

DISCHARGE PLANNING POLICY
AND PROCEDURE
(FOR IN-PATIENTS NOT ON ICPA)

AREA Trust Wide

POLICY SPONSOR: Clinical Governance Manager

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FOR IN-PATIENTS NOT ON ICPA

This document incorporates the good practice discharge procedures for all services, however for Mental Health Services the Care Programme Approach Policy is the key working document for discharge.

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Mental Health Services Only

Joint Protocol and Procedural Guidelines Integration of Care Programme Approach (CPA) and Care Management. For Mental Health Services, the CPA policy is the key working document.

DISCHARGE POLICY AND PROCEDURE

1.0 AIM OF THE DOCUMENT

The aim of this document is to:

- a) set out the responsibility of professional staff and support services in respect of Discharge Planning and transfers
- b) outline the key tasks which will be completed in order to effectively co-ordinate the process.
- c) ensure effective discharge planning that is in accordance with the Trusts Risk Management Strategy.

This document incorporates the good practice discharge procedures for all services, however for Mental Health Services the Care Programme Approach Policy is the key working document for discharge.

2.0 PHILOSOPHY

At Dorset HealthCare NHS Trust we believe that patients and families/carers are central to identifying their health and social care needs in preparation for discharge from hospital.

They will be involved in making decisions and kept informed of plans which allow for flexibility, accessibility of service and individual choice. Early planning for discharge by the multi-disciplinary teams using professional trust, a partnership approach and non-discriminatory practice will ensure a smooth return from hospital to community. Discharge planning should commence as soon as possible after admission or if possible prior to admission. Discharge at short notice should be avoided where possible or when it is not appropriate.

Confidentiality will be observed throughout in accordance with relevant Trust policies, eg. The Protection and Use of Patient Information.

3.0 RESPONSIBILITY FOR DISCHARGE PLANNING

One key individual, nominated by the multi-disciplinary group and involved in the care of the patient will carry the responsibility for co-ordinating the discharge process. This individual will ensure that all necessary action has been taken to:

- a) facilitate discharge from the hospital;
- b) ensure that appropriate arrangements for the organisation of the supporting services required in the community, as identified by the multi-disciplinary team, have been made; and
- c) provide written information to all relevant parties.

4.0 SUPPORTING SERVICES/OTHER PROVISION

4.1 Home Visits

Home visits will be arranged, where an assessment of the home conditions is necessary to affect a successful discharge. This is usually arranged by the Occupational Therapist, Physiotherapist or Social Worker. For Mental Health/Addiction Services this will be carried out by the care Co-ordinator.

Home visits will be carried out prior to and not part of the discharge process. They will be in liaison with all the other services involved and with the consent and the co-operation of the patient, family and carer (if appropriate).

Home visit assessments will be documented and the results communicated to the patient, family, carer and the multi-disciplinary team. A copy of the home visit report will be filed in the health record.

4.2 Medication

For patients who require medication on discharge, arrangements will be made by the key individual up to 24 hours in advance to obtain that medication. For the addiction Service this will be arranged at least a week in advance of discharge.

Arrangements will be made to ensure that up to two weeks supply of medication is available for patients on discharge, except in the case of antibiotics and other stated medications. Unless within the Addiction Service there is premature discharge or discharge against advice.

Patients / relatives / carers (as appropriate) will be given relevant verbal and written information and advice to ensure compliance with the guidelines on how to take that medication. They will also receive any information as is necessary on the medication itself and any associated side-effects. Any discussions regarding medication must be documented.

4.3 Equipment

If equipment is required, the patient's needs at home must be assessed prior to discharge and discussed with the patient and family and carer if appropriate.

If equipment is required, early notification of the order to the Equipment Store (ICES) or other relevant agency is essential. A risk assessment of urgency should be undertaken and the ICES informed whether supply is urgent or not.

Equipment that has to be assessed as special equipment may cause a delay in discharge.

The key individual must endeavour that all necessary equipment either goes home with the patient or is at the patient's home prior to discharge.

