Adult Social Care

Admission and Discharge for Residential Establishments Policy and Procedures

Version 7

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If you would like to make any comments, amendments, additions etc. please email ASCH.AdultCare.Policy@derbyshire.gov.uk

Policy

The purpose of this policy is to set out the process that must be followed when a person is admitted to, or discharged from, one of the council's residential establishments.

All of Derbyshire County Council's (DCC) residential establishments have a Provider Statement of Purpose written centrally. The statement of purpose is a critical document setting out the purpose of each individual establishment. This document is continuously reviewed and regularly updated centrally to reflect any changes to services.

The policy sets out the minimum standards required when a person is admitted to one of DCC's residential establishments. Through effective implementation of this policy, we will achieve safe, consistent, person-centred care for people entering residential care.

Admission, Decision Making and Escalation

When assessing whether an admission to a service is appropriate, the manager on duty at each establishment will make the initial decision about whether the needs of the person can be safely met. The initial decision about whether to admit a person may be subject to general review by DCC as the registered provider. This is to clarify the rationale for the decision and to ensure the best outcome is achieved for the individual, the existing residents and those providing the care and support, recognising that at times, it may be necessary to balance competing factors.

After the person has been admitted, the registered manager (referred to as unit manager (UM) throughout this document), will continue to review whether the placement is appropriate and escalate where they consider re-assessment by the care coordinator is required. Where the unit manager considers the need for reassessment is urgent, it will be escalated through line management to the appropriate level. Where agreement about the suitability of a placement cannot be reached by the professionals involved, a senior member of Adult Social Care leadership team will make the final decision about the placement, having considered all relevant information.

Long Term Admissions and Planned Respite

Pre-admission

For all planned, long-term admissions and planned regular respite, the unit manager or their deputy must be satisfied that they have sufficient information to allow them to decide about whether the person's needs can be met at the home. This information will usually be contained in a core support plan.

Where it is considered necessary, a pre-admission visit should be carried out and any additional information required must be sought from the care coordinator. The decision to admit a person will continue to be reviewed as the relevant assessments are completed. Any concerns about the ability to meet the person's needs must be escalated to the care coordinator making the referral.

For admissions to a residential service for people with learning disabilities, the process at Appendix 1 must be followed prior to any admission taking place. The decision if the person can

be admitted to the service must be logged on the Learning Disability Admission Checklist (Appendix 2). For admission to a home for older adults then the Admission Checklist for Older Adults (Appendix 3) should be completed. The relevant document must be uploaded to the individual's Mosaic documents and decision recorded in case notes.

A Service User Guide (Appendix 4) should be adapted to your establishment and be made available to any prospective individual to read before committing to a placement.

All individuals (including self-funding) admitted to DCC residential homes must meet the eligibility criteria. A person who is self-funding their placement must be assessed and referred by the Prevention & Personalisation team with the unit manager having received a core support plan from the referring care coordinator.

Admission day

The individual should be welcomed into the home and shown their room, communal areas, and dining facilities. They should be informed of all activities and facilities. The call bell system must be explained to them on the day of admission.

The duty manager and wider staff at the care home will ensure the person has the opportunity to discuss the way their care is provided and to communicate their preferences. Where it is not possible for them to clearly verbalise or demonstrate their wishes, these conversations should be held with those who know them best. These conversations should continue and be developed over the first few weeks following admission and at subsequent reviews.

Completion of required paperwork for planned long term admissions and regular respite

Appendix 5 is a list of actions and documentation that must be completed within specific timeframes.

The order in which the residents file should be set up is provided in Appendix 6.

Cancellations

If someone wishes to cancel pre-booked respite, 4 weeks' notice is required. Any cancellation within 4 weeks of the planned stay may incur a charge, which may be waived at the discretion of the service manager (SM) or group manager (GM).

Medication - respite

Individuals should bring enough medication to last for the duration of their stay. The Management of Medication and Health Related Activities Procedure - Residential will be followed regarding medication.

Admissions to Community Support Beds and Interim Care Beds

Pre-admission

Referrals can be made by a health or social care professional once it has been identified that a

person would benefit from accessing a community support bed (CSB) for a short period of therapy prior to returning home or an interim care bed whilst a package of care is being sought.

When a referral is made for a CSB or an interim bed, the referral paperwork will be sent to the manager on duty at the home. The duty manager will decide whether there is sufficient information to accept the referral or whether additional information or clarity is required. The duty manager will make the decision about whether to accept the referral.

Receipt of the referral must be acknowledged as soon as it is received by the duty manager. The duty manager should aim to decide whether it is possible to accept the admission within one hour of the referral being made.

In the event of a referral being made to access a specialist learning disability bed for a short-term placement, these requests should be discussed at the specialist placement meeting in the first instance. Other solutions may already be available without the need for a temporary short-term placement.

Medication

Where a person is admitted from hospital, 14 days' worth of prescribed medication will be provided on the day of admission. Where a person is admitted from the community, the referring care coordinator will arrange for all current medications to be provided to the home to ensure the person is able to access their medication following admission.

Completion of required paperwork

Appendix 7 is a list of the actions and documentation that must be completed when admitting to a community support bed or interim care bed and within what timescale.

A quality questionnaire must be given by the home to the person prior to the end of their stay and the person or their family should be encouraged to complete it.

