COVID-19: Provision of Care within Community Assessment Beds

Newmarket Community Hospital

Standard Operating Procedure
Background

Information from Public Health England (2020) regarding the epidemiology of COVID19:

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China.

On 12 January 2020 it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. This virus is referred to as SARS-CoV-2, and the associated disease as COVID-19.

Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others causing more severe disease such as Middle East respiratory syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) coronaviruses.
On the 11th March 2020 The World Health Organization declared Covid-19 was categorized as a pandemic. Please see Appendix D for the response from the joint UK nursing councils and professional bodies to assist your practice and support. The link below set’s out how providers of community services can release capacity to support the COVID19 preparedness and response. These arrangements will apply until 31 July 2020 in the first instance.

Covid10 Prioritisation within Community Health Services guidance:


Purpose and Objective
This COVID-19 Standard Operating Procedure document is to supplement any existing Standard Operating Procedure Documents relating to the CAB’s.

Contents
- Introduction, purpose of CAB
- Clinical criteria for admission
- Referral Process
- Protocol for treatment of suspected or confirmed COVID19 positive patients
- Protocol when patients whom have been non-symptomatic in Non-COVID19 positive unit develops symptoms
- Cleaning procedures for bed spaces following suspected or confirmed COVID-19 patients.
- Safer staffing processes
- Medical support in hours
- Therapy support
- Patient flow
- Medication processes including TTO’s
- Specialist support
- Patient discharge
- Housekeeping and Facilities
- Visitors
- Out of hours support (non-emergency)
- Senior staff contact details/useful telephone numbers

- Appendix A – PPE procedure Flow Chart
Introduction, purpose of Community Assessment Beds (CAB)

The community assessment beds are provided in Bury St Edmunds and Newmarket.

- Newmarket community hospital (NCH) - Rosemary Ward originally a 19-bed inpatient unit, which in response to the pandemic the bed capacity will increase to 33 beds by December 2020

We also have access to:

- King Suite is a 20 bed; inpatient unit commissioned from Care UK by West Suffolk Foundation Trust (WSFT) and located within the Glastonbury Court Care Home, the operating process for Kings Suite is in a separate SOP.

These services form part of the WSFT Community and Integrated Services Division.

NCH currently provides re-ablement, for patients deemed to be medically optimised, however during this heightened situation the cohort of patients transferred to NCH may be categorised as sub-acute, and may still require some medical interventions. Staff will be required to be responsive to the changing situation; there will also be a focus on the pathway for stepping patients up from home as admission avoidance.

A rapid programme of clinical skills training has been provided to nursing staff, in addition to the current range of services provided around reablement/complex discharge planning/end of life care, an additional range of clinical interventions may be provided for patients in the CAB’s.

Clinical criteria for admission to Rosemary Ward

COVID negative and COVID positive patients (14 days since positive swab)
Patients requiring end of life care
Patients requiring reablement support
Patients requiring interventions of a ‘sub-acute’ level which may include:

- Low level O₂ therapy (2L/min or less)
- IV antibiotic therapy
- Those with NEWS2 of 2 (notwithstanding underlying conditions which may affect this)
- PEG/NG feeds

If the patient is “step up” they can be transferred into NCH once a Covid NOT detected swab has been received or 14 days post Covid detected swab and symptom free.
The above criteria are not exhaustive and the nurse in charge should consider each referral on a case by case basis to ensure that transfer to either unit is in the best interests of the patient.

**Referral Processes**

Referrals will be received via the Hospital Discharge Hub which has been set up in response to the COVID-19 Pandemic as per the following National Guidance. (Discharge SOP hub is available).


It is essential that robust communication takes place between the referrer and the Nurse in Charge (NIC) to ascertain the following and plan admission accordingly: the checks prior to discharge is as follows-

1. The presence of an accurately completed East of England DNACPR document, for each patient who is confirmed not for resuscitation in the event of a cardiac arrest.
2. The confirmation of a documented clinical plan for the patient.
3. Any concerns around the suitability of the referral should be escalated to the Commander on Call for discussion/escalation.
4. Sub acute patients should arrive on each unit by 16:30 to allow for GP review on arrival, if required.

