Team Name: Area ED/VP Team Team Lead: Executive Director - West Approved by: Executive Director – West	Reference Number: CLI.6510.SG.001 Program Area: Transitional Care Policy Section: General
Issue Date: January 19, 2018 Review Date: Revision Date:	Subject: Transitional Care Centres – Admission Criteria

STANDARD GUIDELINE SUBJECT:
Transitional Care Centres – Admission Criteria

PURPOSE:
To outline criteria for admission to a Transitional Care Centre and support decision making of nurse managers/designates and physicians/nurse practitioners regarding the admission of patients. The goal is to ensure care needs can be met effectively and comprehensively within the Transitional Care Centre's human, organizational, financial and environmental resources.

DEFINITIONS:
Medically stable – the medical condition has stabilized and an expected course of either illness, maintenance or recovery can be reasonably predicted.

Complex treatments and interventions – includes complex/complicated wound care; infusions of blood and blood products; fresh post-operative care; rapidly and often changing medications; management of labile and changing blood pressure/ blood sugars, etc.

Convalescent care – care available for people requiring supportive care for the gradual recovery of health and strength after illness or injury. Acute hospital care is no longer required. The length of stay varies depending on individual needs, but usually ranges from one to seven weeks.

Respite care – provides short term admission for intermittent relief for family members who care for a dependent person in the community. There is a daily charge for this service.

Palliative care –end of life care provided for patients who are no longer able to remain comfortably at home and require pain and symptom management, and psychosocial support.

Awaiting placement/interim bed placement – when patients have been paneled for Personal Care Home (PCH), but are unable to return to the community.

IMPORTANT POINTS TO CONSIDER:

- Patients in a Transitional Care Centre do not require around the clock access to onsite medical supervision/intervention or diagnostic services.
- Transitional Care Centres are minimally staffed. If a Registered Nurse (RN) is not available, a Licensed Practical Nurse (LPN) will be designated as in charge, and will have telephone access to a RN in another site. Nursing staff will have telephone access to a physician/nurse practitioner.
- Some Transitional Care Centres may be able to provide intravenous (IV) infusions of routine medications for management of an ongoing, stable condition (e.g. IV antibiotics for a joint infection). However, a patient should be transferred to an acute care facility if IV fluids are required.

PROCEDURE:

General Overview

All patients admitted to a Transitional Care Centre must be medically stable. Transitional Care Centres cannot support patients who are requiring intensive treatments and interventions.

The decision to admit a patient to a Transitional Care Centre is the joint responsibility of the physician/nurse practitioner and the nurse manager/designate. Admissions should be scheduled in advance and there should not be emergency (last minute) admissions. Admissions will occur Monday to Friday, days only.

Patient Eligibility

The following types of patients may be able to have their medical and personal care needs met effectively in a transitional care centre:

- Convalescent;
- Respite;
- Palliative; and
- Interim Placement.

The type of patient able to be admitted will vary from site to site depending upon staffing, environment, scope of practice, patient mix, etc. Additionally, circumstances can also change at a site level from one week to another, based on the same factors.

The Transitional Care Centre should consider the following factors to ensure the patient's needs can be met safely:

- Environmental factors – e.g. secured exits, physical lay-out of the building;
- Complexity of care – e.g. cognitive functioning, wandering behaviours, social behavior concerns;
- Staffing complement – is the current staffing complement adequate to meet the patient's needs;
- Staff education – have the staff received appropriate education for the complexity of care required.

If a patient is to be started on IV medications (e.g. antibiotics, pamidronate), the first dose should be done at an acute care site before being transferred to a Transitional Care Centre.

When a Transitional Care Centre has capacity to admit patients for interim placement, the site will contact the Utilization Facilitator/designate to inform of this available capacity and plan for possible transfer. The Utilization Facilitator/designate may also initiate contact with the site to enquire about possible transfer, should there be a need for interim placement of a patient.

Once the Transitional Care Centre has determined that a patient's care needs can be met and they are appropriate for admission, the physician/nurse practitioner from the transferring hospital contacts the physician/nurse practitioner at the receiving site to request a doctor-to-doctor transfer.

Transfers from Out-of-Region Facilities

- Interim placement patients – may be transferred directly to Transitional Care Centre if the patient was paneled within Manitoba. If the patient was paneled outside of Manitoba, the patient should be considered a medical patient until the patient's Application/Assessment for Personal Care Home can be reviewed by the Regional Long Term Care Panel.
- Medical patients who have not been paneled – should be admitted to an acute care centre first for transition and assessment prior to being transferred to a Transitional Care Centre.

Documentation

The sending facility must send complete and clear information on transfer of the patient, including but not limited to:

- Inter-facility Transport Checklist (if applicable)
- Transfer Sheet
- Current Medication Administration Record;
- Best Possible Medication History(BPMH) and Admission Reconciliation & Order Form;
- Integrated Progress Notes for the past seven (7) days;
- Admitting note, history and physical;
- Current care plan or Kardex;
- Health Care Directive if available
- Advance Care Plan; Goals of Care
- Recent relevant lab and diagnostic reports;
- Comprehensive discharge summary detailing the course of events to date and specific care needs of the patient;
- Copy of the Admission/Assessment (A/A) form and PCH of choice (for awaiting placement patients)

Application for PCH placement and reassessment

- If PCH placement is recommended after admission to the Transitional Care Centre, the Home Care Case Coordinator from the patient's permanent address is responsible to complete the A/A form and present at panel.
- Reassessments must be completed every six (6) months by the nursing staff at the Transitional Care Centre when a patient is paneled and waiting to live in a PCH.

Transportation for interim placement patients

- Refer to Interim Bed Policy and Interfacility Transfers Policy

REFERENCES:

CLI.6010.PL.009 Medication Reconciliation
CLI.4110.PL.008 Interim Placement for Patients Waiting Personal Care Home Placement
CLI.5310.PR.004 Interfacility Transfers