Y Lolfa
Alternative Care Unit

Situation

‘Y Lolfa’ is a 15 bedded Alternative Care Unit which has been created to support improving an Individual’s care by preventing deconditioning of some of our complex Individuals, accelerating discharge and thus decreasing their length of stay in hospital.

The Scope and criteria

- **Selection Criteria:**
- ***Individuals requiring x4 calls per day*** (Personal care, dressing/undressing, monitor skin integrity, assist with transfers, meal prep, medication, assist with toileting
- ***Individuals Requiring x3 calls per day*** (personal care, meal prep, fluid intake, medication and reminiscence therapy)
- ***Individuals requiring x2 Calls per day*** (personal care and meal prep)
- ***Individuals requiring*** Permanent Placement (Residential/Nursing placement dependent on NNA)
- ***Individuals requiring*** Temp Placement
- ***Individuals requiring*** Reablement
- ***Individuals requiring*** Rehousing
- ***Individuals requiring*** Low Level Support
- ***Individuals will be*** identified from the 'live list' for transfer onto Y Lolfa.
- ***Individuals awaiting BD/TDS POC or reablement*** will be given priority for transfer to create flow through the unit.
- ***Individuals only from the Carmarthenshire*** *suitable for transfer onto Y Lolfa*

Scope

- Y Lolfa creates an environment that is engaging to the individual and will offer a communal dining room for meaningful interactions.
- Individuals and families are provided with relevant information regarding the function of Y Lolfa and are advised on the expected length of Stay once patients are transferred into this area.
- Opportunities to train carers / families on the use of equipment or if deemed appropriate administration of medication to facilitate a sooner discharge.
- Staffing requirement has initially been agreed as ***Registered Nurse*** 24/7, this is to provide oversight and support pro-active discharges. There is close working relationships with the community and home first teams and daily Board rounds and weekly Multi-Disciplinary team meetings which supports pull from the hospital setting
- The care plan for the patients on Y Lolfa is developed in line with the care and support plan which has been agreed by the lead commissioner (provider). With a real focus on caring for the frail
- Band 2/3 Health Care Support Workers are educated to pro-actively manage the frail individual and the frailty health care workers are educated to provide a programme of pro- active therapy which focuses on preventing de-conditioning .

Scope continued

- Staff on Y Lolfa will support external services such as hairdressers, podiatry services and will encourage conversations with the patient and their family regarding other services they may benefit from.
- Arts & Health Team are engaged and support changes to the environment which positively impacts on patients by improving success to activities.
- All Individuals transferred to Y Lolfa will have had a comprehensive medication review, a confirmed CPR status or DNARCPR in place
- Medications to the individuals on the ward will initially be administered by the registrant, alternative medication administration options/processes are being explored, which includes self-administration/Patient Group Directives as to suitability
- A pharmacist is working closely with the teams to facilitate prescribing of medication and discharges in a timely manner. Work is ongoing to support self-administration for suitable patients with the intention of increasing independence as well as reducing the reliance on nurse led administration.
- Medical cover is given via the allocated ward doctor – with clear escalation protocols should the patient become unwell

Outcomes to date

- Y Lolfa opened on the 14th November 2022. A service operating procedure has been developed and shared with Health Inspectorate Wales, who were assured that governance processes were in place.
- Quality improvement methodology will be used to evaluate improvements and a member of the quality improvement team has been allocated to support with capturing the relevant data
- Quality metrics are being developed to capture clear outcome measures for patients. This will include qualitative and quantitative measures, including patient experience

Recommendation

QSEC are to take assurance from the report provided that governance arrangements are in place to oversee the development of this unit and that outcomes will be monitored and measured using quality improvement methodologies

Y LOLFA UNIT

Procedure Number:		Supersedes:	SOP	Classification	Clinical

Version No:	Date of EqIA:	Approved by:	Date Approved:	Date made active:	Review Date:

Brief Summary of Document:	The aim of the Procedure is to define and formalise the operational and clinical management of Y Lolfa Unit, GGH to support patient care and flow through the Hospital.
Scope	The SOP is relevant to any member of staff working within the Unit **Selection Criteria:** • ***People awaiting BD/TDS POC or reablement*** will be given priority for transfer to create continuous flow through the unit. • ***People only from Carmarthenshire are*** suitable for transfer onto Y Lolfa due to the availability to create flow and secure care packages. • ***People requiring x4 calls per day*** (Personal care, dressing/undressing, monitor skin integrity, assist with transfers, meal prep, medication, assist with toileting • ***People Requiring x3 calls per day*** (personal care, meal prep, fluid intake, medication and reminiscence therapy) • ***People requiring x2 Calls per day*** (personal care and meal prep) • ***People requiring*** Permanent Placement (Residential/Nursing placement dependent on NNA) • ***People requiring*** Temp Placement • ***People requiring*** Reablement • ***People requiring*** Rehousing • ***People requiring*** Low Level Support • ***People will be*** identified from the 'live list' for transfer onto Y Lolfa. **Exclusion Criteria** • People who are clinically medically unstable/not therapy fit for discharge or who require ongoing specialist rehabilitation • Individuals subject to Infection Control restrictions/Barrier nursing/Covid 19. • Individuals requiring Enhanced Patient Support. • If receiving active Physiotherapy / Occupational Therapy, then individual would not be suitable for transfer onto Y Lolfa. • Individuals displaying disorientation/confusion that will be further exacerbated by the move.