They must be transferred with the following -

- All patients placed in appropriate bed at NCH
- Patient must remain at WSH until 14 days post swab and be symptom free
- COVID+ve
- COVID-ve or awaiting swab
- Patient identified for a Newmarket CAB must be swabbed within 48hrs prior of transfer
Protocol for treatment of suspected or confirmed COVID19 positive patients

See appendices 1 & 2 for PPE guidance

Rosemary ward, any waste generated from suspected or COVID +ve patients must be put into an orange bag, secured and disposed in the usual way.

Cleaning Procedures following suspected or confirmed COVID-19 patients

All processes to follow current NHS inpatients guidance.  
*Video link to demonstration of ‘Donning’ and ‘Doffing’:*

https://youtu.be/zMKUDkrXXsw

Safer Staffing Processes

The unit has a Ward/Unit Manager in situ, who is supported by Sisters/Charge Nurses. All work both clinically and on a management level and have a visible presence on the ward. In addition, during the COVID-19 escalation period clinical skills training will be planned and delivered on both sites by a Senior Project Nurse, who will also provide clinical leadership to support staff with the increased acuity of patient care. Additional agency staff will also be sourced to support clinically with a particular focus on the IVAB pathway. Ward Management responsibilities will remain unchanged.

Nursing staff undertake 11.5 hour shifts over a 2-shift system (day/night) as follows:

<table>
<thead>
<tr>
<th>Day</th>
<th>07:00 – 19:30</th>
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<tbody>
<tr>
<td>Night</td>
<td>19:00 – 07:30</td>
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Nursing Assistants undertake 11.5 shifts over a 2-shift system (day/night) as follows, as well as a Twilight shift:

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<thead>
<tr>
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<tbody>
<tr>
<td>Night</td>
<td>19:00 – 07:30</td>
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<tr>
<td>Twilight</td>
<td>18:00 - 24:00</td>
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Skill Mix as follows (Phase 1):

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<tr>
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<td>3</td>
</tr>
<tr>
<td>Night</td>
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<td>2</td>
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<tr>
<td>Twilight</td>
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A staffing plan has been developed to support the additional 14 beds being introduced on Rosemary Ward due to be opened mid-May 2020 (Phase 2)

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<td>4</td>
</tr>
<tr>
<td>Night</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Twilight</td>
<td>0</td>
<td>0</td>
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</table>

Phase 1 uplift required (by 13.04.20)
RN – 4.3 WTE
NA – 2.15 WTE

Phase 2 uplift required (by 11.05.20), a further:
RN – 2.15 WTE
NA – 4.3 WTE

All staff with be flexed depending on level of patient acuity.

Rostering is supported by Health Roster; rosters are produced 8 weeks in advance, it is recognised however that core staffing is likely to be depleted as the pandemic progresses and skill mix may be compromised and the nurse in charge in each area will be required to prioritise workload and patient interventions as required.

A number of staff were redeployed from their usual departments to support Rosemary Ward. All receiving clinical skills training and were closely supported by senior staff during their redeployment. They have now all returned to the normal place of work.
Agreement will be required regarding identification of critical staffing levels on both units, when patient care is evidenced as significantly compromised and patient/staff safety adversely affected; this will be escalated promptly to Divisional Commander for action.

Examples of interventions which may be reviewed in this event:

- Daily Observations - Only do if clinically indicated.
- Let patients remain in night clothes
- Consider levels of personal hygiene given; focus on pressure area care, continence care, mouth care as a priority.
  - Completion of WSFT audits temporarily suspended

Medical Support

A Consultant Geriatrician working virtually will retain overall medical responsibility for these patients.

Rosemary Ward

Medical provision is now provided Mon-Fri during core hours by Orchard House Surgery GPs; to include daily ward rounds for sub-acute patients.

Medically optimised patients will be reviewed, as requested by staff.

Plans of care will be required for sub-acute patients each Friday to support care and clinical decision making over the weekend.

Visionable facilities (virtual/secure meetings) will support virtual clinical assessment at the bedside, as required.

Out of hours support will be provided by the GP Federation.

Therapy Support

Physiotherapy and occupational therapy staff provide cover for NCH in normal working hours. Additional cover is provided across therapies at weekends during current the pandemic period.

