University Hospitals of Leicester NHS
NHS Trust

Outlying Adult Patients Policy

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Trust Lead:	Gill Staton, Head of Nursing Discharge Improvements
Board Director Lead:	Chief Operating Officer Medical Director Chief Nurse
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CONTENTS

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW.

V1 - the contents of this policy was previously documented in other policies and is now stand alone. This policy supersedes information within the following policies:

UHL Bed Management Policy B24/2003 V2 now superseded by the Capacity and flow escalation policy B52/2017

V2 - minor amends to terminology (bed meetings to tactical command bed meeting etc.). Addition of Outlying flow chart at front of policy. Additions to roles and responsibilities. Change to audit responsibilities.

V3 - minor amends to terminology ('fit' to medically optimised) . Removal of non EPMA wards. Updated reference from Capacity and Flow Escalation Policy B52/2017. to UHL Capacity and Flow Escalation Plan including Whole Hospital Policy. Change from Patients not suitable to outlying to 'outlier risk'. Strengthening of consideration given to staffing implications, continuity of care and escalation of concerns.

KEY WORDS

Outlying/Outlier

Flow, Escalation and Capacity Policy (OPEL levels)

Exclusion Criteria

Clinical Management Groups

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IN LINE WITH TRUST/ CMG OPEL LEVEL 3 and above

Ward Multidisciplinary Teams responsible for identifying suitable patients to outlie at Morning Board/Ward Rounds/afternoon huddles

(Between 2-5 per day)

CMG to compile a list of suitable patients for Capacity and Flow Team / update nervecentre board round or discharge profile

Patients suitability to outlie is documented on Nerve centre and in the patient's medical notes

Ward to advise patient and inform relatives of need to outlie

Patients due to be Discharged the following day should be considered first.

Patients who are medically optimised for discharge should be considered next although dependency and discharge planning

Patients with a clear medical management plan and estimated date of discharge may still be identified as suitable for outlying

'OUTLIER RISK'

'Outlier Risk'–depending on the capacity risks within the Trust consideration should be given to patients within this list.
Lowest Risk – Consider First
• No Infection control issues during the admission
• News score stable either 0 or 1
• Confirmed diagnosis and a discharge plan is in place
• Pain free or on a stable analgesia regime
• Patient has not previously been outlied
• Predicted date of discharge is expected to be within 72 hours
• No Safeguarding concerns during the admission
• Resuscitation status is known and clearly documented
Medium Risk
• Infection control issues resolved and infection control team have approved a move
• NEWS score above 1 but stable and within defined parameters for patient
• Still in the acute phase of their admission but with a clear diagnosis and management plan
• Diagnosis of dementia, mental health disorder or learning difficulty but at baseline
• Grade 3-4 pressure ulcer or complex wound
• Has already been outlied on this admission (for non-clinical reasons)
• Predicted discharge date is expected to be more than 72 hours
• Safeguarding issues raised but a clear resolution to these has been made
• Patients who have a significant visual impairment (registered blind or partially sighted)
• Resuscitation status not defined
Highest Risk
• Active infection control issue
• Diarrhoea or vomiting within 72 hours
• Clinically unstable, unwell or has had a deterioration within the last 24 hours
• Diagnosis is uncertain or unresolved, or there is an on-going illness requiring speciality input
• Patient poses a risk to staff or patients (for example due to significant behavioural issues, known to walk with purpose who have absconded from the ward previously)
• History of dementia, mental health disorder or learning disability
• Patients with a known delirium or confusion
• Uncontrolled pain
• Patients in the late terminal stages of their disease/illness/last days of life
• Patients who are detained in hospital under the Mental Health Act or the Mental Capacity Act- Deprivation of Liberty Safeguards
• Patients who have an elevated Early warning score (EWS) of 3 or more outside of the patients normal physiological state and has not been at that level for at least 12 hours.

Ward staff to update Nerve Centre Board Round or Discharge Profile and prepare documentation, property, medication etc. in readiness for transfer

Capacity and Flow team to advise ward on availability of outlying beds

Patient transfers to take place before 21.00 hours if possible

Ward to handover patient to outlying area.

