Standard Operating Procedure (SOP) – Management of Head and Neck Cancer Referrals during COVID-19

1 Purpose of the Document

Following the COVID-19 outbreak Queen Victoria Hospital NHS Foundation Trust (QVH) has been assigned to act as a cancer surgical centre for head and neck, breast and skin cancers in agreement with the NHSI/E, commissioners, the Kent and Medway Cancer Alliance and the Surrey and Sussex Cancer Alliance.

This Standard Operating Procedure (SOP) is designed to explain the actions, roles and responsibilities of referring trusts and QVH in the management of head and neck cancer cases during COVID-19.

This document should be read in conjunction with the following document:

Regional guidance:

- Appendix 1 - Head and Neck Cancer Management Guidance in Response to COVID-19
- Appendix 2 - Advice on maintaining cancer treatment during the COVID-19 response

QVH SOPS and information:

- Appendix 3 - SOP Head and Neck Microvascular cover at QVH
- Appendix 4 - Adult transfer and discharge policy
- Appendix 5 - QVH Head and Neck Referral proforma
- Appendix 6 - Head & Neck PCR / swab process
- Appendix 7 - COVID-19 Elective Screening Process Scheduler Script

The purpose of this document is to outline the key principles and to detail the tertiary referral processes between referring Trusts and QVH, to ensure the robust transfer and management of patients.

2 General Principles

The aim is to ensure the provision of head and neck cancer surgery for patients in Kent, Surrey and Sussex (KSS) during COVID-19.

QVH will be working in line with and following the Cancer Management Guidance developed by the COVID-19 cancer cell and SOPs set out above.

The SOP relates to admitted surgical procedures and treatment planning diagnostics under general anaesthetic (e.g. panendoscopy, micro laryngoscopy and tonsillectomy). The SOP

excludes the management of non-QVH 2ww and diagnostic requirements, which are not within scope.

The QVH will be designated as a COVID-19 free site.

Referring Trusts should limit the number of surgeons undertaking operating on the QVH site, preferably to one.

This document will be shared with referring Trusts in KSS.

3 Referral Procedure

3.1 Clinical decision making

Patients will be referred to QVH for head and neck cancer surgery through the Multidisciplinary Team (MDT) in line with existing established process. MDTs include Brighton, Guildford and Maidstone. Other MDT's in Kent expected to refer patients to QVH include East Kent Hospitals University NHS Foundation Trust.

MDTs will determine patients appropriate for surgery at QVH in line with current guidance set out in the 'Head and Neck Cancer Management Guidance in response to COVID-19'.

Decision-making re QVH suitability is as follows:

QVH **'Red'** – contra-indications to surgery at QVH

Surgical

- Skull base
- Thyroid needing thoracic access
- Carotid resection needed

Medical

- Renal dialysis
- High risk of hemofiltration
- Indwelling defibrillator
- Concerning echocardiogram requiring Cardiologist perioperative support

QVH '**Amber**' – relative contra-indications to surgery at QVH

Surgical

- Large thyroid/parathyroid – may need thoracic support
- High risk of neurosurgical complications

Medical

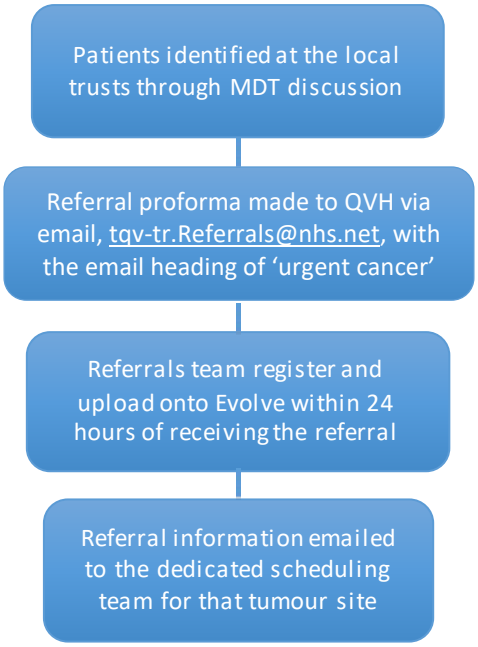
- Complex, high risk co-morbidities

Surgical Decision making for H&N Cancer patients QVH

Final version
Last updated 04.04.2020

3.2 Referral process

The referral to QVH should be made on the QVH referral proforma (please see appendix 5).



4 Scheduling, pre assessment and screening

4.1 Scheduling

On receipt of the referral (from the QVH referrals team) the QVH dedicated head and neck cancer schedulers will contact the patient by telephone to arrange a To Come In (TCI) date for surgery and pre assessment date (face to face or telephone as per 4.2).

The scheduler will inform the patient of requirements for pre assessment and screening prior to admission, including need to self-isolate for up to 14 days prior to attendance.

The scheduler will send a confirmation letter and information booklet to the patient.

4.2 Pre Assessment

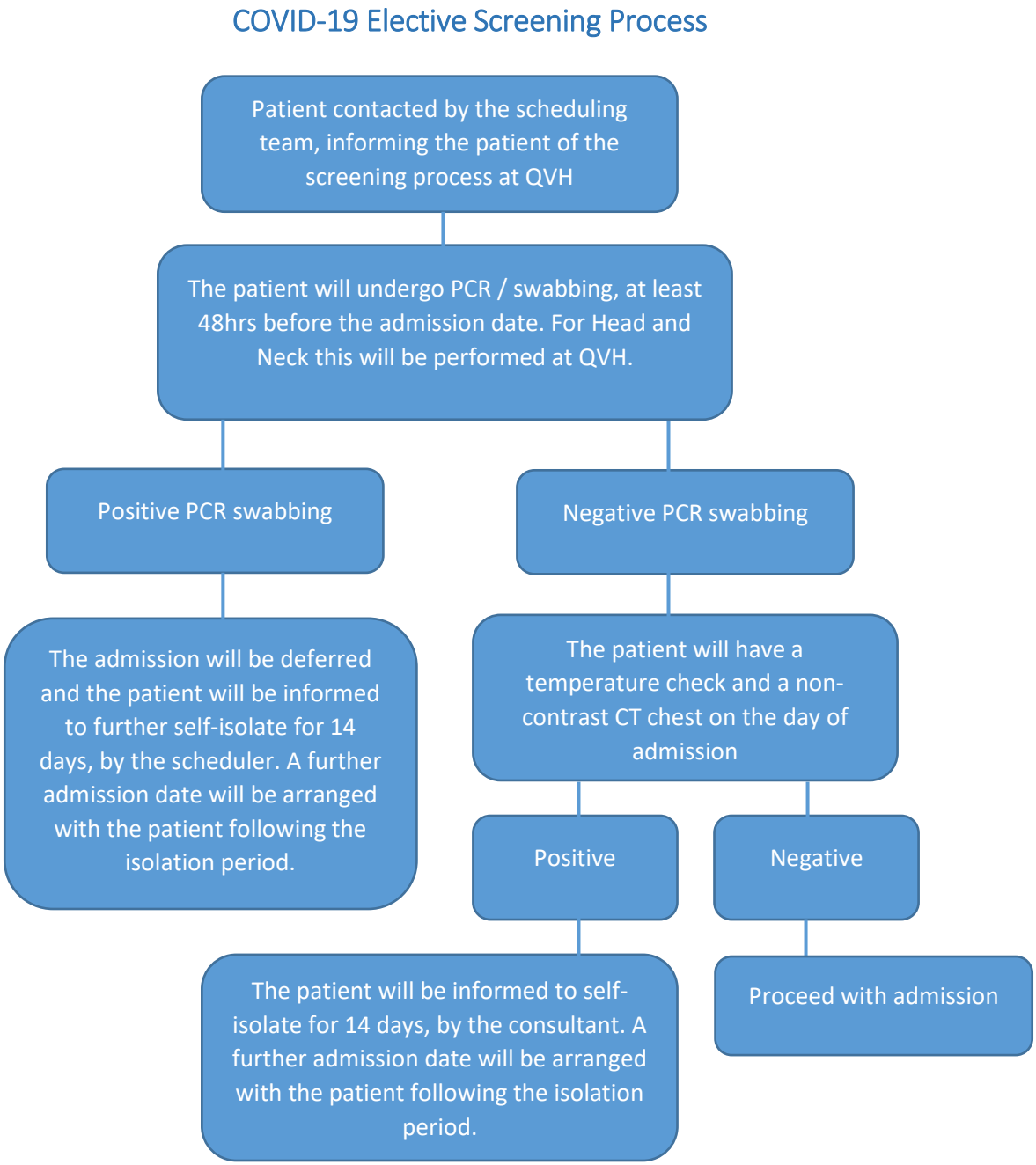
Patients requiring an inpatient admission will attend a one stop face-to-face pre assessment appointment within a week prior to surgery, which will include the following:

- Completion of health screening questionnaire
- Nursing pre- assessment discussion and investigations (BP, ECG, MRSA swab etc
- Anaesthetic review
- Consultation with QVH consultant for consent and review
- Discussions with Dietician, Speech and Language Therapist, Physiotherapist and Macmillan nurse

Patients requiring a day case procedure will be contacted by pre assessment staff for a telephone pre assessment. If further investigations are required, this will be arranged either at QVH if available or at the referring trust if appropriate.

