transfer of care from hospital to community for stroke.)

Encourage people to follow their usual daily routines as much as possible during their hospital stay. (See patient independence in NICE's recommendations on patient experience.)

5 Admission to hospital

See Transition between inpatient hospital settings and community or care home settings for adults with social care needs / Admission to hospital from a community or care home setting for adults with identified social care needs

6 Discharge from hospital

See Transition between inpatient hospital settings and community or care home settings for adults with social care needs / Discharge from hospital to a community or care home setting for adults with identified social care needs

7 After transfer from hospital

Community-based health and social care practitioners should maintain contact with the person after they are discharged. Make sure the person knows how to contact them when they need to.

An appropriately skilled practitioner should follow up people with palliative care needs within 24 hours of their transfer from hospital to agree plans for their future care.

The discharge coordinator should provide people who need end-of-life care, their families and carers, with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge.

A GP or community-based nurse should phone or visit people at risk of readmission 24–72 hours after their discharge.

8 Transition between community or care home and inpatient mental health settings

See Transition between community or care home and inpatient mental health settings

9 Supporting infrastructure

Ensure that a range of local community health, social care and voluntary sector services are available to support people when they are discharged from hospital. This might include:

- reablement (to help people re-learn some of the skills for daily living that they may have lost)
- other intermediate care services
- practical support for carers
- suitable temporary accommodation and support for homeless people.

Have a multi-agency plan to address pressures on services, including bed shortages.

Ensure that all care providers, including GPs and out-of-hours providers, are kept up to date on the availability of local health, social care and voluntary services for supporting people throughout transitions.

Ensure that local protocols are in place so that out-of-hours providers have access to information about the person's preferences for end-of-life care.

See also discharge coordinator.

10 Training

No additional information

11 Health and social care practitioners

Ensure that all relevant staff are trained in the hospital discharge process. Training should take place as early as possible in the course of their employment, with regular updates. It could include:

- interdisciplinary working between the hospital- and community-based multidisciplinary team [See page 9]s, including working with people using services and their carers
- discharge communications
- awareness of the local community health, social care and voluntary sector services available to support people during their move from hospital to the community
- how to get information about the person's social and home situation (including who is available to support the person)
- learning how to assess the person's home environment (home visits)
- how to have sensitive discussions with people about end-of-life care
- medication review in partnership with the person, including medicines optimisation and adherence (for more information see what NICE says on medicines optimisation
- helping people to manage risks effectively so that they can still do things they want to do (risk enablement)
- how to arrange, conduct or contribute to assessments for health and social care eligibility.

12 Carers

A member of the hospital-based multidisciplinary team should discuss the practical and emotional aspects of providing care with potential carers.

Ensure that training is available to help carers provide practical support. The relevant multidisciplinary team should offer family members and other carers of people who have had stroke needs-led training in how to care for them. For example, this could include techniques to help someone carry out everyday tasks as independently as possible. Training might take place in hospital or it may be more useful at home after discharge.

See systems to ensure safe transfer of care for stroke.

The relevant multidisciplinary team should consider offering family members and other carers needs-led training in care for people with conditions other than stroke. Training might take place in hospital or it may be more useful at home after discharge.

The community-based multidisciplinary team [See page 9] should review the carer's training and support needs regularly (as a minimum at the person's 6-month and annual reviews). Take into account the fact that their needs may change over time.

Members of a community-based multidisciplinary team could include:

- GP
- community nurse
- community mental health practitioner
- social worker
- housing officer
- voluntary sector practitioners
- community pharmacist
- therapists
- registered manager.

Glossary

carer

someone who helps another person, usually a relative or friend, in their day-to-day life. This is not the same as someone who provides care professionally or through a voluntary organisation

carers

someone who helps another person, usually a relative or friend, in their day-to-day life. This is not the same as someone who provides care professionally or through a voluntary organisation

older people

generally this refers to people aged 65 years and over. But it could refer to people who are younger, depending on their general health, needs and circumstances

Sources

Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27

Your responsibility

The guidance in this pathway represents the view of NICE, which was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider

public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties. Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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