(See Page 13. For printable version and enlarged 'Outlier Risk' Assessment)

1 INTRODUCTION AND OVERVIEW

1.1 The rise in the number of acute admissions to the University Hospitals of Leicester (UHL) NHS Trust has led to an increase in the need to accommodate patients outside of their speciality or base wards. This process is referred to as outlying. At such times (Operational Pressures Escalation Levels; OPEL Level 3 and above) it is essential that clinical teams work together to identify the most appropriate patients who can be outlied to ensure that acutely ill patients can be nursed within suitable clinical areas. This policy outlines the principals for outlying that should be used in line with the UHL Capacity and Flow Escalation Plan including Whole Hospital Policy.

1.2 Where possible the decision to outlie patients should be made and carried out during daytime hours 07:00-19:00 hours and patients should only be outlied after 21:00 hours in exceptional circumstances i.e. Patients are waiting in the Emergency Department (ED) to be admitted to the assessment units and/or expected numbers of admissions are greater than the admitting capacity available. It is the responsibility of the Clinical Management Group Heads of Operations/Duty Management Team to make this decision in conjunction with Senior Manager and Director on Call.

1.3 Patients should only be outlied **once** during their inpatient stay (excluding moves to and from assessment areas/discharge lounge).

1.4 A Datix incident form is to be completed for any patient outlied if there are any adverse patient safety concerns as a result of being outlied from their base ward.

1.5 This document sets out the University Hospitals of Leicester (UHL) NHS Trust Policy for the management of outlying adult patients (those 18 years of age and over) within UHL.

1.6 The aim of this policy is to:

a) Achieve effective utilisation of the Trusts bed capacity.

b) To ensure safe and clinically appropriate outlying.

c) To provide acute admitting/specialist bed capacity to support emergency flow.

d) To ensure the safety, dignity and duty of care for both patients and staff who are involved in the process of caring for adult patients in clinical environments outside their own specialty and/or additional emergency capacity.

1.6 This Policy will guide and support all staff involved in outlying patients within their Clinical Management Groups (CMG) to ensure:

a) Equitable access to appropriate beds for all patients admitted to UHL.

b) Patients are treated with respect, dignity and in accordance with UHL values.

c) Accommodation of patients in single sex areas (with the exception to Critical Care / High Dependency Unit (HDU).

d) The risk of patients being exposed to Healthcare Associated Infections is minimised.

2 POLICY SCOPE –WHO THE POLICY APPLIES TO AND ANY SPECIFIC EXCLUSIONS

2.1 This policy applies to all staff working for UHL, those staff working in a contracted capacity and staff contracted with partner agencies or NHS Trusts working within UHL.

2.2 This policy relates specifically to the outlying process of patients admitted to adult beds (18 years and over) within University Hospitals of Leicester (UHL) NHS Trust.

2.3 This policy does not apply to Children, Women's and Children's CMG – please refer to internal escalation process determined by admitting capacity availability.

3 DEFINITIONS AND ABBREVIATIONS

3.1 **Outlying** by definition is when there is a non-clinical need for an adult patient to transfer to another clinical environment outside of their speciality or base ward. For the wider detail of outlying within the context of bed management, please refer to: UHL Capacity and Flow Escalation Plan including Whole Hospital Policy

3.2 **OPEL Levels** Operational Pressures Escalation Levels in line with CMG bed management contingencies; refer to UHL Capacity and Flow Escalation Plan including Whole Hospital Policy

3.3 **The SAFER Patient Flow Bundle (SAFER)** is a practical tool to reduce delays for patients in adult inpatient wards. The bundle blends five elements of best practice to reduce length of stay and improve patient flow and safety and is used in conjunction with the Red2Green Bed days approach. For further details please refer to:

Emergency Care Improvement programme/ NHS Improvement:

Rapid Improvement Guide to: 'The SAFER Patient Flow Bundle'

Rapid Improvement Guide to: 'Red to Green Bed Days'

3.4 **Assessment units**: AMU (Acute medical Unit) /CDU (Clinical Decisions Unit)/SAU (Surgical assessment Unit), OAU (Oncology Assessment Unit).

4 ROLES-WHO DOES WHAT

4.1 Chief Operating Officer, Chief Nurse and Medical Director are Executive Leads for this Policy.

a) All beds within the Trust remain under the executive responsibility and management of the Chief Nurse/Chief Operating Officer/Medical Director.

b) The day to day operational responsibility for capacity and flow through UHL is managed by the Trusts Capacity and Flow Team.

