

Remote Rapid Discharge Protocol for New Patients with Intestinal Failure (IF) in the COVID-19 Crisis



Rational:

- The ability of centres to admit new patients with IF will be reduced or paused during the COVID-19 crisis.
- The aim of this protocol is to allow remote discharge of parenteral nutrition (PN)-dependent patients from their referring hospital, where appropriate and feasible, in order to:
 - a. reduce the risk of infection with COVID-19 for this cohort in their hospital
 - b. free beds in acute hospitals
 - c. minimise transfer to alternative providers such as IF centres
- It should be noted that the benefits and risks will be considered carefully to achieve safe and rapid discharge, acknowledging that the NHS is operating under extreme circumstances where rapid discharge is an extremely high priority compared to normal circumstances. As such, all clinical aspects of care may not be as complete as would happen in normal circumstances, in order to achieve the goal of safe and rapid discharge.
- Referrals will be considered from across England. There will be rationing of services based on clinical need and wider NHS burden during the COVID-19 crisis. Given the immediate requirement for bed capacity to manage patients infected with COVID-19, the remote discharge of PN-dependent patients in Acute Admitting hospitals (with Accident & Emergency Departments) will be prioritised over those occupying beds in hospitals without Accident & Emergency Departments.
- Furthermore, given the extreme pressure on in-patient and community care (including home parenteral nutrition (HPN)) facilities and teams, discharging new patients with palliative needs on HPN may not be possible for a period of time. Alternative palliative measures are recommended wherever possible through engagement of the appropriate specialist hospital and then community teams.
- The patient will remain under the care of the referring team, who will be directly responsible for all on-going non-IF aspects of care. All (IF-related or non-IF related) requirements for readmission will be back to the referring hospital.

Patient requirements:

- Patient must be clinically and metabolically stable
- Patient COVID status must be known pre-discharge; decision to discharge will be individualised if COVID positive.
- Patient is not for palliation PN
- Patient must be on a stable PN script
- Patient must not require on-going intensive inpatient clinical management
- Patient must not require intravenous medications not available in the community
- Aspects of other discharge requirements have been addressed prior to discharge:
 - Management of stoma/laparostomy/wound bags
 - District nurse provision
 - Oxygen requirements
 - Housing/Mobility/Personal care/Support packages for domestic circumstances

- All other medications available following discharge (including any subcutaneous medications and ancillaries)

Method:

1. Referring team to contact IF centre

- a. THE REFERRER HAS RECONSIDERED ALL OTHER FEEDING OPTIONS (ORAL/ENTERAL) TO REDUCE OR CEASE PN. ONLY REFER IF ON-GOING PN IS ABSOLUTELY NECESSARY.
- b. The decision to refer a patient is made by a senior member of the referring team on the basis of the above criteria
- c. A telephone discussion takes place to explore the feasibility of remote rapid discharge
- d. A written referral is emailed to the IF centre (IF centre specific forms are used)
- e. The IF centre provides the referring team with the documents required for rapid remote discharge
- f. The referring team will return the following: (*)
 - i. Consent form of patient agreeing to have Home PN
 - ii. Completed referral form including remote discharge checklist (**)
 1. Diagnosis
 2. Co-morbidities (e.g. Diabetes, IHD, COPD)
 3. Clinical situation (medical/surgical summary)
 - a. Drains still in situ? (if yes – plan?)
 - b. Wound manager system?
 4. Dietetic summary
 - a. Weight history
 - b. Daily requirements
 - c. Enteral feeding routes? (NG/NJ/PEG/PEGJ/DETF)
 5. Recent images with reports (including CXR)
 6. Brief plan of management (to-date)
 - iii. Accurate Fluid balance for 2 days
 - iv. Recent blood results (***)
 - v. Information about Central Venous Catheter (CVC) access including image (if possible)
 1. Type
 2. Site
 3. Lumen number
 - vi. Present PN script + any additional fluids + flushes
 - vii. Medication list (especially if any IV medication)
- g. The referring team provides all the necessary contact details to allow swift communication between members of the relevant teams (pharmacy, dietetic, nursing team)

2. The IF centre will process the referral

- a. Information of acceptance for remote rapid discharge is sent to the referring team
- b. Review of documentation of 1.e.
- c. Formulate final PN script

- i. MCB suitability must be checked
 - ii. MCB + fluid combination must be considered
 - iii. If none of the above meeting requirements – application for compounded bags
 - iv. Taurolidine lock
 - v. IV PPIs
 - vi. Flushes
- d. Seeking Home Care Company provision
 - i. Depending on availability of PN supply and nursing capacity
 - 1. Promote patient/family training after discharge
 - 2. Nursing provision if 1 and 2 not possible (Advise that 24hr connection possible)

3. Preparing Discharge

- a. Installation date confirmation
- b. Home care company visit pre discharge to be arranged

4. Follow up arrangements

- a. HPN-related issues to be directed to IF centre.
- b. All other issues to be directed to referring team.
- c. Encourage appropriate blood monitoring via GP (this might be difficult to achieve). If not possible, to take place at referring hospital if needed (referring team to organise)
- d. The patient will remain under the care of the referring team, who will be directly responsible for all on-going non-IF aspects of care. All (IF-related or non-IF related) requirements for readmission will be back to the referring hospital.
- e. When the COVID crisis is over, HPN care will continue as required but the patient will be managed in entirety by the referring team and will have to be re-referred to the IF centre if further input is needed.

5. Documentation

- a. Clear documentation must be ensured
- b. All members of the teams caring for the patient must be clear about their responsibilities

* Referral form

**Remote Discharge Check list

***List of required recent blood tests