- Anyone who lack capacity, have a DOLS in situ, or behavioural concerns.
- The risk of falls will need to be assessed on an individual basis, but the priority must be to ensure safety, visibility and prevent further falls.
- Individuals awaiting specialist investigation or assessment for ongoing issues (unless a definite plan for this has been organised).
- Anyone who have care needs that are primarily Mental Health
- Repatriations from other health boards will not be accepted into the transitional care unit.
- Individual risk assessments regarding the use of non-invasive ventilation, supplementary oxygen or enteral feeding support will be dependent on long-term use, individuals' ability to self-manage, and appropriate space availability.
- Complex wound care will need be reviewed prior to admission to ensure Y Lolfa can appropriately manage the wound, or the appropriate support from CNS / outpatient wound clinic appointment to support this.
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Y Lolfa capacity is 15 beds, this is not to be exceeded or surged further under any circumstances.

Complex Social grounds:

Exclusion on Complex Social Care & planning grounds includes:

- Social Care assessments and care planning incomplete to the extent that no discharge destination has been agreed.
- Decision Support Tool (DST) assessments under CHC processes are incomplete with no agreed discharge destination.

This list is not exhaustive and does not replace clinical decision-making.

Visiting:

- Provide relevant information regarding function of Y Lolfa and expected LOS once transferred.
- Inform Family/Carers
- Family / Carers are encouraged to actively engage with individuals and their care needs on the unit to optimise transfer to their next discharge destination.
- We will continue to use the booking system adopted within the hospital, but flexible visiting arrangement will be agreed on individual basis depending on the support needs of the individual and to prepare informal carers / family with the level of care required on discharge. Opportunity will also be given on any training to informal carers / family on equipment or administration of medication to facilitate a sooner discharge.
- Communications Department will support the best way to communicate the purpose of the unit with family and to ensure appropriate signage.

The Unit Team

Individuals on Y Lolfa will have oversight from a ***Registered Nurse*** 24/7.

The agreed discharge care needs and support of the individual will be replicated on Y Lolfa.

Daily board rounds initially will be introduced and reviewed. Weekly meeting with the discharging team around the individual will be held on a Tuesday.

Daily review by Intermediate Care MDT.

Observations

Clinical observations will be determined by the agreed discharge care needs and will be assessed on an individual basis. As part of the transfer to Y Lolfa baseline observation will be agreed prior to discharge from the acute ward area.

Once a day blood glucose monitoring will be carried out for Non-Insulin Dependent Diabetic Mellitus, or in situations where clinical conditions require further testing. Insulin Dependent Diabetic Mellitus will follow hospital protocol of x4 a day, or if hypoglycaemia is indicated.

Individuals will continue to receive therapeutic anticoagulation treatment whilst on the unit, administered by the RN.

Care Records and Risk Assessment will continue to remain under the WCNR for consistency and continuity.

A Datix System has been set up as Y Lolfa- which will capture incidents that on the unit to identify themes and action improvement plans.

- **Therapeutic Activities**

Y Lolfa will create an environment that is engaging to the cohort group and will offer a communal dining room for meaningful interactions.

We will also support external services such as hairdressers, podiatry to individuals, but will welcome conversations with the individuals / family regarding other services they may benefit from. i.e reflexologist.

Depending on individual circumstances, time away from Y Lolfa with appropriate care and support can be facilitated.

We will involve the Art Team to support the environment and develop engaging activities.

- **Nutrition and Dietetics**

The nursing team will manage the nutrition and hydration of individuals and will follow correct escalation process for dietetics input based on individual risk assessment.

- **Synbiotix**

Y Lolfa will use the same systems for ordering meals and ensuring that each individuals diet is appropriate for the individual and receive clinical signoff. Steffan Ward staff will continue to be able to access this system to ensure sign-off is done in a timely manner in the absence of substantive staff on Y Lolfa.

- **Therapies input**

All therapy needs will be addressed prior to transfer onto Y Lolfa, and clear evidence of discharge from their speciality. Any ongoing needs of that individual are identified and maintained through the nursing team.

Caution must be given to individuals requiring re-ablement as the unit might not be able to provide the level of input required to improve / maintain function.