4.2 Director on Call:

a) Is available 24 hours a day 7 days a week inclusive of weekends and bank holidays contactable via the UHL switchboard.

b) Out of office hours - provide executive support to the on call team and link with the Clinical Commissioning Group and NHS England/ NHS Improvement. On call Director to communicate increased pressure on the system in accordance with agreed guidelines.

c) Communicates with Chief Operating Officer and Senior Manager as appropriate.

d) Has overall responsibility for decisions made to outlie patients.

4.3 CMG Clinical Directors /Head of Operations/Deputy Head of Operations/Heads of Nursing/Deputy Head of Nursing

a) Have a responsibility to ensure that outlying is carried out in line with this policy and in line with CMG Operational Pressures Escalation Levels (OPEL)
b) Ensure that processes are in place to provide a list of suitable patients to outlie to the bed, capacity and flow teams to meet CMG capacity requirements and that nerve centre is updated to reflect the patients' outlying status.
c) Ensure that processes are in place to review Ward MDT staffing levels on wards receiving outlied patients due to the potential for increased acuity and therapy needs.
d) Ensure an outlying 'nerve centre' list is maintained within the CMG to enable review of patients by medical teams.
e) Ensure CMG processes are in place to provide named designated Consultant cover and Junior Doctor support for outlied patients that ensures continuity of clinical care and communication.
f) Ensure patients outlied from the CMG have clear agreed written Clinical Criteria treatment plans with Expected Dates for Discharge (EDD).
g) Monitor number of patients outlied per month and incidents relating to outlying at CMG quality and safety boards.

4.4 Head of Capacity and Flow/UHL Senior Manager on Call (SMOC)

a) Support and facilitate plans made by CMG Heads of Operations (Hoops) to enable the emergency and elective flow of patients throughout the Trust.

b) Lead the tactical command bed meetings held 4 times daily that should determine the ability to provide sufficient admitting capacity and influence the decision making.

c) Keep Director on call appraised of whole hospital position in relation to capacity and demand and on any internal/external issues which might affect patient flow.

4.5 Duty Manager/Clinical Site Team:

a) Work with CMG leads to identify suitable areas to provide additional admitting capacity to support emergency and elective flow throughout the Trust.

b) Work with 'Silver on Call' to ensure that CMGs have identified suitable patients to outlie and that ward staffing is able to accommodate this.

c) Receive reports on numbers of outlyers/ outlyer locations from CMG leads.

d) Decisions to outlie after 21.00 hours should be discussed and agreed with the Senior manager on call/ Clinical site team.

4.6 Consultants:

a) Consultants or Specialist Registrar level Doctors are responsible in conjunction with the wards multidisciplinary team for identification of patients suitable to outlie. This should be undertaken at 'Daily multidisciplinary Board'/'Ward rounds' and at 'Afternoon Huddles'.

b) Documentation to be completed on both Nerve Centre and in the Patients medical notes, highlighting exclusion if patients are not appropriate outliers. (on average 2-5 patients should be identified from each ward each day when on Opel level 3 and above)

c) Patients who are outlied will be reviewed daily during the working week by a named designated clinician (Consultant level or Specialist Registrar) as part of The SAFER Patient Flow Bundle in line with CMG processes, unless the patient

is on an agreed criteria led pathway. (If not discharged within 5 days from the pathway the patient should be reviewed). At weekends the outlying consultant will visit all wards and see those patients where there are clinical concerns or a potential discharge. It is preferable that CMG's identify a medical team that can provide continuity of care to the patients outlied.

d) Ensure patients outlied have clear agreed written Clinical Criteria treatment plans with Expected Dates for Discharge (EDD).

e) Ensure actions are in place to facilitate prompt discharge of patients early in the working day, every weekday (early morning Board rounds, early TTOs, good use of discharge lounges etc.).

4.7 Matrons

a) Provide managerial and clinical advice, and where necessary, practical support with the implementation of the Trust Outlying policy with particular reference to ensuring patients are identified and those identified meet the outlying criteria when on OPEL level 3 and above.

b) Supports the Head of Nursing in providing clinical expertise and advice on clinical risk issues associated with outlying patients particularly if needing to identify patients in the medium to high risk categories.

c) Supports General and Service Managers with risk assessments for additional capacity and sources any patients who could be outlied required from within their respective areas.