All necessary training in how to use the equipment will be provided by the company supplying the equipment. Verbal/written information will also be provided.

4.4 Transport

Transport arrangements will be made with the patient and carer. If patient transport is required this should be booked via Ambulance Liaison 24 hours in advance in accordance with the needs of the individual patient.

Transport will be provided in accordance with the criteria laid down by the Ambulance Service.

5.0 CARE PLANNING / DISCHARGE PLANNING

5.1 A discharge plan is commenced on admission and the process will:-

- allow care plans to be discussed and agreed with patients/carers;
- allow sufficient time and support to enable patients to make decisions regarding their future discharge management;
- allow opportunity for the different disciplines to discuss and agree the care plan and discharge plan;
- enable the patient/carer and multidisciplinary team to be informed as soon as the decision to arrange discharge has been made.
- if appropriate a referral should be made to the Local Authority Services to assess the carers needs.

5.2 Once the discharge date has been set the key individual should:

- ensure the patient and carer are given adequate notice of discharge;
- discharge at short notice should be avoided if possible. *Refer to Policy on Accelerated Discharge;*
- ensure appropriate transport is organised;
- ensure community services are in place, e.g. District Nurse, Meals on Wheels, with dates and times of implementation and any follow up appointments booked;
- ensure the home is prepared, equipment in place and someone is at home or will accompany the patient to see them settled in;
- ensure dressings and medication are supplied;
- ensure appropriate discharge information is provided for the patient/carer;
- ensure that the carers needs are included in the follow up package of care eg respite care arrangements.
- if appropriate, follow up or out of hours service, patients must be referred to the service on discharge and given contact details.

5.3 If the patient takes their own discharge, then a contingency plan is arranged and as much put in place as possible before the patient leaves. If the discharge occurs out of hours it may not be possible to arrange all aspects prior to discharge but these will be arranged as soon as normal hours resume.

6.0 RISK SCREENS

A risk screen must be completed prior to discharge to determine the level of risk and ensure that the package of follow up care is appropriate for any risks identified.

7.0 DISCHARGE PLANNING DOCUMENTATION

7.1 On admission to Dorset HealthCare NHS Trust all patients will have an appropriate assessment and social history recorded by the admitting nurse or doctor. It will include the patient's likely needs and/or problems on discharge and the arrangements to be made to ensure a smooth and effective discharge to the community environment.

7.2 The discharge care plan must be used by all relevant professionals within the hospital and agreed professionals from outside agencies, e.g. Social Worker.

7.3 There will be documentation relating to:

a) A Discharge Summary which is copied for the patient/carer/rest home/nursing home/another hospital, as appropriate. This will include a contact name/number.

And/or a GP letter which will be sent within 10 working days of discharge

- All relevant details of the patient's diagnosis, treatment, care and medication while an in-patient
- Details of ongoing or new community support requested
- Details of out-patient or check-up appointment booked
- Details of drugs and medication arranged
- When, on discharge, the care of a patient is to be transferred from one GP to another, on either a temporary or permanent basis, both GPs will be informed of the above information.

b) Verbal/written Information given to patient/relative/carers regarding their discharge arrangements and follow up care if applicable.

c) Verbal/written information given to patient/relative/carers on medication, use of equipment, etc.

d) A Discharge Checklist or Care Pathway. A key individual will be responsible for checking and signing that all agreed action has been taken before a patient is discharged. All in patient services have discharge pathways or checklists in place.

8.0 RESIDENTIAL / NURSING HOMES

8.1 Where it appears that the patient is unlikely to cope if discharged, they should be referred to a Care Manager/Social Worker, unless it has been decided that the patient needs to remain in an NHS bed. People who are self funding may request an assessment of needs by Social Services and be offered help and advice regarding suitable placements. Those who require assisted funding will be subject to a full care assessment. Whenever possible patients will be helped to return to their own home. The person in charge of the respective home and the GP responsible for residents care will be kept informed of all relevant details of care required.