An exercise station will be available for individuals in order to reduce situations of deconditioning. This will be proactively encouraged and supported by the nursing and wider team. Therapy will provide the necessary training to support ongoing therapies.

- **Medication Administration**

All individuals transferred to Y Lolfa will have had a comprehensive medication review, a confirmed CPR status or DNARCPR in place.

Currently the Registrant will have to administer medications to the patients on the ward. Alternative medication administration options/processes are being explored, including self-administration/PGD as to suitability. A pharmacist will work closely with the pharmacy team and nursing team to facilitate prescribing of medication and discharges in a timely manner.

They will also work towards self-administration for suitable individuals to reduce the reliance on nurse led administration, this will be alongside liaising to reduce the medication round intensity and frequency for individuals to minimise the medication burden.

- ***Pharmacist***

*T*o support medication administration at ward level. There are a number of individuals whose definitive needs outline requirement for home care visit for medication administration. The Pharmacist may also review medication with a view to reducing the need for that home care visit and reduce package overall thus increasing the chance of care package becoming available sooner.

- **Medical Oversight.**

In the event of someone becoming medically unwell, the individual will be reviewed and assessed by the doctor/on-call doctor out of hours. Should on-going medical treatment be required, the individual will be transferred to an appropriate acute environment for ongoing management.

As part of the Welsh Patient Administrative System (WPAS), all individuals admitted onto Y Lolfa are required to be under a named consultant. In this instance, Dr Eiry Edmunds will be the named clinician attached to Y Lolfa for this administrative purpose only.

The Junior doctor / on-call team will oversee the routine medical management until day of discharge.

Before admission onto the Y Lolfa baseline observations and parameters agreed with the discharging consultant need to be documented.

Any person scoring on the NEWS or outside the agreed parameter will follow the hospital escalation process.

- **Identification, Admission and Discharge Process (Short Term)**

A shared 'live list' with Social Care of appropriate people will be maintained to facilitate continuous flow of suitable individuals onto Y Lolfa. Admission to the Unit facilitated through identification of individuals 'triggered' to Brokerage (Social Care) by the respective Clinical Teams, led by the Unit SR.

The Sister / Senior Nurse Managers and the Discharge Liaison Team will also support person identification through reviewing and updating the 'live list' following the medically fit meeting on Thursdays.

The 'live-list' must be shared with the Site Management Team.

Once transfer has been agreed the referring ward will

- Discharge Medication will need to be arranged, dispensed and sent with the individual to Y Lolfa.
- An active medication chart with at least 7 days left on it.
- Send all medications with the individual.
- Inform first point of contact / next of kin.
- Ensure all medical notes and documentation are sent.

Individuals should not be transferred to Y Lolfa between 8pm and 7am. If, in exceptional circumstances admissions are arranged out of these hours then only individuals identified on the Shared 'Live List' to be transferred to Y Lolfa.

Safe transfer of care out of the acute hospital will remain the responsibility of the Ward Sister supported by Discharge Liaison Nurses.

- **Staffing Model:**

The revised requirements for the Y Lolfa model based on the below roster would be:

	15 beds

	RN (+ Band 6 supernumerary M-F)	HCSW	FLO	Total unregistered
Early	1	2	1	3
Late	1	1	1	2
ND	1	2	-	2

Revised requirements						
Staff	**Band 7 Supervisor**	**Band 6**	**Band 5**	**Band 2**	**band 3 Frailty workers**	**Clerica**

This model would not require a Band 7 supervisor as this would be provided by the Band 7 on Steffan.

The financial implications would be as follows:

Additional Requirement	**R/N**	**HCSW & Other**

The Roster will be reviewed every 6 weeks, or sooner if needed as the need arises.

Allocate will reflect the agreed Roster to separate Y Lolfa from Steffan to ensure appropriate cover and any escalation of shifts can be easily identified and appropriately managed.
A cost code will be generated to capture an accurate cost pressure of Y Lolfa.

Data collection and analysis will be determined, and regular performance review will be undertaken to measure the impact of Y Lolfa.

- **Hotel Services:**

The required cleaning and catering establishment to provide a seven-day service is:
1 x 27.5 (0.6 WTE) £24,009.47 (includes weekend enhancements)

2 x 17.5 (0.45 WTE) £14,570.37 (includes weekend enhancements)

To be read in conjunction with:	
Patient information:	Include links to Patient Information Library

Owning committee/group	The Alternative Care Model – Task and Finish Group. HoN – Olwen Morgan DHoN – Iona Evans Senior Nurse Manager – Sion Davies

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved: dd/mm/yyyy
1	New Procedure. Add lines below etc. when the SOP is reviewed/amended.	

Keywords	Please detail all keywords that staff can search for to locate this document