4.3 Screening

In order to maintain a COVID-19 free site all patients will require screening ahead of admission including PCR/swab test, temperature check and non-contrast CT chest as follows:



5 Admission

For major cases, patients will be admitted the day prior to surgery.

On arrival, patients will report to Radiology and receive a temperature check, clinical assessment (to check the patient is asymptomatic) and non-contrast CT of chest.

If the CT of chest and temperature are normal, patients will be advised to proceed to the admitted ward areas.

If results are of concern, patients will be advised by their Consultant / Registrar that the surgery will be deferred to an alternative date. The patient will be advised to self-isolate for a further 14 days. The consultant will inform the scheduler to rearrange the TCI date.

During the patient stay, the patient will be under the care of the admitting Consultant and out of hours Trust SOP (please see Appendix 3).

The patients will be supported by the QVH Clinical Nurse Specialist (CNS) team from MDT to post op.

In the event of patients requiring an emergency transfer from QVH, the QVH Adult Transfer and Discharge Policy should be followed (please see appendix 4).

6 Patient follow up arrangements

For major cases, patients will receive post-operative face to face follow up at QVH. This appointment will include surgical team consultation, follow up with CNS and wider multi-disciplinary team and any required dressing changes.

For daycase procedures telephone follow up will be undertaken where appropriate. If face-to-face consultation is required by the clinical team, this will be arranged at QVH.

In the case of a post-operative bleed following discharge patients will be advised to attend their local A&E for examination and any immediate treatment required. Once stabilised the clinician in the A&E should contact the Site Practitioner team (01342 414000) at QVH, in and out of hours, to agree further for management and repatriation, referring A&E departments will be advised of this process.

7 MDT follow up

Following surgery the MDT co-ordinator at QVH will send the operation notes and histology to the relevant MDT for discussion within 48 hours of receiving the final histology report.

The MDT should then review the patient and agree the treatment and care plans.

8 Transport

Patients should make their own travel arrangements to QVH where possible.

Further transport options are being explored via volunteers.

9 Key QVH Contacts

- Cancer, Access and Performance Manager:
  Victoria Worrell victoria.worrell2@nhs.net

- General Manager:
  Kathy Brasier k.brasier@nhs.net

Head and Neck Cancer Management Guidance in Response to COVID-19

The following guidance has been produced by the COVID-19 South East Cancer Cell, 30th March 2020

1 Key Points

- For use to determine access to services when capacity is limited
- Higher priority chemotherapy will have protected access to available capacity
- Priority is determined by the absolute benefit a therapy provides to patients receiving that therapy

2 Purpose of document

The following is guidance for the provisioning of Head and Neck cancer services during the period of the COVID-19 pandemic and its emergency management. It is intended to guide and support decisions made locally/regionally and should be used in conjunction with any guidance from expert bodies. These should not be viewed as being prescriptive, and cannot cover every possible scenario and therefore will require individual MDTs and clinicians to make decisions based upon their best clinical judgement.

3 Current Pathways

Continue to use current referral methods as much as possible. If this changes, you will be notified

4 Referrals

4.1 Triage of referrals

- The emphasis is on the triage of the referral once received rather than putting off the referral. This is so that patients are logged in the system even if the decision is to defer treatment for now. Cancer cell are working on deferral codes and there will be central guidance on this to follow:

  https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/cancer-alliance-information-on-managing-cancer-referrals-19-march-2020.pdf
- Ensure senior clinicians have access to Trust laptops in order to be able to provide triage service / primary care advice
- Need to ensure safety netting in place for all referrals to ensure follow-up occurs appropriately post-pandemic

4.2 TWR referrals

- All 2-week referrals should be logged and then followed up following the cessation of the pandemic.
- Ensure appropriateness of 2ww waits. Consider two level triage – on receipt of initial referral and then again on the telephone to check symptoms with patients and the need to be reviewed within the urgent timeline and also that the patients want to proceed with the referral. Will also potentially allow ordering the first test prior to patient being seen to reduce visits to the hospital.
- A telephone conversation will count as first visit on the revised CWT

5 First hospital attendance

Consider one stop services e.g.

a) An OMFS clinic with ability for review, local anaesthetic biopsy and pre-op assessment as required.
b) Neck lump clinic with ability for review, ultrasound scan and fine needle aspiration or core biopsy.

6 Diagnostics

- Consider initial telephone triage to highlight the imaging required so that on the day of the face to face consultation the diagnostic imaging may be potentially completed.
- Try to maintain normal diagnostics for as long as possible. Consider deferring CT thorax in early stage tumours until after the pandemic, or alternatively use a PET-CT as a single imaging modality.
- Think about how GA EUA, panendoscopy and biopsy could be delivered
- Unlikely that FNE services can be offered as routine for diagnosis as requirement for full PPE. May be limited to cases with very high diagnostic suspicion of cancer and plan to obtain biopsy at the same examination.
- De-prioritise dental assessments during this period. Restorative dentistry which involves high speed drilling or scaling with an ultrasonic scaler are aerosol generating procedures and should be stopped during this period.

7 MDT Meetings

- Revise MDTs as per BAHNO to minimum quorum of single specialist from each discipline. Coordinate presence 24 hours before each meeting (forward plan rotas risk being unhelpful due to unplanned absence)
- How many people actually need to attend the meeting and can it be kept as virtual as possible?
- MDTs should record the treatment recommended as well as the ideal treatment if that is altered because of COVID-19
- Referring Consultant to send a clear plan of what they feel is their treatment plan

8 Arbitration/Ethics group

- Consider forming this within your team – ENT/OMFS/Anaesthetics/Oncology to allow of rapid decision making around urgent cases outside of the MDT o discuss any contentious treatment decisions or difficulties with resources. There are guidelines due to come out with regards these decisions and several Trusts already have overarching Ethical committees to help with difficult decisions.

9 Treatment

- Surgical treatment plans should be minimal. Could procedures be done in a staged fashion or reconstructed at a later date? Can free flaps be avoided? Consider age and co-morbidities of the patient . Is adjuvant treatment required? Could it be de-escalated or postponed? Is chemotherapy required?
- General anaesthetic procedure should be done with the patient having an endotracheal tube (not with an LMA)
- Can tracheostomy be avoided? High aerosol production and risk
- If elective surgical capacity is constrained discuss with MDT if radiotherapy can be used as alternative.
- Consider surgical neck dissection in preference to sentinel node (as may avoid second procedure)
- Ask MDT if PET evidence of primary would suffice for treatment plan if node biopsy already confirmed cancer
- Avoid neoadjuvant chemotherapy
- Where possible consider hypofractionated radiotherapy regimens to reduce fraction burden on department and hospital visits for patient (55/20#).
- 70/35# shouldn't be in common use but should be substituted for 65/30#
- Consider minimizing RT volumes in an attempt to reduce the need for peg/ngt, and consider treating the ipsilateral neck where previously treated bilateral. Reducing chemorad, only radiotherapy for post op. Chemorad for only the most robust of patients.
- Consider stopping all weekly Cisplatin at 200mg/m2 (5 weeks from 6) Moving to reactive NGT and away from prophylactic RIG.
- Avoid prophylactic RIG/PEG placement (high exposure risk procedure) and plan for reactive NGT placement if dysphagia develops.
- Talk to dietitian staff about support for NGT over RIG/PEG
- Palliative fractionation- consider 8/1 or Quad Shot over 20/5
- Plans for COVID radiotherapy as per department
- Cat 1 patients for treatment wherever possible.
- Radical H&N radiotherapy is Priority 1 as per NHSE priority table
- See the attached NHS document: Clinical guide for the management of cancer patients during the coronavirus pandemic with regards how to prioritise both surgical and radiotherapy patients.

10 Follow-ups

- To do virtually as able

11 Recurrence

- Have a pathway in place for patients who contact during this period who are concerned about recurrence. Consider telephone triage and then review the patients as required to decide on next steps.
- Discuss with staff in isolation about their capability to triage telephone enquiry

12 Palliation

- Involve local teams as much as possible and keep at home as able.

13 Current Guidelines

- Current guidelines available (This is changing on a regular basis and the most up to date guidance from NHSE, BAHNO, ENT-UK and BAOMS should be used):
    - *British Association of Head and Neck Oncologists:* https://www.bahno.org.uk/bahno_statement_on_covid-19.aspx https://www.bahno.org.uk/bahno_laryngectomy_guideance_during_covid-19_pandemic.aspx
    - *ENT-UK:* https://www.entuk.org/covid-19
    - *British Association of Oral & Maxillofacial Surgery:* *https://www.baoms.org.uk/professionals/omfs_and_covid-19.aspx*
    - NHSE: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/specialty-guide-acute-treatment-cancer-23-march-2020.pdf
    - NHSE: https://www.england.nhs.uk/coronavirus/secondary-care/other-resources/specialty-guides/

Publications approval reference: 001559

30 March 2020

Dear colleagues,

Advice on maintaining cancer treatment during the COVID-19 response

Thank you for all you are doing to respond to the COVID-19 emergency and, in particular, to continue to care for and support our cancer patients during these unprecedented times.

