**Appendix D**

**Procedure for Hospital Admissions where there is an existing Homecare package**

## **Purpose:**

Developing a single point of contact for acute admissions and communication for Homecare providers.

To ensure that Homecare clients do not experience delays in returning home and resuming their existing Homecare package.

Once medically fit and “No Criteria to Reside” the provider will agree to restart the existing homecare package within 48 hours where admissions have been tracked via the HIS Single Point of Contact. Any changes whilst in hospital that result in an increased package could mean this is not possible in the anticipated timeframe. To assess on a case-by-case basis.

## **Context:**

Somerset Council’s commissioned Homecare providers receive payment for care whilst the person is in hospital for at least 2 weeks. This timeframe can be extended depending on the individual’s circumstances. We want to create a good practice standard for all Homecare providers and acute hospitals to be able to support admissions and discharges with the right information, in the right place and at the right time.

## **How to: From the point at which person is going to hospital.**

1. Homecare Provider contacts Adult Social Care’s Hospital Interface Service (HIS) at [histauntondeane@somerset.gov.uk](mailto:histauntondeane@somerset.gov.uk) or [hisydh@somerset.gov.uk](mailto:hisydh@somerset.gov.uk).
2. Provider will send an individuals care plan to the HIS team. This will contain most of the information needed to support a rapid discharge when ready. HIS team may contact provider for further details as necessary.

Example of information needed:

* Name of person
* Next of Kin / key contact
* Date of Birth
* NHS number
* Day / time of transfer to hospital and which hospital (if known)
* Copy of current (live) support plan and details of any changes over the period preceding admission.
* Name of provider and key contact point for information
* Establish LA funded or self-funded

1. HIS will:

* Establish the current situation regarding the person admitted which will include, Hospital location, ward location and admission status. The HIS Team will send this information directly to the Homecare provider on the same day, including discharge plan arrangements if known.
* Update Health and Eclipse records including a message to Sourcing Care of admission status for them to update SWIFT records.
* Attach a copy of the care plan to the persons notes.
* Link with the MDT and Discharge facilitator and ensure the Homecare provider is kept up to date with the discharge plan at point of No Criteria to Reside.