4.8 Ward Sisters/Charge Nurses/Nurse in Charge

a) Provide managerial support at ward level for the implementation of the Trusts Outlying policy; with particular reference to ensuring patients identified meet the outlying criteria.

b) Ensure that patients suitable for outlying are identified during Board/ Ward rounds and at afternoon huddles when on OPEL level 3 and above.

c) Ensure Outlying list is compiled (patients to be identified on nerve centre Board round or Discharge profiles and in the medical notes if not suitable to outlie and reason for decision) and provided to the Bed, capacity and flow teams in line with CMG OPEL levels.

d) Escalate to Ward Matron/ CMG Senior Team if consideration is being given to medium to high risk patients.

e) Communicating with the patients family/carers regarding the transfer to another ward or speciality.

f) Complete a Datix incident form for patients outlied if there are any adverse patient safety concerns as a result of being outlied.

4.9 Bed Management Teams / Capacity and Flow /Flow Coordinators /Bed Co-ordinators:

a) Day to day responsibility in hours for the placement of elective and emergency admissions.

b) Maintains patient inflow and outflow of admission units and escalates capacity problems to the CMG Management Team.

c) Communicates timely and accurate bed states, capacity issues and CMG actions if any to site Duty Managers.

d) Monitor and record patient movement and ensure maximum utilisation of Discharge Lounges.

e) With the support of CMG Management team, responsible for initiating, implementing and communicating the CMG out of hour's bed management contingency plans and informing the Duty Managers.

4.10 Infection Prevention Team

a) Provide Infection Prevention (IP) advice to ward based nursing and medical staff, Duty Managers and CMG Bed Management Teams in line with Infection prevention outlier exclusion criteria.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS –WHAT TO DO AND HOW TO DO IT

5.1 If there is a need to outlie patients, between 07:00-19:00 hours Monday to Sunday, this should be done in line with plans identified by the CMG Senior Management Teams and enacted by the Patient Flow and Duty Management teams outside of normal working hours.

a) It is the responsibility of the ward who is outlying the patient to another area to give prior notice/ fully inform the patient, family or carers of the need for them to be outlied.

b) The Nurse looking after the patient on their original ward must provide the receiving ward with a verbal handover and update Nerve Centre regarding the care of the patient.

c) Bed management leads will communicate regularly with the Duty Manager to ensure that outlier information is up to date on nervecentre.

d) Patients who have been outlied to another ward or speciality must be reviewed by a Named designated Consultant / Specialist registrar daily. This will ensure that any further investigations can be undertaken in a timely manner and ensure facilitation and interpretation of results in hours. It will also allow for the reuse of these beds if the patients are discharged from acute care.

e) Patients will continue to have timely, on-going treatment or continued discharge planning whilst on the outlying wards.

f) Patients will not be outlied after 21.00 hours if at all possible.

5.2 **All Adult Patients** should be considered suitable to outlie. The Trust is committed to ensuring that all patients are cared for in the most appropriate environment to meet their ongoing clinical needs and recognises that the best course of action is not to outlie, but where outlying decisions are needed these must ensure minimal risk to patients and staff.

Patient Selection must consider:

a) Patients who are due to be discharged the following day should be considered first as they are likely to be a lower risk and will avoid delays in other speciality areas although this will reduce early morning flow in the CMG's patients have been outlied from.

b) Patients who have been assessed as medically optimised for discharge should be considered next, although dependency and discharge planning and the impact this may have on the receiving ward should be considered.

c) Appropriate patients who may not have been assessed as medically optimised for discharge may still need to be identified as suitable for outlying in the event that acutely ill patients from the Emergency department and the Trusts Assessment Units need to be accommodated into specialist areas.

d) Patients must have a clear medical management plan and Estimated Date of Discharge that can be followed on the outlying ward to aid continuity of care.

e) The receiving ward can accommodate the care needs of the individual patient. This will differ depending on the specialism of the patient outlied and the area being outlied too (equipment needs, environmental needs/ staff competency etc).

f) **The following patient selection should be used as guidance.** Any deviation from this should be justified in the patients' medical record and nerve centre with steps taken to reduce any risk present.