As you know, we are clear that the NHS must ensure that cancer diagnosis, treatment and care continues during the response to the COVID-19 emergency. This means:

- **Essential and urgent cancer treatments must continue. Cancer specialists should discuss with their patients whether it is riskier for them to undergo or to delay treatment at this time.**
- Where referrals or treatment plans depart from normal practice, safety-netting must be in place so that patients can be followed up.
- Urgent consideration should be given to consolidating cancer surgery in a COVID-free hub, with centralised triage to prioritise patients based on clinical need.

We have secured the use of almost all independent hospitals across England and their capacity should be used for cancer diagnosis and treatment.

In short, given the COVID situation is likely to persist for some time, rather than deferring cancer care, continuing to provide it through ringfenced facilities and reconfigured care pathways is generally more appropriate.

In London, the spread of the virus has been ahead of many other parts of the country, and local systems have been planning how best to maintain cancer services during the response period. The purpose of this note is, based on the London experience, to provide advice to local systems on how they should continue to manage cancer referrals and cancer surgery during the COVID-19 pandemic.

2WW referrals and cancer diagnostics

All patients should be considered on the basis of clinical need, and the level of risk, both patient- and service-related.

National advice has already been issued on the management of 2WW referrals for cancer. Local systems should continue to manage referrals in line with NG12 and this additional advice wherever possible.

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/cancer-allianceinformation-on-managing-cancer-referrals-19-march-2020.pdf

In primary care, where a patient meets the criteria for urgent referral under NG12 but, in view of current circumstances, the GP in discussion with the patient decides not to make a suspected cancer referral because this might be more clinically risky for the patient, the general practice should ensure the patient is appropriately safety netted, monitored and can be followed up if symptoms worsen or do not resolve.

Where a patient is referred as a suspected cancer referral and assessed virtually/by telephone, and a decision is taken not to undertake diagnostics currently due to risk to the patient, the secondary care provider should keep this patient on their patient tracking list (PTL) to ensure they can be appropriately followed up. Patients should be fully involved in reaching this decision and given advice on how to report worsening or new symptoms.

If a patient is referred as a suspected cancer referral and is not available or declines a diagnostic or other appointment due to self-isolation or shielding guidance, they should remain on the secondary care provider PTL to enable their appropriate and proactive follow-up.

Where a diagnosis of cancer is confirmed, and to minimise the patient's overall risk they are not listed for treatment immediately, then the patient should remain on the trust PTL and a decision to treat recorded if the patient has agreed to treatment. Again, patients should be involved in reaching this decision and given advice on how to report worsening or new symptoms.

It is essential that we retain records of those people who need urgent investigation for possible cancer, so that they can be followed up and diagnosed or have cancer ruled out at the earliest opportunity.

Cancer surgery hubs

Regional offices, Cancer Alliances, local systems and providers are already making plans for the continuity of cancer services during the COVID-19 response. Each local system will have its own challenges, and many will be

different from those in London. However, based on the experience in London (which in turn has drawn on the experience of Italy), we are recommending to regional offices and local systems that, as you develop and implement your own local plans for cancer, you consider incorporating the following features:

1. **A central triage point within a local cancer system**

   All cancer patients should be considered by their MDT.

   Any patients recommended for cancer surgery should be referred to a central, clinically-led triage point. This may be placed at a regional or local cancer system (Cancer Alliance) footprint level, depending on local circumstances.

   The triage system will: prioritise patients for surgery on the basis of clinical need, and the level of risk, both patient- and service-related; and match patients with appropriate surgical specialisms and capacity across the cancer system.

2. **Consolidation of cancer surgery on 'clean' sites**

   Where local circumstances permit, cancer surgery should be consolidated on a 'clean', COVID-19-free site within the local system. This could include independent sector provision where this has been secured.

   This will require arrangements for COVID-19 testing for all potential admissions 48 hours before surgery.

   For any cancer patient found to be COVID-19 positive, clinicians will need to decide locally when that patient will be considered fit for surgery, and be considered alongside other urgent surgery within a hospital treating COVID-19 patients.

3. **Clinical guide for the management of non-coronavirus patients requiring acute treatment: Cancer**

   Advice has been published to support clinicians in treatment decision-making and prioritisation, and to inform conversations about treatment with patients:

   https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/specialty-guide-acutetreatment-cancer-23-march-2020.pdf

   We will share with Cancer Alliances details of the structures put in place in London to assist with your local planning.

Cancer Alliances and national support

In many local systems, Cancer Alliances will be well placed to lead or support work to organise the configuration of local cancer services and manage patient flows, particularly for those patients for whom the clinical risk of delay is high. Regional teams will Cancer Alliances to help them deliver these arrangements.

All current advice on handling cancer patients is available on the NHS England and NHS Improvement website:

- https://www.england.nhs.uk/coronavirus/wpcontent/uploads/sites/52/2020/03/specialty-guide-acute-treatment-cancer-23march-2020.pdf
- https://www.england.nhs.uk/coronavirus/wpcontent/uploads/sites/52/2020/03/cancer-alliance-information-on-managingcancer-referrals-19-march-2020.pdf

The national cancer team and national specialised commissioning team will work with regional offices and Cancer Alliances to monitor preparations across the country, and will offer more intensive support where requested in areas where plans are not as advanced. This may be of particular relevance in the context of rarer cancers where there are relatively small number of providers.

If you have any questions or you feel the national cancer team can provide any particular support, please don't hesitate to contact us at: england.cancerpolicy@nhs.net.

Kind regards,

Dame Cally Palmer
National Cancer Director

Professor Peter Johnson
National Clinical Director for Cancer

Professor Steve Powis
National Medical Director

Queen Victoria Hospital NHS
NHS Foundation Trust

Standard Operational Policy (SOP) – Head & Neck Microvascular cover at QVH

As part of the '**The QVH Management of Head & Neck Cancers Local Head & Neck Multi-Disciplinary Team' - Classification V4 on Trust Q-net**

OVER ARCHING DOCUMENT	The QVH Management of Head & Neck Cancers Local Head & Neck Multi-Disciplinary Team V4
DATE RATIFIED	November 2018
DATE FOR REVIEW	November 2021 December 2019 Updated
DISTRIBUTION	Head and Neck MDT, OMFS QVH multidisciplinary team, Q-net
DIRECTOR LEAD	Dr Edward Pickles, Medical Director
AUTHOR	Pauline Mortimer, Head & Neck Cancer Clinical Nurse Specialist Mr Brian Bisase, OMFS Consultant
EQUALITY IMPACT ASSESSMENT	
THIS DOCUMENT	**Will form an adjunct (appendix) to - The Management of Head & Neck Cancers Local Head & Neck Multi-Disciplinary Team. version 4 – when ratified**

Enquiries - SOP – H&N Microvascular cover out hours QVH

All enquiries relating to this document should be addressed to:

Addressee: Mr Brian Bisase - Consultant Maxillofacial Surgeon & Head and Neck Lead Clinician
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Email: Brian.Bisase@nhs.net

Addressee: Mr Ken Sneddon - Consultant Maxillofacial Surgeon and Clinical director
Telephone: 01342 414000
Email: ken.sneddon@nhs.net

Addressee: Mr Keith Altman - Consultant Maxillofacial Surgeon and Medical director
Telephone: 01342414359
Email: keithaltman@nhs.net

The overarching policy sets out the operational management standards for the Queen Victoria Hospital NHS Foundation Trust as the designated surgical centre for the treatment of Head & Neck Cancer patients living in the locality and that managed by the Kent & Medway Cancer Network.

The Multi-disciplinary Head & Neck Cancer team at the Queen Victoria Hospital NHS Foundation Trust is committed to providing co-ordinated, world class treatment and rehabilitation throughout the patient journey founded on evidence-based practice, continuing professional development, service improvement and development. The practices outlined in this policy reflect our ongoing commitment to providing high-quality patient care; respecting equality and diversity; maintaining privacy and dignity and co-ordinating care with primary and tertiary providers whilst offering information and support to patients, their families and carers that enable them to make informed choices about their care.

This SOP is an adjunct to further detail and an important part of maintaining this high quality world class H&N cancer and reconstructive service

QVH geographical location for context - The Queen Victoria Hospital NHS Foundation Trust (QVH) has a unique geographical location sited between three head and neck cancer MDT's, namely Maidstone, Brighton and Guildford within the Kent, Surrey and Sussex Cancer Alliance. QVH is a regional Tertiary Referral Centre for Cancer and Reconstructive surgery. Patients diagnosed with head and neck cancer are treated at QVH flow within these localities and sometimes further afield according to patient address and/or patient choice. QVH serves a population of 2.5 million.

Documentation for reference

This part of the operational Policy is written in conjunction with standards indicated in:

- Improving Outcomes in Head & Neck Cancers-The Manual (NICE, 2004)
    - *"It is important that each MDT includes, or has access to, surgeons who are proficient in reconstruction, including microvascular techniques"*

- Manual for Cancer Services 2014 Version 1.1: Head & Neck Measures (NHS England, 2014)
    - *Quality Measure 14-2I-112*

- Head and Neck Cancer: United Kingdom National Multidisciplinary Guidelines. The Journal of Laryngology & Otology Volume 130, Number S2, March 2016
    - *No specific recommendations on nature of cover for H&N and free tissue transfer of patients*

- B16/S/a 2013/14 NHS STANDARD CONTRACT FOR CANCER: HEAD AND NECK (ADULT) - SERVICE SPECIFICATIONS – page 10
    - *A range of surgeons who specialise in different aspects of head and neck cancer should be available to work together for complex surgery including tumour removal and reconstruction. In addition, 24 hour emergency surgery is to be available for management of impending flap failure.*

Document Location

This SOP and document will become an appendix in - The Management of Head & Neck Cancers - Local Head & Neck Multi-Disciplinary Team v4 following approval at Clinical Governance as an addendum to the existing document.