Escalation process

If, following the arrival of a person from hospital, the receiving manager on duty considers the referral was inappropriate for any reason, this will be escalated immediately to the relevant Integrated Discharge team**. A hospital concerns monitoring form on Mosaic must be completed within 24 hours of the admission or safeguarding referral where appropriate**.

This is a critical part of the escalation process and will ensure that the referral process into community support beds improves for all stakeholders. Examples of inappropriate admissions are:

- the person's needs are not as set out in the referral paperwork
- medication is wrong or missing
- equipment is not sent with the person

Unplanned Emergency Admissions

(For admissions to a residential service for people with learning disabilities, the process at Appendix 1 & 2 must be followed prior to any admission taking place.)

It may be necessary for people to be admitted in unplanned and/or emergency situations for a short period of assessment or respite. In this situation, the duty manager, or the senior member of staff on shift will receive the relevant service plan from the referring care coordinator. It is essential the duty manager or authorised officer has all necessary information in place within 24 hours. This may include liaising with key professionals involved (e.g., care coordinator, GP care coordinator, SPA team, GP, pharmacy etc.).

For emergency admissions taking place out of hours, a representative from the Out of Hours team will complete the relevant service plan. They will contact the unit manager on call and will support the home with the admission. The Out of Hours team will also contact the allocated team in Adult Social Care in the appropriate area who will complete any relevant documentation.

If the emergency admission is from hospital, the hospital must provide sufficient information when making the referral.

Escalation and review

Where a person is admitted to an establishment in an emergency for a period of respite or assessment by a multi-disciplinary team, a review will be undertaken by the care coordinator or other allocated worker within 5 days of the admission. Where the unit manager considers there should be a more urgent review, this will be escalated through line management channels and a review will take place within 24 hours where it is considered necessary.

The unit manager and service manager can agree to cancel periods of planned respite for other people following an emergency admission if they consider this is necessary. The unit manager and service manager can agree to add additional staff to the rota following an emergency admission if it is considered necessary.

Document Tracker

Individuals staying with the service as a long-term resident or for an extended period must have their documents tracked to ensure reviews of relevant documentation takes place in a timely manner. A template of a document tracker is available as Appendix 8 for those services that do not have this system in place.

Discharge Planning

Planned discharge to another setting

Where a discharge is planned, the person and their family must be supported to move to the alternative setting that has been identified.

A review meeting must be held with all interested parties to review the approach. This will be

coordinated by the allocated care coordinator.

All services received within the home (GP, district nurses etc.) must be informed that the person has left the service.

Procedures that must be carried out prior to discharge

The duty manager or an authorised officer must complete the admission and discharge form on Mosaic when a person is discharged. A case note must also be added to state that the person has left the service stating where they have been discharged to. An alert should be sent to any relevant DCC key workers.

Discharge from a respite stay

Any money saved on the personal allowance system must be repaid back to the person, by the home.

If someone wishes to stay again the booking must be arranged with their allocated care coordinator.

Medication

People being discharged from a community support bed, or a long-term bed must be discharged with 14 days' worth of medication. This allows plenty of time for a repeat prescription and additional medication to be arranged.

Medications must be discharged in accordance with the Management of Medication and Health Related Activities Procedure - Residential.

Emergency discharge

This usually occurs when someone is being transferred into hospital. The duty manager or authorised officer must ensure that the medical professionals are made aware of the following and that the information is taken with the person to hospital:

- the client information sheet - which is regularly updated to reflect any changes
- Positive Behaviour Support (PBS) Plan (if applicable)
- Do not attempt cardiopulmonary resuscitation (DNACPR)/ReSPECT form
- current medication and copy of Medication Administration Record (MAR)
- Herbert Protocol (if applicable)
- change of clothes/nightclothes and essential toiletries
- Health and Social Care Infection Control Transfer Form

If an escort is required, this should be provided by a relative/friend and only by the home as a last resort and where possible whilst maintaining safe staffing levels.

Mental Capacity and Deprivation of Liberty Safeguards

Where a person lacks capacity to make a decision about where to live to receive care and support, there should be evidence of this on the person's file on admission. Where there is no capacity assessment available but where the unit manager considers the person may lack capacity to make a decision about where to live and/or to make decisions about their care and treatment, a capacity assessment should be undertaken.

Where a person lacks capacity, and it may be that they are being deprived of their liberty, an application must be made to the supervisory body to authorise this. An urgent application can be made if this is necessary.

Approval and Authorisation History

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Name	Job Title	Date
Authored by Emma Benton	Senior Project Officer	February 2015
Approved by Jane Parke	Development and Compliance	February 2015
Authorised by	Policy and Procedures Group	February 2015
Authorised by	Quality & Compliance	August 2023

Change History

Version	Date	Name	Reason
Version 1	May 1995		New Policy
Version 2	January 2010	Jane Parke	Review and rewrite as per CQC requirement
Version 3	April 2015	Emma Benton	Review and rewrite
Version 4	August 2019	Alison Briddon	Review, rewrite and retitled
Version 5	July 2021	Quality and Compliance	Review and rewrite
Version 6	July 2022	Quality and Compliance	Review
Version 7	September 2023	Quality and Compliance	Review and update