All therapy staff are employed by WSFT. Day to day they are managed by their respective Professional Leads. There is capacity to flex the staffing levels and banding, in response to bed flow pressures and staffing needs.
Rosemary Ward

A physiotherapist (B5) and occupational therapist (B6) are present Mon – Fri, together with a rehabilitation assistant. The therapy staff are rotational so that periodically they change. This allows good practice and wide skill sets to be shared and learned, benefiting patients and other staff considerably.

A senior physiotherapist (B7) and a senior occupational therapist (B7) oversee both off-site units, providing ad hoc and planned cover for leave etc., as well as professional and clinical support for the rotational therapy staff.

The rehab assistant provides therapy support Mon – Fri. This post is rotational, but on a less formal basis, to allow flexibility and responsiveness.

If the patient is isolated there may be restricted opportunities for therapists to provide a range of assessments and interventions. This includes stair assessments which may result in a greater number of patients living downstairs post discharge. This will likely increase equipment provision to support their level of function due to the high risk of deconditioning during this period of isolation.

Clinical Emergencies
The process for managing clinical emergencies will be unchanged from the current process; basic life support should be commenced where appropriate and the emergency services contacted for repatriation back to the West Suffolk Hospital.

Deteriorating Patients
It is recognised that both Rosemary Ward are nurse-led units with only intermittent medical support. When the clinical condition of a patient gives cause for concern this will be managed according to the skill set of the clinical team on site, mindful of the extent of interventions possible on the unit and the need to consider potential urgent return to the acute setting within the context of potential pressures being faced by the ambulance service. Where possible, Patient Group Directives will be developed/made available to support these clinical interventions.

Patient Flow

- Unless required to be in hospital (see Annex B in document above), patients must not remain in an NHS bed.
- Based on the criteria included in the above document, acute and community hospitals must discharge all patients as soon as they are medically optimised.
- Transfer from the ward should happen within one hour of that decision being made to a designated discharge area (this will not be possible in either CAB facility, due to CQC registrations). Discharge from Hospital should happen as soon after that as possible, normally within 2 hours.

CAB is required to undertake:
A daily clinical review of all patients asking the following questions:

- Why not home?
- What needs to be different to make it possible to go home?
- Why not today? Most people medically optimised should go home.

EDD and expectations agreed with the patient on admission to CAB Monitoring and increasing bed capacity.

After the first phase of discharging people from acute care it is important to maintain this approach in CAB to ensure flow.

**Patient documentation**
Patient records are held on eCare at Newmarket and at Glastonbury Court.

**Shift Handover**
Shift handovers take place at the bed side; this gives staff the opportunity to introduce themselves and to undertake a visual assessment of the patient. Confidentiality must be maintained; if visitors are present they should be asked to vacate the area for a short period.

Staff handover sheets are updated by night staff and information documented must be concise. Usual IG processes should be followed.

**Medication Processes**
Rosemary Ward are supported by WSFT Pharmacy Department and are provided with support from a Pharmacy Technician. A supply of ward stock is available in the Medication Room, the content of which will be reviewed by Pharmacy colleagues.

Rosemary Ward are committed to promoting independence and will work towards supporting patients to self-administer their medication.

Controlled drug, fridge temperature and drug room temperature checks are to be completed and recorded daily; these should continue during the COVID-19 escalation period, supported by the Ward Manager and supernumerary staff/senior managers.

There is SOP for Single drug administration (SDA) to use used in emergencies only

![SoP Single Drug Administration, CAB's](SoP Single Drug Administration, CAB's)

**Rosemary Ward** – TTO’s are prescribed by the GP provider on eCare, the task is then created by the nurse to request pharmacy to dispense the medication.

TTO’s are delivered by courier 3 times daily to Rosemary Ward.
**Specialist Services**
Rosemary Ward have access to all WSFT specialist services (clinical and non-clinical) as well as St Nicolas Hospice Care, including:

- Infection Prevention Team
- Integrated Tissue Viability Team
- Diabetes Team
- Resuscitation Team (for training purposes)
- Clinical Skills Team
- Education Team
- Human Resources Team
- Catering
- Facilities and Estates

Rosemary ward benefits from a twice daily courier collection/delivery service, which transports mail/samples/medication/supplies between West Suffolk Hospital and Rosemary Ward.