Named Designated Clinicians with their respective specialties including those with microvascular expertise (Locality Measure 14-1D-104i)

The agreed designated clinicians for the diagnosis and assessment of Head & Neck Cancer at the Queen Victoria Hospital are:

Mr B Bisase, (BSB) Consultant Head & Neck Surgeon (Oral & Maxillofacial Surgeon). Clinical lead for head and neck cancer, QVH. Core member of the West Kent (Maidstone) Head and Neck MDT

Mr P Norris, (PMN) Consultant Head & Neck Surgeon (Oral & Maxillofacial Surgeon). Core member of the West Kent (Maidstone) Head and Neck MDT

Mr L Newman, (LON) Consultant Head & Neck Surgeon (Oral & Maxillofacial Surgeon). Chair & Core member of the West Kent (Maidstone) Head and Neck MDT

Mr A Gulati, (ABG) Consultant Head & Neck Surgeon (Oral & Maxillofacial Surgeon). Core member of the West Kent Head and Neck MDT

Mr J Dhanda, (JAG) Consultant Head & Neck Surgeon (Oral & Maxillofacial Surgeon) Core member of the Sussex (Brighton) Head and Neck MDT and core member of the Surrey (Guildford) Head and Neck MDT.

Mr Zaid Sadiq, (ZS) Consultant Head & Neck Surgeon (Oral & Maxillofacial Surgeon) Core member of the Surrey (Guildford) Head and Neck MDT. ***Commencing 2nd January 2020***

Mr Navdeep Upile, (NUP) Consultant Head & Neck Surgeon (Ear, Nose and Throat Surgeon). Core member of the West Kent Head (Maidstone) and Neck MDT and West Kent Thyroid MDTs

Mr K Kapoor, (KVK) Consultant Head & Neck Surgeon (Ear, Nose and Throat Surgeon). Core member of the Guildford Hampshire Head and Neck MDT and Guildford Thyroid Cancer MDTs

Mr C Davies-Husband, (CDH) Consultant Head & Neck Surgeon (Ear, Nose and Throat Surgeon). Core member of the Sussex (Brighton) Head, Neck and thyroid MDTs

Queen Victoria Hospital NHS
NHS Foundation Trust

Daily ward round & daily operating on microvascular inpatients

Location of clinic	Mon	Tues	Weds	Thurs	Fri	Sat/Sun
H&N oncology ward rounds including microvascular patients (*excluding leave)	Dhanda (JAG)	Sadiq (ZS)	Bisase (BSB)	Gulati (ABG)/Newman (LON)	Norris	** On Call OMFS team
Potential microvascular operating lists	Theatre 6 (JAG/ZS) + Theatre 3 Infrequently (Kapoor KVK)	Theatre 6 Infrequently (CDH)	Theatre 6 (ABG/LON) + Theatre 7 Infrequently (Upile NUP)	Theatre 6 PMN/BSB)		

*excluding leave when it becomes the responsibility of the OMFS trauma consultant to ensure the patient is seen by an appropriate grade of clinician (OMFS consultant, ENT H&N consultant, H&N fellow or senior OMFS registrar)

** when it is the responsibility of the OMFS trauma consultant oncall to ensure the patient is seen by an appropriate grade of the oncall team (OMFS consultant or registrar oncall) and problems identified of which are discussed with the H&N microvascular surgeon's team in the 1st instance

Minimal detailed stipulation in the documents referred to in – 'Documentation for reference' above.

During the working – operational policy

There are 6 designated OMFS Consultants who are trained and experienced in microvascular surgical technique. **Mr B Bisase, Mr L Newman, Mr P Norris, Mr A Gulati, Mr J Dhanda and Mr Z Sadiq (from January 2 2020).** There is a 24 hour, 7 day per week (365 day per year) provision for the rescue of reconstructive surgical flap compromise at QVH. This cover is provided by these 6 Designated Clinicians. The Designated Clinicians are all non-resident but undertake to be available to operate as soon theatre staff and facilities are available when a microvascular related problem is identified (by the on call team on site when out of hours).

All patients undergoing microvascular flap surgery at QVH are nursed on the CCU level 2/3 for the first 48 hours post operatively. This is the most likely period (in literature) for microvascular transfer components of surgery to occur. These patients are kept under close review during the post-operative period by the designated CCU nursing staff and on-call specialist registrar as well as being reviewed once daily by the H&N oncology consultant morning ward round and twice daily by the H&N Fellow or on call registrars; if need be, more frequently if the clinical condition of the patient requires closer review. Flap observations are recorded as per the **principal clinicians'** instructions ***(*principal clinicians'** = ***consultant/s who operated on that particular patient and hold ultimate responsibility or their designated clinician such as H&N fellow leading the ward round)***. Any signs or concerns of flap compromise are reported immediately to the principal clinician, his/her operating colleague and/or the on call OMFS Consultant Clinician.

There is a paucity in literature as to the no. of cases that need to be done in a single unit/year or the number of clinicians that need to be available or practising this expertise in order to deliver a high quality service. At QVH, it is felt that the person/ people that will know the patient best in the event of a microvascular emergency are, in the 1st instance, the principal clinician or his/her operating team respectively. It is also understood that there is a close working relationship allowing clinicians to cross cover each other's patients where necessary in or out of hours putting the patient 1st. This is demonstrated by the daily supra specialty consultant oncology ward round and by the out of hours operational policy below

Out of hours - Operational Policy

By nature of the weekly microvascular operating lists spread throughout the week and daily mid-week ward rounds the intensity and whole patient care amounts to 1:6 and when including leave – up to 1:4. It is important to note that it is rare and infrequent that failing free flaps are salvaged at 5-7 days and beyond (in literature) and thus often advice given and an elective procedure can be done in day time hours.

In the event of any signs or concerns of flap compromise:

On call registrar and on call consultant OMFS should be informed. The assessment should be tailored to determine the need for a microvascular trained consultant to give advice over the phone or attend in person. All 6 surgeons agree to ensure either they as principal clinician or their operating colleague will be available and contactable in the 1st 48-72 hours of a major case including microvascular free transfer. If for any reason they are both expected not to be available a contingency cover of another appropriately trained colleague (one of the other 4 microvascular trained) will have been sought prior to their joint absence. Surgeons who have acute inpatients but are both away will communicate the arranged cover to the OMFS consultant on call.

This is with exception of an unexpected emergency prior to cover being sought. In this rare and unlikely event the situation should be alerted to the OMFS consultant on call and Site practitioner and the on call OMFS consultant surgeon is to assist in coordinating the safest resolution for the patient (e.g.: d/w BSUH microvascular colleagues for advice, D/w QVH plastic surgery colleagues for advice, transfer out of QVH)

Summary:

Option 1

- The principal clinician

Option 2 **(***The principal clinician not available)*

- Their operating colleague for that case

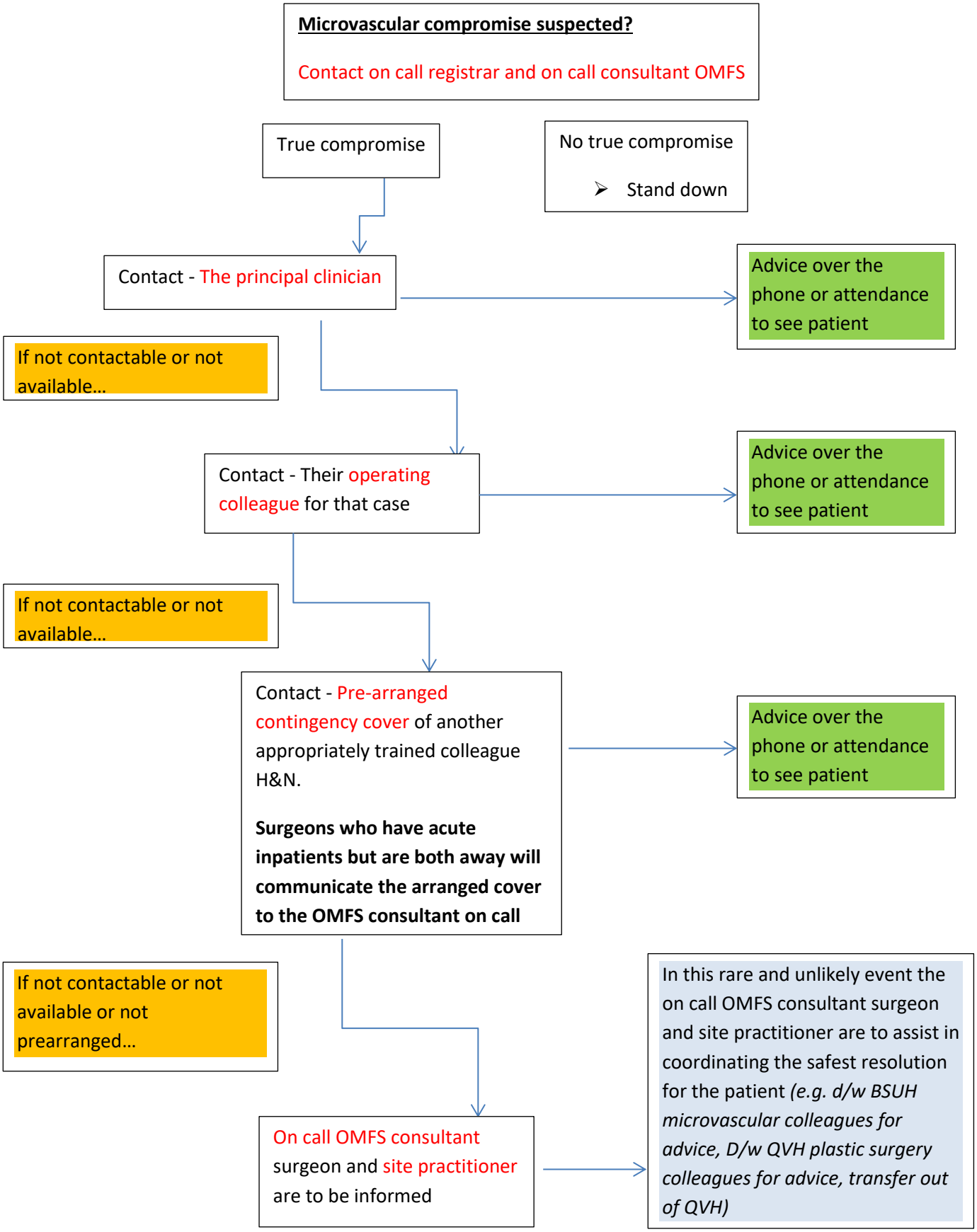
Option 3 **(***The principal clinician not available & their operating colleague for that case)*