Outlier Risk Assessment –depending on the capacity risks within the Trust consideration should be given to patients within this list
Lowest Risk – Consider First
• No Infection control issues during the admission
• News score stable either 0 or 1
• Confirmed diagnosis and a discharge plan is in place
• Pain free or on a stable analgesia regime
• Patient has not previously been outlied
• Predicted date of discharge is expected to be within 72 hours
• No Safeguarding concerns during the admission
• Resuscitation status is known and clearly documented
Medium Risk
• Infection control issues resolved and infection control team have approved a move
• NEWS score above 1 but stable and within defined parameters for patient
• Still in the acute phase of their admission but with a clear diagnosis and management plan
• Diagnosis of dementia, mental health disorder or learning difficulty but at baseline
• Grade 3-4 pressure ulcer or complex wound
• Has already been outlied on this admission (for non-clinical reasons)
• Predicted discharge date is expected to be more than 72 hours
• Safeguarding issues raised but a clear resolution to these has been made
• Patients who have a significant visual impairment (registered blind or partially sighted)
• Resuscitation status not defined
Highest Risk
• Active infection control issue
• Diarrhoea or vomiting within 72 hours
• Clinically unstable, unwell or has had a deterioration within the last 24 hours

- Diagnosis is uncertain or unresolved, or there is an on-going illness requiring speciality input
- Patient poses a risk to staff or patients (for example due to significant behavioural issues, known to walk with purpose who have absconded from the ward previously)
- History of dementia, mental health disorder or learning disability
- Patients with a known delirium or confusion
- Uncontrolled pain
- Patients in the late terminal stages of their disease/illness/last days of life
- Patients who are detained in hospital under the Mental Health Act or the Mental Capacity Act- Deprivation of Liberty Safeguards
- Patients who have an elevated Early warning score (EWS) of 3 or more outside of the patients normal physiological state and has not been at that level for at least 12 hours.

g) The clinical reasons for patients identified as not suitable and excluded from outlying must be stated in the patient's medical notes and signed by a doctor at Specialist registrar level or above. Excluded patients must have their outlying status reviewed daily. If a patient is outlied against medical advice, the Service Manager/Matron from the outlying CMG should investigate why the exclusion instructions were not adhered to following the completion of a Datix incident form.

h) Patients from assessment areas (AMU/CDU/SAU) will only be outlied following discussion and agreement with the Consultant available on the assessment unit. The situation within the emergency department may be compromising the care and safety of patients with the increasing risks of prolonged wait times for assessment beds.

i) Any concerns, at any time should be escalated to the medical team on shift that day, failure to respond by the team doctors should be escalated to the consultant without delay.

j) Patients with known or suspected dementia or who are cognitively impaired will only be moved for reasons pertaining to their care and treatment. It is acknowledged in cases where **OPEL Escalation Level 4** or above is declared, there may be a substantial risk for new patients arriving to the emergency department. Outlying of patients may present less of a risk overall, however every effort must be made to prevent moving patients with a confirmed or suspected diagnosis of dementia or Clinical frailly score of 7-9. If the patient lacks capacity their family should be informed of their move prior to the move occurring.

k) If staff experience difficulty in identifying suitable patients to be outlied to another speciality, this must be escalated to the CMG Matron on call as soon as possible. The CMG team should seek advice if there are any unresolved issues relating to patient outlying.

5.3 The Process of Outlying Patients

a) In line with the Clinical Management Groups OPEL levels; Consultants or Specialist Registrar level in conjunction with the multidisciplinary team will identify patients suitable to outlie at 'Daily Board'/'Ward rounds' and at

'Afternoon Huddles'. (on average 2-5 patients should be identified from each ward each day when on Opel level 3 and above)

b) Documentation to be completed on both Nerve Centre and in the Patients medical notes, highlighting exclusion if patients are not appropriate outliers.

c) The Patient and family/carers need to be advised of the transfer to another ward or specialty.

d) Each patient who is moved from an admissions unit or base ward, to another ward area, has a clinical handover that is updated in Nerve Centre detailing all clinical data relating to the patients admission.

e) All Medical and Nursing documents, medication and property should transfer with the patient to the outlying ward.

f) Specific risk issues **must be** communicated verbally to the receiving ward, staff on duty will need to re assess the patient when they arrive on the ward.