**Patient Discharge**
The Rosemary Ward team ensure that discharge/transfer discussions take place with the patient and family (as appropriate) immediately upon admission. Discharge/transfer date is reviewed at each daily R2G Board Round to ensure as short a LOS as possible.

The MDT work closely together to ensure that discharge takes place promptly when the patient has achieved all goals/been discharged from each professional. Social Care staff work closely with the team to confirm that all support arrangements are in place. During the COVID-19 escalation period there is no requirement to send the usual Assessment and Discharge notifications to Social Care colleagues.

Where possible discharges should take place during the morning to ensure time for unforeseen circumstances to be addressed and a timely admission to the ward subsequently.

Transfers of care into community health teams (CHT) are made via the Single Point of Access system, access via Evolve (accessible via the eCare system). Robust patient details are required, including details of each patient’s COVID-19 status; staff should also ensure adequate supplies of dressings, etc. If medication is to be administered, staff should ask the CHT to contact the ward to discuss this more fully; every attempt should be made to reduce/remove the need for community nurse visits during the COVID-19 escalation period, by encouraging patients/relatives/friends to undertake care/interventions.

Patients being discharged to a Care Home should be swabbed for Covid-19 up to 48 hours prior to departure. See Appendix 5

**Clinical Incidents**
All incident reporting should be maintained via the Datix system, access via the Trust Intranet. All incidents are reviewed and investigated by the senior team and learning shared with colleagues.

**Housekeeping and Facilities**
Housekeeping and maintenance within Rosemary Ward is provided by WSFT.

Clinical staff have responsibilities for cleaning patient equipment such as manual handling equipment, observation machines, computers, commodes, Mowbray Toilet Frames. Patient equipment should be cleaned between each patient use and labelled with green ‘I am clean’ labels. Consideration will need to be given during Covid to patient specific equipment, such as BP cuffs.

**Emergency Procedure (non-clinical)**
Rosemary Ward staff are familiar with emergency procedures and follow the WSFT policies and procedures. Should an emergency occur the NIC should co-ordinate the appropriate response and liaise with appropriate senior staff, who may initially be supporting remotely.

**Procedure in the event of a death (see Appendix 4)**
In the event of a patient death on Rosemary Ward, please refer to Appendix 4 Mortuary Standard Operating Procedure - Deaths at Newmarket Hospital and Glastonbury Court.

All staff will work towards completion of the on-line module for Verification of Expected Death, which will allow them to complete this process promptly.

It is recognised that due to the lack of visiting during the Covid-19 escalation period, staff will be asked to inform relatives of the death of loved ones by phone, support for managing this process will be included in the training package currently being delivered.

**Security Concerns.**
WSFT maintains a ‘Zero Tolerance’ approach and aggression towards staff is taken seriously, the WSFT Security Manager is available during core hours to give advice and support. Out of hours difficulties should be escalated to the Clinical Site Manager via bleep 888 (01284 713000) or for more urgent matters (9) 999.

*Discuss wording with Brod*

It is acknowledged that Rosemary Ward is a small unit without access to security staff on site; staff should be mindful of their own safety and security and that of patients; should any concerns arise and immediate assistance be required, staff could contact the emergency services by dialling (9) 999.

**Visiting Hours.**
To reflect the national lockdown to limit the spread of coronavirus (COVID-19), we are restricting visitors to our hospitals.

No visitors will be allowed to any of our hospital inpatient wards, except in the following circumstances:

- **For a child who is a patient**
  - One named parent or responsible carer, who lives in the same household
  - Visiting hours are unlimited

- **For a woman in labour**
  - A partner or birthing partner, who lives in the same household
  - To accompany the woman throughout labour

- **For people who are dying**
  - One named person
  - Visiting will be limited to one hour per day, at a consistent time to be agreed with the ward manager

- **For people who have a learning disability or severe dementia**
  - Named carer(s) who live in the same household or attend the person professionally, as required on the basis of individual need
  - Visiting hours to be agreed with the ward manager, as required on the basis of individual need

In the event that the named parent/carer/partner develops a high temperature, breathing difficulties or a new continuous cough, or another person who lives with them becomes unwell, they must follow the national guidance and stay at home

**GP Practice Contact Numbers in Hours 8am-6pm**
Rosemary Ward –

- Oakfield Surgery – 01638 662018

**Out of Hours Support (non-emergency)**

For support and advice during out of hours periods, please contact the Clinical Site Team: 01284 713000, bleep 888.