- Pre-arranged contingency cover of another appropriately trained colleague H&N surgeon

Option 4 *(if no prearranged cover or unexpected unavailability of 1,2,3)*

- On call OMFS consultant surgeon

Queen Victoria Hospital NHS
NHS Foundation Trust



Queen Victoria Hospital NHS
NHS Foundation Trust

Adult Transfer & Discharge Policy

CLASSIFICATION	Clinical
TRUST POLICY NUMBER	CL.3007.5
APPROVING COMMITTEE	Clinical Governance Committee
RATIFYING COMMITTEE	Clinical Governance Committee
DATE RATIFIED	14 August 2017
DATE FOR REVIEW	14 August 2020
DISTRIBUTION	All staff
RELATED POLICIES	Care of Patients with Acute Mental Health Needs Admission Policy
DIRECTOR LEAD	Director of Nursing & Quality
AUTHOR	Kathy Brasier – Elective Head of Nursing
CONSULTATION	
EQUALITY IMPACT ASSESSMENT	061017-1
THIS DOCUMENT REPLACES	CL3007.4

Contents

Appendices

Appendix 4

Executive Summary

- All admissions, transfers and discharges will be planned with the involvement of the family, close friends or carer.
- Transfer and Discharge are essential to equip patients and carers with the knowledge, understanding and support to prevent or minimise further episodes of ill health.
- Discharge Planning will begin in Pre Assessment Clinic prior to Admission or on Re-admission as required. The Estimated Date of Discharge (EDD) must be identified by the multidisciplinary team within 24 hours of admission.
- For the purpose of this policy, adult refers to any person 17 years and over.
- For adults with Acute Mental Health needs please refer to Section 10 as well as following all general principles and other related policies.
- The following minimum information must be provided (where applicable) to either the receiving hospital, GP, or community nurse on discharge of the patient:

    - name
    - date of birth
    - address
    - unique identifier (where possible this must be the NHS number)
    - Emergency contact details (Next of Kin)
    - Presenting condition, treatment received and investigations performed
    - records of care
    - known preference and assessed needs
    - previous medical history including GP's contact details
    - any infection requiring ongoing management, with current plan included
    - medicines
    - any medication changes
    - Known allergies
    - key contact person from the Trust
    - reason for transfer if appropriate
    - Any unresolved issues or known risks
    - Future appointment details
    - Comments on patient's dependency levels
    - Any psychological issues identified or risk of harm to self or others.

- Information provided to the department must be documented in the patient's health

records for any inpatient transfer.

- Information provided to the patient and healthcare provider on discharge must be documented in the health records in the form of an Electronic Discharge Notification (EDN).
- Paediatric patients are covered in the separate Paediatric Admission, transfer and discharge policy.

1 Introduction

- This policy is designed to standardise and provide a safe co-ordinated approach to the management of Transfer and Discharge for all adult patients at the Queen Victoria Hospital NHS Foundation Trust (QVH). The whole process must be seen as a multi-professional approach involving input and effective communication from all healthcare staff.

1.2 The Transfer and Discharge are important components of a patient's healthcare journey and must be achieved to ensure the transition is completed without undue stress to the patient providing all the information required to ensure continuity of care in the receiving hospital or department, community services or with the family and or carer. There are four distinct stages which combined together complete the patient experience. These may be defined as:

Inpatient episode
Process of discharge
Transfer / Handover of Care – Internal transfer and external transfer including Emergency (out of hours)
Outpatient Follow up

Patient groups

Inpatient – any adult receiving overnight care
Outpatient – any adult using hospital services on an appointment basis
Day Case – any adult who is admitted and discharged on the same day

1.3 This policy aims to clarify the support and information required along with the responsibilities of all staff involved in the adult Transfer and Discharge process. All clinical staff will along with appropriate managers and administration staff be involved at some stage with the requirements of this policy.

1.4 Throughout this document the title Ward Matron /Deputy/ Discharge Coordinator is used to denote the registered health care professional (i.e. Nurse) with overall responsibility for planning the assessment and discharge of patients.

1.5 Unless defined otherwise the term "movement" will include the Transfer and Discharge of a patient.

1.6 Unless defined otherwise, an 'Outlier' will be an adult patient waiting to come into the

Trust from another hospital and / or waiting to return.

1.7 This policy will apply for transfer and discharge at all times of the day or night.

Definitions

- Handover of care is the exchange of quality documented information provided to the receiving department / hospital detailing the treatment and important factors relating to the care and safety of the patient being transferred. The transfer of patients is the same as handover of care.
- Electronic Discharge Notification (EDN) (appendix 1) – This is an electronic form used to document patient discharge information such as medication and treatment that can be sent to the General Practitioner (GP) electronically and printed for the patient or other healthcare providers.

2 Scope

This policy applies to all staff involved with the transfer / handover of care or discharge of adult patients.

3 Duties

All staff – responsible for adhering to this policy

Chief Executive – overall responsibility for all movement of patients involving the Trust.

Ward Matron/ Deputy – The Ward Matron or Deputy is responsible and accountable for ensuring all the information necessary to plan and manage movement arrangements is communicated and used in the patients best interests. They must ensure all the processes outlined in the policy are followed enabling a safe and timely high quality outcome. To ensure the elective bed booking system is always kept up to date and to complete a DATIX report in the event that something untoward occurs in relation to transfer or discharge.

All Clinical Staff must ensure the following:

4

- documentation is completed, up to date and accurate prior to following the transfer of a patient
- relevant people involved in the process have been informed
- all equipment required for the transfer is available and ready for use
- arrange a competent escort for the patients movement if required
- accurate and timely information regarding the infection status to the receiving area is provided

- the policy is adhered to and any deviations must be safe and in the patients best interest.
- Liaise with external Multidisciplinary Team (MDT) to ensure a safe discharge process
- Completion of the EDN, ensuring that the patients GP has received a copy within 24 hrs of discharge.
- Patients and their GP's are given full information on medication changes including medication prescribed at the time of discharge, reason for medication changes and any adverse reactions or allergies to medicines experienced by the patient during admission. To assist discharge, doctors must ensure that take home medications (TTO) are written up before patients leave Recovery to ensure safe and effective discharge can take place.

Site Practitioner - responsible for first line site management decisions out of hours**.**

*Head of Nursing - t*o provide support for the processes within the policy and ensure any operational problems encountered with any patient movement are resolved.

Infection Prevention and Control Team – to provide support and advice to staff for a patient with a possible or known infection.

Administration Staff – to provide accurate and timely information regarding the patient to the relevant areas, particularly in relation to patient transport or the need for step down/HDU or ITU beds.

Multi Disciplinary Team (MDT) A group of healthcare professionals with shared responsibility for care – to facilitate the safe discharge of patients from the Trust by ensuring they receive effective assessment, treatment and if required necessary equipment to overcome the problems that may affect their ability to carry out essential daily activities of living once at home.

Pharmacy Department – to ensure prescriptions are checked and medication dispensed according to the information within the Electronic Discharge Notification form

Discharge Coordinator – to ensure complex patient discharges are managed in a safe and timely manner liaising with relevant members of MDT to facilitate effective transfer of care.

4 Patient Groups

Patient groups can be categorised as follows:

- Discharge - Adult patient being discharged from QVH to their home or place of care. The discharge process is the same for all adult patients however there are additional requirements to specific categories of patients detailed in section 10 below. (These special groups are mental health, elderly patients from Minor Injuries Unit (MIU), homeless, Self-discharge against medical advice and patients with learning disability needs).
- External transfer/ handover of care (transfer out) - Adult patients transferred to another hospital. This can be either:

- An emergency transfer which is also classed as transfer out of normal hours.
- A non-emergency transfer – due to the nature of the work at the QVH this will always be arranged during normal working hours (08:00 – 20:00).
- Internal Transfer (handover of care) - Adult patient being transferred from one department to another within QVH for continuing care.

