

NHS Foundation Tru



Hospital at Home Pathways, Inclusion and Exclusion criteria

Hospital at Home enables patients who present to acute, community or primary care to receive hospital care within their home or residence for up to 14 days.

There are key clinical pathways to support acceptance onto the service. Acceptance onto the service is not limited to these pathways alone.

Patients with multiple long-term conditions and/or frailty have been shown to have excellent outcomes in Hospital at Home - any older patient with a frailty score of 4 or above is worthy of a focused discussion around place of care. To provide further guidance we have also listed some common inclusions and exclusions:

Accepted common clinical pathways include

- Frailty
- Covid- 19
- COPD
- Hypertension
- Pneumonia

• Heart failure Atrial fibrillation

 Infection – cellulitis, gastroenteritis are common ones, but will consider all infections.

At MRI only additional pathways are considered such as:

- Renal fluid overload (CKD or nephrotic syndrome)
- Post-operative colorectal/hepatobiliary
- Conditions that meet high risk inclusion criteria and not exclusion criteria (see overleaf).



Referrals are not solely based on these pathways - suitable medical patients from all specialties can be considered for Hospital at Home. We recommend you review the high-risk inclusion criteria and exclusion criteria overleaf and discuss with the consultant and the Hospital at Home team.

Patients with the following criteria should be considered for Community Hospital at Home (face to face home visits):

Frailty conditions:

- Over 65yrs
- Clinical Frailty Score (CFS) 4 or above
- Current Package of Care (POC) in place indicating that patient needs support with activities of daily living (ADL's)
- Currently residing in a residential/nursing care home
- Housebound and bedbound
- 2 or more hospital admissions in the past 12 months
- All orthostatic hypotension

- All falls or risk of falls
- Delirium
- Registered blind, or with visual impairment
- Deafness
- Communication issues
- On Long Term Home Oxygen
- Mobility issues
- Difficulty with transport unable to come to hospital if face to face review is needed (community H@H can visit at home instead).





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Exclusion criteria - not suitable for Hospital at Home

- New oxygen requirement
- NEWS 5 or above
- Requiring intravenous therapy without support of OPAT (MCR-IV or Wythenshawe OPAT teams)
- No acute medical needs (medically fit)
- Acutely deteriorating/haemodynamic instability
- Social circumstance meaning patient would be unsafe at home
- Those with primary diagnosis directly relating to Gynaecology or Pregnancy
- Mental Health Crisis.

High risk inclusion criteria - discuss with team

- NEWS \geq 3
- Infection of unknown source
- Neutropenic/immunosuppressed
- Delirium/cognitive impairment (considered if NOK able to support 24 hrs a day)
- Worsening acute kidney injury
- End of life care
- New or suspected fracture
- Safeguarding concerns.

High risk related to remote vital sign monitoring - discuss with team

- Bilateral axillary lymph node dissection as limits remote monitoring capability
- Heavy tattooing to upper arms as limits remote monitoring capability
- Digital literacy challenges (considered if NOK able to support 24 hrs a day)
- Literacy challenges (considered if NOK able to support 24 hrs a day)
- Dexterity challenges (considered if NOK able to support 24 hrs a day)
- Inadequate access to ability to charge devices/ability to store devices safely.

Please speak to the teams directly about any patient that can be considered for Hospital at Home

Step down referrals from MFT hospital sites (remote monitoring) can be made via new consult referral on Hive. To discuss a patient with the team contact:

- North Manchester 07973 642433
- Central Manchester 0161 7018917
- South Manchester 07552 771256

Community (face to face visit) Hospital at Home referral numbers:

- North Manchester 0161 667 3292- option number 3.
- Central Manchester 0161 529 6262/ 07977 813868
- South Manchester 0300 303 9650