Standard Operating Procedure:
Care Management for Clinically Optimised Patients in In-patient Hospital Beds

Introduction

Hywel Dda University Health Board (HDUHB) is committed to ensuring patients receive safe, timely, effective care underpinned by person-centred and prudent health care principles.

This document sets out a standardised approach to the care management of clinically optimised patients (see CO definition paper) in hospital beds within HDUHB to ensure the most effective use of all skills and resources to enable care for those with the greatest need first, to do only what is needed, no more, no less and do no harm, and to reduce inappropriate variation in care across the system.

Definition: Clinically Optimised

A patient is considered “clinically optimised” if a clinical decision has been made by the registered professional(s) that the patient is ready for transfer or discharge from an inpatient hospital bed (NHS Wales Data Dictionary) from either an acute or community setting. The registered professional must be part of the multi-disciplinary team (MDT) and have discharge/ transfer rights.

The term “clinically optimised” applies to all adults occupying an NHS hospital bed, who are 'clinically optimised' ready to return home or move on to the “next stage of care”. The 'next stage of care' refers to all destinations outside of NHS hospitals, including home, commuting care, residential care and Hospital at Home services.

A patient is considered clinically optimised when **both** the following criteria have been met:

- Acute medical needs have been addressed. Their medical condition is stable, and no further hospital-based care is required.
- No longer requires specialist hospital-based MDT interventions. Any ongoing care can be provided outside a hospital setting (including rehabilitation needs).

Background

Data demonstrates that a significant proportion of patients within HDUHB hospitals are clinically optimised and do not require hospital-based care. Currently there is no agreed differentiation between the management of patients who require hospital-based care, and those who do not, resulting in clinical time and resources being

utilised on clinically optimised patients that could be redirected to those with greater clinical need.

Whilst clinically optimised patients do not require hospital-based care, they do require a level of care to maintain their clinically optimised status and prevent harm from deconditioning and hospital acquired infections.

Clinically Optimised Management Process

When a patient meets the identified criteria, they will be declared clinically optimised. Patients identified as clinically optimised should have ongoing discharge planning to enable them to leave the hospital as soon as possible. Whilst these arrangements are being made, their care provision should be modified to support their care transition towards leaving the hospital, with an emphasis on preventing harm and deterioration, maintaining and/or improving their functional and cognitive ability and promote social interaction.

All clinically optimised patients will remain under the care of a named consultant, and as no further in-patient hospital-based medical or MDT interventions are required they will be managed via the agreed health board “Care Management for Clinically Optimised Patients in In-patient Hospital Beds” process as outlined in this document.

If at any point the patient’s condition changes and they do not meet the criteria for clinically optimised anymore, their status will be changed to not-clinically optimised, and their care management will be based on clinical need as identified by the relevant MDT.

Medical care and responsibilities

When the patient has been identified as clinically optimised the responsible medical team will:

- Ensure that a ‘What matters to me’ conversation has been undertaken with the patient and/or their family.
- Ensure that an accurate Criteria Led Discharge document is in place, communicated and placed in the medical record, which has been informed by the ‘What matters to me’ discussion.
- Review the patients “Do Not Attempt Cardiopulmonary Resuscitation” (DNACPR) status and document any ceilings of care in the medical record.
- Where appropriate transfer the patient’s medication to a long-term medication chart
- Complete the patient’s Discharge Advice Letter (DAL) and identify any follow-up actions that might be needed in hospital whist they are awaiting discharge or transfer.
- Ensure that the patient’s change in status is recorded on the digital patient flow system.
- Attend the daily ward board round for a virtual review and update on the patient’s condition (no face-to-face patient review or new investigations are needed unless a change in the patient’s condition has been identified).
- Respond promptly to any escalations regarding a change in condition.

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Patients will be cared for and monitored by the nursing staff on the ward and any changes in condition will be escalated to the responsible clinician by the nursing team during the patient's continued hospital stay. In the event of a change to a patient's clinical condition, and following review by the medical team responsible at the time of the escalation, the patient will be reviewed by a senior member of their consultant team at the earliest opportunity, and a decision made on further management and the appropriateness of the discharge plan.

Nursing Care and responsibilities

The patients nursing care needs will be maintained throughout their continued hospital stay and the following actions undertaken on all clinically optimised patients as a minimum:

- Twice daily NEWS scores.
- Maintain nursing assessments and condition specific observations, and outcomes of care recorded in line with the requirements of the Welsh Nursing Care Record (WNCR).
- Promptly escalate any changes in the patient's condition to the named medical team and monitor response and document on WNCR.
- Support all activities of daily living and promote and encourage self-care through a reablement approach.
- Prevent deconditioning by ensuring patients are out of bed, mobilised and dressed each day (where appropriate) and nutrition and hydration needs are met.
- Prevent delirium and maintain cognitive function by ensuring patients are orientated to time, day and date, and are informed of each step of their care and discharge planning.
- Maintain and document, at least twice weekly communication with the patient and their family on progress with discharge plans and any changes in condition.
- Encourage visiting and trips away from the ward were appropriate.
- Where possible promoting and providing ward/ hospital activities which support improvements in patient's cognitive and functional ability and encourage social interaction.
- Advise the patient's family of the Call for Concern offer and process.

Therapy Care and responsibility

Therapy input will continue as required throughout the patient's continued hospital stay to:

- Maintain and promote individual patient's health, functional ability and self-care
- Prevent deconditioning
- Provide support and advice for the development of ward activities to support the above.

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Governance and Oversight of outcomes

Operational management teams will maintain live lists of all clinically optimised patients and will monitor the impact of this process on:

- Optimal Hospital Flow
- Quality and safety of patient care
- Impact of length of stay and discharge planning
- Patient and families experience of care
- Patient outcomes
- Staff experience
- Staffing workload and resource management

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