5 Minimum Patient Information for all External Transfer and Discharges

All patients being transferred out or discharged regardless of circumstance will have as a minimum the following information:

- name
- date of birth
- address
- unique identifier (where possible this must be the NHS number)
- Emergency contact details
- Presenting condition, treatment received and investigations performed
- known preference and assessed needs (transfer)
- any infection requiring ongoing management, with current plan included
- medicines given
- any medication changes
- known allergies
- key contact person from the Trust
- reason for transfer if appropriate
- Any unresolved issues or known risks
- previous medical history including GP's contact details (for transfers)
- Future appointment details if arranged
- Comments on patient's dependency levels
- Any psychological issues identified or risk of harm to self or others.

6 Internal Transfer / Handover of Care (including out of hours)

6.1 *Transfer / handover from one ward to another ward (giving and receiving information)*

The Lead Nurse or Ward Matron/ Deputy, together with the Site Practitioner and surgical team will discuss and finalise the plan for transfer. The level of care must be

discussed with the nurse of the receiving department to ensure the staff have the required expertise and facilities to continue to provide the appropriate level of care;

The following needs to be completed prior to transfer:

- The transferring department must document in the patient health record the transfer confirming the following;
- The surgical team have reviewed the patient, agree the transfer and have documented this in the medical notes;
- The risk of the transfer has been assessed prior to the movement to ensure emergency equipment is provided where necessary;
- The patient's infection control status has been confirmed. If there is a risk, the receiving ward has been notified and an appropriate environment allocated.
- All relevant notes (this contains the minimum information detailed in section 5 above), charts, medication, dressings and patient's belongings have been provided for the transfer;
- A qualified nurse familiar with the patient's history will accompany the patient and provide a handover to the receiving department;
- The relatives have been informed of the transfer.

6.2 *Transfer handover of care to and from theatres and recovery (giving and receiving information)*

All patient notes (including the prescription chart and risk assessment booklet but excluding other nursing documentation) must accompany the patient to theatre and on return post surgery.

The WHO Checklist will record the handover between the ward and theatre (including recovery) and on return. The following sections must be completed and signed at each stage by the person handing over responsibility of care to ensure the appropriate information has been handed over to the receiving department;

- Prior to transfer to theatre
- Sign in before induction of anaesthesia
- Time out before skin incision
- Sign out on completion of surgery
- Recovery handover and discharge (back to the ward/ department)

7 External transfer / handover of care – non-emergency transfer to another hospital

The Discharge Coordinator in conjunction with the nurse caring for the patient and the surgical team must finalise arrangements for the patient to be transferred once the decision has been made. This includes communication with the receiving hospital, the patient and their relatives ensuring the appropriate paperwork is completed. The following must be completed and confirmation written in the nursing notes prior to transfer:

- The surgical team has documented in the medical notes / EDN that the patient

has been referred to and accepted by the receiving hospital, the names of individuals concerned should be highlighted in the medical notes. The name of the accepting Consultant must be clearly written within the medical notes.

- Correct transport arranged, with appropriately trained staff available for the escort if required;
- The patient's property is packaged and ready to go with them and the Patient Property Book is completed.
- Specialist equipment is available for the transfer as required;
- The relatives or carers have been informed;
- The receiving hospital staff have all the necessary information and are aware of the estimated time of arrival;
- The minimum patient information detailed in section 5 is provided to the receiving hospital by ensuring the Transfer letter is inserted in the Extra Section of the EDN which is printed and sent with the patient and a copy sent to the patient's GP. If for any reason the EDN cannot be printed the information in section 5 must be included and documented within the handover process.
- Photocopies of medical notes, drug charts, latest and/ or relevant test results, transfer letters and medical photographs may be sent in a post-safe envelope for the journey and the hospital informed if photographs are deemed to be distressing. Patients will not have access to their notes or photographs during transfer.

8 External transfer / handover of care – emergency transfer out from the QVH (this is also the out of hours process)

The Site Practitioner and a senior clinician must be involved in the transfer process. The actions detailed below must be documented in the patient's nursing notes by the nurse responsible for care;

- The patient's condition is stabilised
- Correct transport arranged e.g. Paramedic Ambulance;
- The receiving hospital has been contacted and has all the necessary information for patient transfer;
- Adult Critical Care Network Transfer Form (Appendix 2) is completed and copy sent with patient if applicable;
- The minimum patient information detailed in section 5 above, is provided to the receiving hospital; by ensuring the EDN is printed and sent with the patient and a copy sent to the patient's GP. If for any reason the EDN cannot be printed the information in section 5 above must be included and documented within the handover process.
- Appropriately trained staff are available for the escort if required eg: nurse/ anaesthetist;
- Photocopies have been made of the medical notes including drug charts, latest and/ or relevant test results, operation notes, history sheets and medical photographs. These should be in a post-safe envelope for the journey and the receiving hospital informed if photographs are deemed to be distressing;

- The Consultant has been informed of the transfer;
- The patient's property is sealed and ready to go with them and the Patient's Property book has been completed;
- The relatives or carers have been informed and given travel instructions if following in a car;
- Specialist equipment is available for the transfer. E.g. tracheostomy kit, portable suction, listed and returned to QVH after a safe transfer.
- Clinical handover by a competent individual to the ward/ departmental staff and relevant members of the team at the receiving hospital.
- Complete a DATIX.

9 Discharge – general process for all adult discharge from the QVH (see section 10 for additional requirements)

9.1 Pre assessment Clinic (PAC) must flag up post-operative care needs which may arise on discharge. Discharge planning begins as soon as the patient is admitted to the ward area. The estimated date of discharge is identified within 24 hours of admission. The MDT has a shared responsibility for ensuring a discharge date and plan is implemented within 24 hours. The Ward Matron/ Deputy has ultimate responsibility to ensure the discharge process has been commenced. Prior to the day of predicted discharge, the nurse allocated to the patient must ensure all elements of the discharge process are completed. It is critical any equipment or community service requirements are arranged at the earliest opportunity to avoid delays to the patient discharge.

9.2 The EDD is recorded and reviewed on a daily basis by the MDT following the surgical ward rounds.

9.5 Patients, relatives and carers are informed during admission that they will be discharged from the ward as early as possible on the day of discharge, once deemed medically fit by the surgical team;

9.6 Patients are fit for discharge when physiological, social, functional and psychological factors or indicators have been taken into account following a multi-disciplinary assessment if appropriate;

9.7 One day prior to discharge, the nurse needs to ensure that the patient's EDN has been completed and checked by the pharmacist and appointments have been requested for their follow up;

9.8 On the day of discharge, the nurse is responsible for ensuring that written and verbal advice (where required) has been given to the patient, relatives or carers regarding their medications/ dressings/ equipment required.

9.9 The following documentation will accompany the patient on discharge:

- Copy of Electronic Discharge Notification Form (Appendix 2) (please ensure all the minimum data in section 5 above is included)
- Appointments Information;
- Written information regarding treatment where required;
- Contact details of ward

9.10 The minimum information provided to any receiving healthcare professional (District Nurse, GP, Nursing Home) on discharge is the following;

- Copy of Electronic Discharge Notification Form (Appendix 2) (please ensure all the minimum data in section 5 above is included)
- Additional information sent as required

9.11 The recording of the information provided on discharge is documented by the nurse responsible for the patient who must ensure the Discharge Checklist/ Complex Discharge Planner (See page 22, adult admission booklet) is completed.

9.12 Discharge out of normal working hours should follow the same process as above.

9.13 Discharge between 21.00 and 06.00 is required to follow the standard processes but must be at the patients request and not the request of QVH.

10 Additional Discharge requirements for Patients with Specific Requirements

10.1 *Patients with Psychiatric illness*

Refer to the Trust policy, Care of Patients with Acute mental Health Needs located on the Qnet/ policy and procedures/ clinical policy folder. Patients suffering from a psychiatric illness must be discharged to the relevant mental health team under the direction of a consultant psychiatrist if required. This must have been agreed prior the admission of the patient to the hospital. If patients are discharged directly to their home, the psychological therapy team within the Trust need to be consulted to ensure appropriate follow-up in the community has been organised.

10.2 *Discharge of the elderly from the Minor Injuries Unit (MIU)*

Patients must be assessed on general health/ social factors. These must include the adequacy of home arrangements. Elderly frail patients should receive priority for transport and their GP informed of their discharge within 24 hours of this taking place. Prior to discharge of any patient from MIU it must be ascertained whether that patient requires a full community assessment following discharge, this should be instigated by the practitioner looking after the patient in conjunction with the patient's GP.

10.3 *Self Discharge against medical advice*

The decision that a patient is fit for discharge can only be made by the Consultant responsible for the patients care or someone to whom the Consultant has delegated authority. Every effort should be made to persuade the patient to stay and complete their treatment. Self-discharge against medical advice usually falls within the following categories:

- *The patient understands the risks they are taking in leaving hospital* – in this instance the patient has the right to refuse treatment and leave.