**Senior Staff Contact Details.**

Sharon Basson, Head of Nursing  07970 421903/07576672327/01359760083
Amanda Keighley, Senior Matron  07984 664015
Sue Jones, Assistant Service Manager  07817090135
Kevin McGinness – Local Area Manager - 07989224286

The commencement of portering services at Newmarket has been confirmed commencing the w/c 11th May and will be available on site between 6am – 10pm on weekdays.
### Appendix 1 - Recommended PPE/inpatient settings

#### References

**Table 1**

<table>
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<tr>
<th>Getting</th>
<th>Context</th>
<th>Disposable Gloves</th>
<th>Disposable Plastic Apron</th>
<th>Disposable Fluid-resistant coveralls/overalls</th>
<th>Surgical mask</th>
<th>Fluid-resistant (Type II) surgical mask</th>
<th>Filtering face piece respirator</th>
<th>Eye/face protection</th>
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<td>Adult hospital and emergency department, mental health, learning disability, autism, dental and maternity settings</td>
<td>Performing a single system generating procedure(^2) on a possible or confirmed case in any setting outside a higher risk acute care area(^b)</td>
<td>✅ single use(^d)</td>
<td>✗</td>
<td>✅ single use(^d)</td>
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<td>✗ single use(^d)</td>
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<td>Operating theatre with possible or confirmed case(^b) – Inc. AGPs`</td>
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1. This may be single or reusable face/eye protection/full face visor or goggles.
2. The list of aerosol generating procedures (AGPs) is included in section 5.1 at [www.gov.uk/government/publications/aerosol-generating-procedures](https://www.gov.uk/government/publications/aerosol-generating-procedures) (Note AGPs are undergoing a further review at present).
3. A case is any individual meeting case definition for possible or confirmed case. [https://www.gov.uk/government/publications/enhanced-contact-precautions-for-covid-19](https://www.gov.uk/government/publications/enhanced-contact-precautions-for-covid-19) (Note AGPs are undergoing a further review at present).
5. Single use refers to disposables or single-use reusables, excluding personal protective equipment (PPE). Single use single use refers to single use single use refers to single use single use.
6. Single use single use refers to single use single use refers to single use single use.
7. Risk assessment use refers to using PPE when there is an anticipated/actual risk of contamination with opsonised, droplets of blood or bodily fluids.
9. Ambulance staff covering patients are not required to change or upgrade PPE for the purposes of patient transport.

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**Nursing and Midwifery Council (2015) The Code. NMC**
COVID-19 Safe ways of working

A visual guide to safe PPE

General contact with confirmed or possible COVID-19 cases:
- Eye protection to be worn on risk assessment
- Fluid resistant surgical mask
- Disposable apron
- Gloves

Aerosol Generating Procedures or High Risk Areas:
- Eye protection - eye shield, goggles or visor
- Filtering facepiece respirator
- Long sleeved fluid repellent gown
- Gloves

Clean your hands before and after patient contact and after removing some or all of your PPE
Clean all the equipment that you are using according to local policies
Use the appropriate PPE for the situation you are working in (General / AGPs or High Risk Areas)
Take off your PPE safely
Take breaks and hydrate yourself regularly

For more information on infection prevention and control of COVID-19 please visit:
# MORTUARY STANDARD OPERATING PROCEDURE

## DEATHS AT NEWMARKET COMMUNITY HOSPITAL AND GLASTONBURY COURT

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<tr>
<td>REVIEW INTERVAL</td>
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<tr>
<td>AUTHORISED BY</td>
<td>Tracey Green</td>
</tr>
<tr>
<td>AUTHOR</td>
<td>Tracey Green/Trudy Wright/Helen Ballam/Charlotte King</td>
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| LOCATION OF COPIES | 1. Mortuary SOP file –  
2. Matron’s Office  
   Newmarket Community Hospital  
3. Kings Suite, Glastonbury Court |

## Document review history

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1. GENERAL

When a patient dies at Newmarket Hospital the following procedures must be followed:

Newmarket

- Death recognised, GP or nurse verifies death. For GP verification in hours call Orchard house or otherwise 111 for out of hours service. Phone the family if not present. Ask family if they have preferred funeral directors – ideally in advance of death.