5.4 On-going Management of Outlying Patients

a) The receiving ward sister/co-ordinator takes overall responsibility for the safe ward placement and on-going care and management of the patient who has been outlied onto their ward.

b) There will be a designated medical review (Specialist registrar or above) of the patients a minimum of once in every 24 hour period every day Monday to Friday unless on an agreed criteria led pathway. At weekends the outlying Consultant will visit all outlying wards and see those patients where there are clinical concerns or a potential for discharge. It should be documented in the patient notes that a review had been undertaken.

c) Ensure patient's progress towards safe and effective discharge is maintained

d) Make recommendations/arrangements to repatriate patients to their original speciality if their condition deteriorates or progress is not as per expected pathway.

e) Respond promptly to ward requests to review outlying patients e.g. if NEWS scores deteriorating.

f) Ensure patients who are outlied have appropriate treatment and medication regimes prescribed including Tablets To Take Out (TTO's).

g) Ensure relevant departments (imaging etc.) are advised of the patient move in order that outstanding Patient requests can be processed.

h) CMGs to ensure an outlying list is maintained within the CMG to enable review of patients by medical teams. Ensure the patient is identified as an outlier on that ward on nervecentre Board round or Discharge profile.

i) Any risk or incidents related to the outlied patients should be escalated in line with the normal CMG escalation processes and reported via the datix incident reporting route.

5.5 Capacity Meetings

a) Identification and need for patients who have been outlied is to be determined at the Trust tactical command bed meetings. These meetings are held at

specific points in the day but times can be adjusted according to the organisational response levels required.

b) These meetings will focus on the provision and availability of daily admitting capacity for Emergency and Elective activity.

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 Any appropriate training should be given to the necessary individuals responsible for bed management within the CMG. This should be mandatory as part of the local induction for staff commencing employment within UHL.

7 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Number of patient incidents relating to outlying	**CMG HON**	**Nerve Centre/Patient Centre**	**On-going monitoring of outliers with monthly reporting to CMG quality and safety boards**	**CMG Quality and Safety Boards**

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

UHL Capacity and Flow Escalation Policy: B52/2017.

Patient transfer and escort policy B30/2004

Escalation for potential elective operation cancellation policy B11/2015

Capacity and Flow Escalation Policy.

Business continuity management UHL Policy B1/2003

The SAFER Patient Flow Bundle, NHS Improvement 2017

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.2 The updated version of the Policy will be uploaded and available through INsite Documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts PAGL system

Outlying Adult Patients Policy: Guide on a Page

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(Between 2-5 per day)

CMG to compile a list of suitable patients for Capacity and Flow Team / update nervecentre Board round or Discharge Profile

Patients suitability to outlie is documented on Nerve centre and in the patient's medical notes

Patients due to be Discharged the following day should be considered first.

Patients who are medically optimised for discharge should be considered next although dependency and discharge planning may impact on the receiving ward

Patients with a clear medical management plan and estimated date of discharge may still be identified as suitable for outlying

Please see over leaf: 'Outlier Risk' – depending on the capacity risks within the Trust consideration should be given to patients within this list.

Identify patients with the lowest risk first.

Ward to advise patient and inform relatives of need to outlie

Ward staff to update Nerve Centre Board Round or Discharge Profile and prepare documentation, property, medication etc. in readiness for transfer

Capacity and Flow team to advise ward on availability of outlying beds

Patient transfers to take place before 21.00 hours if possible

Ward to handover patient to outlying area.

‘Outlier Risk’–depending on the capacity risks within the Trust consideration should be given to patients within this list.
Lowest Risk – Consider First
• No Infection control issues during the admission
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• Patients who are detained in hospital under the Mental Health Act or the Mental Capacity Act- Deprivation of Liberty Safeguards
• Patients who have an elevated Early warning score (EWS) of 3 or more outside of the patients normal physiological state and has not been at that level for at least 12 hours.

Please be mindful of the individual care needs of the patient. This will differ on the specialism of the patient being outlied and the area that they are being outlied too

(Environmental /equipment needs/ staff competency etc.)