- *The patient is unable to understand the risks associated with discharge* due to their medical condition (i.e. confusion, shock, pain etc) or due to mental health problems – In this situation the surgical team will need to act in the patient's best interest and

should involve psychology at the earliest opportunity following both the Mental Capacity Act (MCA) and Deprivation of Liberty guidance (DOL's) available on the Qnet.

If a patient wishes to self-discharge, the Ward Matron/ Deputy should contact:

- A member of the Surgical Team
- Site Practitioner
- Social Services if it is felt necessary, in and out of hours following a risk assessment
- Psychological therapies if appropriate
- A DATIX should be completed

The self-discharge form (Appendix 3) should be signed by the patient and the doctor and filed in the patient's medical notes.

In the event of the patient refusing to sign the self-discharge form, this must be recorded in the patient's medical/nursing notes. The doctor/nurse must inform the patient's General Practitioner within 24 hours.

10.4 *Discharge needs of people who are homeless*

It is vital that consideration is given to the housing situation of patients to ensure that patients are not discharged to inappropriate places, or become homeless as a result of their stay in hospital. Appropriate risk assessments must be carried out and passed on to primary care staff or other service providers as appropriate.

It is usually the role of Social Services to facilitate the care of people over 65 in liaison with the local homeless unit. The needs for those under 65 are covered by the local homeless unit. All Social Services have a homeless department attached to them. Patients should be referred back to the area they have come from, if safe and agreeable, and if any concerns refer to the local homeless unit. Referrals should be made within office hours as early in the day as possible to ensure that accommodation can be found. Information and resources can be found on the internet under Homeless Pages and Homeless UK.

10.5 *Discharge of patients with specific care needs*

Where patients experience difficulties in understanding and agreeing with the discharge care planned for them, it is the responsibility of all staff to ensure that they have access to the services of an interpreter or access support to ensure the patient or carer has a full understanding of the plan. In this context an interpreter may include a signer or Braille contact for hearing and visually impaired patients respectively. Additional written information appropriate to the level of understanding may be sourced.

Additional planning by the senior clinician in charge of the patient and nursing team may be needed for the following specific care needs on a case by case basis:

- Patients who are living alone, who are frail, elderly or live with a carer who may have difficulty coping. People living in sheltered housing or other warden assisted accommodation should be treated as living alone, as wardens will only assist in emergencies and cannot provide continuing care;

- Vulnerable Adults at Risk;
- Terminally ill patients;
- People with a continuing disability, including those discharged from long stay hospitals to return to the community, and those with sensory impairment;
- For patients requiring community care, it is the responsibility of the Lead Nurse to give a minimum of 24 hrs notice of discharge to community agencies and inform carers or relatives (with the patient's permission). Should a longer period of notice be requested this will be negotiated between the Trust and the agency/ individuals concerned.

10.6 Any additional discharge issue detailed in section 10 must be documented in the patient notes.

11 Medication on Discharge

11.1 *Medication process on discharge for in-patients*

Any medication required for the patient must be documented on the EDN by the clinician responsible for the care of the patient. This must be sent to the pharmacy department during normal working hours for screening prior to dispensing either from ward stock or by the pharmacy department who will arrange delivery of patient's medication to the ward.

Out of normal working hours the doctor must complete the EDN and the nurses on the ward will provide a TTO pack as available on the ward. In exceptional circumstances following discussion with Site Practitioners the patient will be given a completed FP10 prescription form for any drug not available as a TTO pack if it has not been prepared previously by the pharmacy department.

Patient's own medications must be returned to them including CD's.

11.2 *Medication process for day case patients*

The EDN is completed by the doctor and the medication is dispensed by the nurse in charge of the patient's care. Any drug that is not within the ward stock must be obtained from pharmacy.

11.3 *Medication information for the patient*

The patient must be given the medication along with relevant information for each drug in addition to a medicines helpline card. The nurse or pharmacist dispensing the medication for the patient must ensure they have the correct information.

12 Joint Discharge Planning and Delivery

12.1 When a patient has been identified through screening as needing a community care assessment or community care, the Discharge Coordinator must liaise with the MDT to plan, coordinate and manage the care of the patient. When care needs are identified to enable a safe transfer of care, a notice request for assessment must be

completed and sent to the relevant Social Services. Consent must be obtained prior to this process being completed.

12.2 It is the Ward Manager/ Deputy responsibility to ensure all service providers participating in the planned community care are kept fully informed of the plans, status and their contribution to it. The allocated social services care manager and the nominated multi disciplinary team member is responsible for notifying the Ward Matron/ Deputy of the progress and the outcome of their discharge planning.

12.3 Disputes between the Trust and other agencies participating in the assessment and discharge planning process will be handled in accordance with the principles and procedures laid down in the appropriate Clinical Commissioning Group (CCG)/ Social Services department resolution of disputes document. These can be obtained from the relevant Social Services department. Complex issues should be discussed with the Trust's legal department.

13 Home Assessment Visits Prior to Discharge

13.1 Where it is considered necessary, and appropriate, a home assessment visit and the fitting of home equipment, adaptations or individual aids, the needs and wishes of the patient and their carers must be assessed by an Occupational Therapist and / or Physiotherapist, possibly in conjunction with the Social Services in the patient's home locality where possible. However, this is a rare situation.

13.2 Where it is determined that the patient's ability to cope at home will be aided by the fitting of appropriate equipment, the patient and their carers must agree and be involved in the choice, understand its purpose, be trained in its use, and be fully informed of the costs involved. Discharge planning procedures must accommodate the identification of essential adaptations required to the place of discharge.

13.3 It is the responsibility of the therapists to ensure that any essential home equipment, adaptations, individual aids/ orthotics have been installed, provided, or arranged before the patient is discharged.

14 Training and Awareness

New staff will be introduced to the policy if relevant during their local induction process.

15 Equality

This policy and protocol will be equality impact analysed in accordance with the Trust Procedural Documents Policy, the results of which are published on our public website and monitored by the Equality and Diversity team.

16 Review

This policy will be reviewed in 3 years time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

17 Monitoring Compliance with this Policy

Appendix 4

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual or dept. responsible for the monitoring	Frequency of the monitoring activity	Group/committee which will receive the findings/ monitoring report	Committee/ individual responsible for ensuring that the actions are completed
The handover/transfer requirements between care settings for giving and receiving information. Recording of handover /transfer Out of hours handover / transfer process	Compliance in Practice (CiP) and ad hoc audit	Discharge Coordinator	Monthly audit.	Nursing Advisory Group (NAG)	Head of Nursing, Matrons and Director of Nursing and Quality to review compliance and subsequent actions monitored and communicated to directorate meetings or taken to ward meetings.
The discharge requirements for all patients The discharge information to be given to the receiving healthcare professional The information to be given to the patient on discharge How a patients medicines are managed on discharge Recording of information to the receiving healthcare professional and patient Out of hours discharge process	Compliance in Practice (CiP)	Discharge Coordinator	Monthly audit.	Nursing Advisory Group (NAG)	Head of Nursing, Matrons and Director of Nursing and Quality to review compliance and subsequent actions monitored and communicated to directorate meetings or taken to ward meetings.

18 References

- National Health Service Litigation Authority Risk Management Standards 2012-13 - http://www.nhsla.com/RiskManagement/

3/3/2010

SUSSEX CRITICAL CARE NETWORK

NHS

Adult Critical Care Transfer Form

To be used for all adult patients transferred to Critical Care - this is a legal record of transfer

PATIENT DETAILS

Name .....

Address .....

.....Postcode .....

NHS Number .....

DOB ..... Male ☐ Female ☐

ADMISSION DETAILS

Transferring Hospital .....

Receiving Hospital .....

Transferred to ITU ☐ HDU ☐ Theatre ☐ Ward ☐ Other ☐

Level of care: Level 1 ☐ Level 2 ☐ Level 3 ☐ Vent ☐

STAFF ARRANGING TRANSFER

At Transferring Hospital: Referring Consultant

Name .....

Speciality i.e. A/E, ITU, Med, Surg, Other .....

At Receiving Hospital: Receiving Consultant

Name .....

Speciality i.e. A/E, ITU, Med, Surg, Other .....

Checklist – Must be completed before transfer

Decision made by consultant ☐

Formal referral letter complete ☐

Patients health records photocopied ☐

Results/X-rays/Scans present/transferred ☐

Relatives aware of transfer ☐ .....
Name/relationship

Fracture Precautions, Spinal, Long Bone, Cervical, Thoracic, Pelvis ☐

Informed Receiving Hospital of Departure ☐

Neuro checklist if appropriate ☐

Transferred from: ICU ☐ WARD ☐ A&E ☐ THEATRE ☐ OTHER ☐

REASON FOR TRANSFER

Non-clinical ☐ Repatriation ☐ SPECIALIST TREATMENT/TERTIARY REFERRAL ☐

Diagnosis .....