- Notice of death form completed, one copy (white) placed in the deceased patient’s notes.

- Following verification, the family’s own funeral director or Southgate of Newmarket (01638 662480) should be called to collect the deceased. Next of kin should collect the Medical Certificate of Cause of Death (MCCD) from the GP, if they are able to issue. Completion of cremation forms will be organised by the funeral director and GP, if required.

Deceased must be released and documentation completed as detailed in Section 3.

Collection of MCCD

- **GP issue**: NOK should collect the Medical Certificate of Cause of Death (MCCD) from the GP, when it is ready. Completion of cremation forms, if required will be organised by the funeral director and GP.

- **WSFT issue**: NOK should collect the Medical Certificate of Cause of Death (MCCD) from the BSO, when it is ready. Completion of cremation forms, if required will be organised by the funeral director, WSFT doctor and mortuary if patient has been transferred.

Deceased must be released and documentation completed as detailed in Section 3.

2. GUIDANCE WHEN TO CALL THE POLICE OR REFER TO THE CORONER

**Police Attendance**
Police should only be called if the death was violent or suspicious, there is a question of self-neglect or neglect by others, the death occurred after detention in police or prison custody or under the mental health act or may be a suicide or contributed to the actions of the deceased. If someone is admitted and dies of stab wounds, gunshot wounds or signs of an assault, etc they will be treated as a suspicious death but if there is the belief that there has been any illegal activity having contributed to the death then this should be treated as suspicious. The Senior Coroner clarifies that if there is tangible evidence of 3rd party involvement then this would warrant police attendance. If in doubt then the police should be called.

**Referrals**

If the circumstances warrant a referral to be made to the Coroner then this is to be done by a doctor. The Bereavement Office on 01284 713410 or Mortuary on 01284 713399 may be contacted for guidance.

The deceased should still be collected as per section 1. If the Coroner wishes the deceased to be transferred to a hospital mortuary, this will be arranged by the Coroner’s Office.

The expectation is that a death should be only be referred to the Coroner if:

- The cause of death is unknown;
- It cannot readily be certified as being due to natural causes;
- The deceased has not been seen by a doctor during his last illness, or was not seen within the last 14 days or viewed after death;
- There are any suspicious circumstances or history of violence;
- The death may be linked to an accident such as a road traffic accident or fall down stairs (whenever it occurred);
- There is any question of self-neglect or neglect by others;
- The death has occurred or the illness arisen after detention in police or prison custody (including voluntary attendance at a police station);
- The deceased was detained under the Mental Health Act;
- The death is linked to an abortion;
- The death might have been contributed to by actions of the deceased (drug or solvent abuse, alcohol abuse, self-injury or overdose);
- The death could be due to industrial disease;
- The death is related in any way to the deceased’s employment;
- The death occurred during an operation or before full recovery from the effects of an anaesthetic;
- The death may be related to a medical procedure or treatment whether invasive or not that occurred within the last 30 days;
- The death may be due to lack of medical care;
- There are any unusual or disturbing features to the case;
- It may be wise to report any death where there is an allegation of medical mismanagement.

A doctor can properly issue a medical certificate of death if:

- He/she is satisfied that he can state correct cause of death AND
- The cause of death is entirely natural AND
- He/she has attended patient for their last illness and EITHER
  - seen within 14 days
  - he/she viewed body after death
3. RELEASE OF A BODY

1. The appropriate funeral director is contacted, after the death is verified to collect the body.

2. A deceased release form must be completed in full (appendix 1), this needs to be signed by a member of staff and funeral director to acknowledge receipt of any property and confirmation of deceased patient’s identification.

3. When completing property details, gold and silver must not be used. Items of jewellery must be listed as yellow or white metal.