AMBULANCE DETAILS

Time contacted ☐☐ Ambulance Reference number ☐

Estimated arrival time ☐☐ Time arrived at unit ☐☐ Time left unit ☐☐

PRE TRANSFER – VENTILATION, MONITORING & LINES

VENTILATION	ABGs	MONITORING & LINES
Spontaneous, mechanical, bag ☐	PO_2 ☐	Please circle monitoring, lines required for journey
T/ET Size ☐ Lip Level ☐	PCO_2 ☐	ECG ☐
Ventilator Mode ☐	HCO_3 ☐	ABP NIBP ☐
Tidal Volume (V_T) ☐	PH ☐	Temperature ☐
PEEP ☐	SPO_2 ☐	SPO_2 ☐
FiO_2 ☐	Post Intubation CXR ☐	$ETCO_2$ ☐
Peak Inflation Pressure ☐	Other	CVP ☐
Resp Rate ☐		Peripheral lines ☐
Saturation ☐		Urinary Catheter ☐
		NGT/OGT ☐
		Balloon Pump ☐

UNDER OBSERVATION CHART *for use during transfer*

TIME use 24 hr clock	HRS / MINS	UNIT / AMB											
Drugs/Fluids													
Tidal Volume													
Peak Inflation Pressure													
PEEP													
FiO_2													
Respiration Rate													
SpO_2													
$ETCO_2$													
Temp													
Rhythm													
Pupils Reaction/Size	L	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Pupils Reaction/Size	R	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
GUIDE CHART FOR PUPIL SIZE	220													220
9mm	210													210
	200													200
8mm	190													190
	180													180
7mm	170													170
	160													160
6mm	150													150
	140													140
5mm	130													130
	120													120
4mm	110													110
	100													100
3mm	90													90
	80													80
2mm	70													70
	60													60
	50													50
	40													40
	30													30
URINE OUTPUT														
OTHER FLUID OUT														

ANY PROBLEMS - Equipment, Clinical or Organisational

This is the legal record of transfer and must be dated, signed & returned

BLUE	- Insert in Patient Notes at Recipient Site
YELLOW	- Post to the Critical Care Network, 36-38 Friars Walk, Lewes BN7 2PB
GREEN	- Fix into the Transferring Hospital's Notes

ESCORTING PERSONNEL

Doctor

Name.....

Grade..... Spec.....

Transfer Course Attended ☐ YES ☐ NO

Nurse/ODP

Name.....

Grade..... Spec.....

Transfer Course Attended ☐ YES ☐ NO

Signature of Escorting Doctor + bleep no..... **Date**.....

SUSSEX CRITICAL CARE NETWORK

NHS

Adult Critical Care Referral Letter (to be completed by referring Doctor)

PATIENT DETAILS	ADMISSION DETAILS
Name ..... Address .... Postcode ..... DOB ..... Male ☐ Female ☐	Referring Hospital ..... Consultant ..... Referred by ..... Bleep No ..... Date and time referred ..... Accepted by .....Bleep No ..... Date and time accepted .....

HISTORY (including date and time of incident and cranial/spinal injuries)

PAST MEDICAL HISTORY

USUAL MEDICATION

NEURO-ASSESSMENT (non-ventilated patient)

Neuro patients only Have the following parameters been achieved?	$PaO_2 \geq 13$ kPa		$PaCO_2$ 4.5-5 kPa	
	MAP ≥80		Sedated and paralysed	

RESULTS

Date/Time		**Date/Time**	
Hb		Na^+	
WCC		K^+	
Platelets			
Glucose		HCO_3	
Date/Time		Urea	
INR		Creatinine	
APPT			
Others			

SUMMARY OF CARE/INTERVENTION

Drugs/IV fluids given	Dose/volume infused	Date/Time
Tetanus toxoid		
Mannitol Urinary catheter must be inserted if Mannitol given		
Phenytoin		
Crystalloid		
Colloid		
Blood		

Next of kin: Tel No: Notified: Yes ☐ No ☐

Transfer with the patient: Observation chart ☐ Medical notes ☐ X-rays ☐ CT scans ☐
Adult Critical Care Transfer Form

Signed: Print: Grade:

Date:

JP/AL March 2010

Appendix 2 Electronic Discharge Notification

Queen Victoria Hospital NHS Foundation Trust *NHS*
NHS Trust

Date:

GP Surgery *Discharge Id:*

Dear Dr

Discharge Notification

The patient was admitted under the care of MR (Specialty:) into Ward at QUEEN VICTORIA HOSPITAL on The patient was discharged on

Patient: *Address:*
D.O.B.:
NHS No.:
Hospital No.:

Clinical Assessment

Mode of Admission:

Presenting Problem:

Diagnosis:

Past Medical History:

Procedures / Investigations:

Complications / Problems During Stay:

Patient Status:

Summary and recommendations to GP:

Allergies

Allergy: Nature of reaction.

Medication on Discharge

Clinician: **Designation:** **Date:** **Bleep:**

Comments: Free text

Drug	Dose	Frequency	Route	Duration	Supply	GP continue?
Drug name	Dose	Frequency	Route	Duration	Ward TTO Pack	No

Notes

Management

Primary Care Plan

Destination on Discharge:

GP to Review On Discharge:

Care Arrangements Made:

Information Given to Patient and Relatives:

Secondary Care Plan

Future OP Appointment Booked:

Appointment Details:

Certificate Given:

Further Report:

OPD Plan:

Copy to Patient/Family:

Completed By:

Appendix 4

Appendix 3

SELF DISCHARGE FORM FOR PATIENTS

I confirm that I have decided to discharge myself from the Queen Victoria Hospital against medical advice and that I fully understand the consequences of that decision and the risks I am taking for myself and my health. These have been explained to me by the responsible health professional. I take full responsibility for this decision and its consequences.

ID LABEL

Signed……..

Witness ……

Date……..

In the event of a patient refusing to sign a form, a note to this effect must be made in the patient's medical records.

Queen Victoria Hospital NHS Foundation Trust

QVH Head and Neck Surgical Treatment Referral Proforma

Please email to **tgv-tr.Referrals@nhs.net – with email subject 'URGENT CANCER'**

Queen Victoria Hospital NHS Foundation Trust	
Patient Name:	**Patient DOB:**
Patient NHS Number:	
Patient Address:	**Patient Contact Details:**
Date of Referral:	**Referring Hospital:**
Patient informed of transfer of care: Y/N	
Named visiting surgeon (if applicable) and if the operation will be an independent or joint case:	**Key Worker:**
Diagnosis/Stage of Disease:	**Latest MDT Outcome:**
Planned Surgery/Surgical Details:	
Urgency of Surgery < 2 weeks, 2- 4 weeks or >4 weeks:	
Imaging Transferred Y/N	**Pathology Report Included Y/N**
Psychosocial considerations of note:	
Comorbidities (including performance status/medications/allergies):	

COVID-19 PCR Swabbing Head & Neck

Inpatient Admissions – performed at QVH
Head and Neck
Skin

The schedulers will contact the IPACT on a Monday, listing the patients booked for the following week, including their date of admission.

The IPACT will contact each patient, via telephone to arrange a date, time and location at QVH to perform the PCR swab.

The PCR swab will be performed at least 48hrs ahead of the date of admission.

The IPACT will monitor the results and contact, via email the consultant and scheduler, stating positive or negative for COVID-19

A decision will be made, by the consultant to either proceed to admission or defer admission and advise the patient to self-isolate for a further 14 days. The scheduler will contact the patient following this self-isolation to arrange a further date of admission.

Appendix 7

Scheduler Elective Screening Script

You will need to undertake strict self-isolation for 14 days before coming to the Queen Victoria Hospital (QVH) for admission. This means you are unable to leave the house under any circumstances other than an emergency. You are only allowed to see the people you live with in your household. If you, or a family member, have symptoms of COVID-19 which may include; feeling unwell, have a temperature or persistent cough you must contact the Surgical Team Scheduler immediately (QVHheadandneckschedulingteam@nhs.net) and **DO NOT** attend the hospital.

On the day of admission, all patients due to have a general anaesthetic will be required to have a low-dose chest CT scan to screen for evidence of respiratory changes which may be related to COVID-19. The reason for this is that the presence of COVID-19 in your lungs will place you at additional risk during your admission and post-surgical period.

The date of your admission will be XXXX.

The date of your PreAssessment appointment will be XXXX. This will be face to face/ telephone.

Please be advised;

- You will be contacted by the Infection Control Team to arrange a PCR test/ Swabbing at least 48hours ahead of your admission date. You will be required to attend QVH for this procedure. A date, time and location will be arranged by this team. They will contact you by telephone
- The results of this screen will be sent to your Consultant prior to admission and if a positive result if reported you will be provided with further instructions as your date of admission will be deferred
- Your temperature will be checked on arrival at QVH
- Please go straight to the Radiology department and book in for your CT chest
- CT scan will be performed
- <u>You are not to attend the ward, or any other areas of the hospital, prior to the CT scan</u>
- You will remain in the Radiology Department until the scan has been checked. You will be given further instruction following the CT scan.

If your SCAN is CLEAR – you will be instructed by the **Radiographer** who undertook the CT scan to continue to the ward area or Main Theatres for admission
If the SCAN shows any concerns – your **Consultant/Registrar** will attend Radiology to meet with you and discuss the next steps

If we are unable to proceed to surgery you will be instructed to return home and an alternative date of admission will then be arranged. You will then need to undertake a further 14 days of self-isolation prior to your admission date.

We must advise you due to ongoing COVID-19 issues that your surgery may be postponed prior to, or on the day of your booked surgery.

We will send a letter to you in the post confirming your date and time of admission together with a patient information leaflet regarding the chest CT scan process.