4. The form must be kept with the medical notes as part of the patient record.

5. The deceased will be laterally transferred to the funeral director’s stretcher.

---

**Appendix 1**

**RELEASE OF DECEASED PATIENT**

<table>
<thead>
<tr>
<th>NAME:</th>
<th>MRN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE OF BIRTH:</td>
<td>DATE OF DEATH:</td>
</tr>
<tr>
<td>PROPERTY:</td>
<td></td>
</tr>
</tbody>
</table>

I confirm I have collected the property as listed above and checked the patient’s ID tag as being correct (3 identifying factors).

| SIGNATURE: |
| PRINT NAME: |
Appendix 5

**Discharge from hospital/community assessment bed to care home**

The health and care system now more than ever need to support each other so that we can manage COVID-19; providing good care and support to people and doing all we can to reduce the spread of the virus. To support providers we are improving the information which will provide clear and accurate information about the COVID-19 status of people being discharged and some advice on managing any risk of infection.

During the COVID-19 response it will not be possible for care homes to visit a potential resident in hospital/community assessment bed to assess their care needs. West Suffolk NHS Trust has further enhanced the Integrated Health and Social Care Discharge Hub which will support communication re discharges. We will continue to discharge patients on one of the 4 discharge to optimise and assess pathways. The assessment of care needs will be undertaken by the discharge planning teams, care home trusted assessor and social care staff.

All patients will be swabbed prior to discharge; the Information from the test result along with any relevant care information will be forwarded to the care home.

If you have not received the swab result within 72 hours of the swab being taken you can contact the Discharge Hub between their working hours.

The Integrated Discharge Hub is staffed 7 days a week 8am to 8pm – located in the discharge planning social care office space

Telephone no: 01284 713474
The Care Home Trusted Assessors can be contacted on Telephone no: 07817 057206.
To help provide information on COVID status and management of patients we are completing the following for all patients who are discharged to the community.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>DOB:</th>
</tr>
</thead>
</table>

| Date of admission | |
| Date of onset of symptoms |
| Date of swab | Result: |
| Outcome of swab (Result) |
| Required oxygen therapy | Yes | No | Date discontinued: |
| Apyrexial | Yes | No | Last temperature recorded |
| Respiratory symptoms |

The following guidance has been provided by Public Health England to support the management of patients in care home on discharge from hospital

<table>
<thead>
<tr>
<th>Upon discharge, patient/resident has…</th>
<th>What care is required upon discharge?</th>
<th>What care is required upon first sign of symptoms?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Symptoms of Covid-19</td>
<td>Provide care in isolation</td>
<td>Provide care in isolation for 14 days of discharge from hospital</td>
</tr>
<tr>
<td></td>
<td>• Resident does not leave room (including for meals) for 14 days</td>
<td>• Resident does not leave room (including for meals) for 14 days</td>
</tr>
<tr>
<td></td>
<td>• Staff wear protective equipment &amp; place in clinical waste after use</td>
<td>• Staff wear protective equipment &amp; place in clinical waste after use</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tested positive for Covid-19 and No longer showing symptoms and Completed isolation period</th>
<th>Provide care as normal</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If a resident has no symptoms of Covid – 19

What care is required upon discharge?
- The care home should provide care as normal.

What care is required upon first sign of symptoms?
- Provide care in isolation if symptoms occur within 14 days of discharge from hospital.
- Resident does not leave room (including for meals) for 14 days after onset of symptoms or positive test.
- Staff wear protective equipment and place in clinical waste after use.
- Consult residents GP to consider if re-hospitalisation is required.

If resident has tested positive for COVID-19, is no longer showing symptoms and has completed an isolation period:

What care is required upon discharge?
- The care home should provide care as normal

What care is required upon first sign of symptoms?
- N/A

If the resident has tested positive for COVID-19, is no longer showing symptoms but has not yet completed isolation.

What care is required upon discharge?
- Provide care in isolation
- Resident does not leave room (including for meals) for 14 days after onset of symptoms or positive test
- Staff wear protective equipment & place in clinical waste after use.
What care is required upon first sign of symptoms?
- N/A

Completed by:  

Date:
Process for Patients returning to Care Home following Acute Admission

Acute Setting

1. Identify patient 48 hours prior to discharge
2. Swab taken and sent to Pathology
3. Discharge information prepared & communicated to care home (To include test results and date)

- Negative Result
  - Normal Discharge process to Care Home

- Positive or No Result
  - Care Home able to provide appropriate isolation or cohort area
    - Discharge to Care home
  - Care Home unable to provide appropriate isolation or cohort area
    - Local Authority to identify alternative appropriate accommodation

Care Home Setting