8.2 The rest home/nursing home will be provided with a copy of the discharge summary.

9.0 TRANSFER TO ANOTHER HOSPITAL/UNIT/PRISON

- Notify hospital/unit, give a verbal history, reason for transfer and arrange time
- Inform patient and Next Of Kin (NOK)
- Arrange transport
- Complete nursing transfer report including diagnosis, NOK details and whether notified, details of treatment plan and medication, summary of care given, immediate physical/safety/psychological needs
- The medical staff will document reason for transfer in the medical notes
- Copies of medical notes and drug chart will be sent with the patient
- Risk screen
- Section papers including section transfer papers if appropriate
- Section 117 transfer if appropriate
- If transfer is to another mental health unit, a discharge letter should be sent to nominated consultant within 5 working days.

10.0 INFORMATION TO SOCIAL SERVICES

The Single Assessment Process ensures that there is an integrated approach by health and social care. Patients have to give their consent for information to be shared with other services. If the patient does not have capacity, then decisions to share information will be done in their best interests.

11.0 CONTINUING HEALTH CARE

11.1 Eligibility Criteria and Process

Please refer to the Dorset and Somerset Strategic Health Authority Policy and Eligibility Criteria for NHS Funded Continuing Care.

11.2 Respite Care

Respite care is provided within Dorset HealthCare NHS Trust in the following locations:

Children with Physical/Learning Disabilities

- Castle Hill

Adults with Physical/Learning Disabilities

- The Cedars
- Delphwood
- Douglas House

Respite care is available for appropriate patients who meet the local criteria. For patients who have regular admissions the discharge arrangements are often more straight forward as they are already in place and will change very little. A simplified discharge checklist will be more appropriate (See Appendix 3) in these circumstances.

12.0 HOUSING

Patients without suitable accommodation may be directed to housing authorities or housing providers for assistance. For example:

- Citizen's Advice Bureau
- Bournemouth Church Housing Association
- Local Council Housing Department

13.0 PATIENTS WHO REFUSE TO BE DISCHARGED

- No one has a right to remain indefinitely in a NHS bed. If a patient refuses to be discharged from hospital, all efforts should be made to secure their agreement by exploring all options.
- If all options have been explored and there is still no agreement, the hospital may begin to implement discharge in an appropriate and sensitive manner.
- *Refer to Trust Policy on Delayed Discharge and the Strategic Health Authority Policy and Eligibility Criteria for NHS Funded Continuing Care.*

14.0 AUDIT

The discharge process is subject to an annual audit by Dorset HealthCare NHS Trust and whenever possible involving Social Services to ensure that the organisation continues to meet patients and carers needs.

REFERENCES

DEPARTMENT OF HEALTH (1995) *NHS Responsibilities for Meeting Continuing Health Care Needs*. HSG(95)8/LAC(95)5.

DEPARTMENT OF HEALTH (1995) *Discharge from NHS Inpatient Care of People with Continuing Health or Social Care Needs. Arrangements for Reviewing Decisions on Eligibility for NHS Continuing Inpatient Care*. HSG(95)39/LAC(95)17.

DEPARTMENT OF HEALTH (1994) *Hospital Discharge Workbook*.

DEPARTMENT OF HEALTH (1991) *Welfare of Children and Young People in Hospital. The Children Act and the Education Act 1993*. HSG(91)1.

DORSET and SOMERSET STRATEGIC HEALTH AUTHORITY *Policy and Eligibility Criteria for NHS Funded Continuing Health Care*.

DEPARTMENT OF HEALTH (May 2002) *Local Authority Circular: Fair Access to Care Services – Guidance on Eligibility Criteria for Adult Social Care*

DORSET HEALTHCARE NHS TRUST

Name of Patient

Home Address

.....

.....

I hereby declare that following my request to be allowed to take my discharge from Hospital, it has been explained to me that my discharge cannot be advised just yet and that to leave the Hospital before being advised to do so by the medical staff could have an adverse effect upon my health. I further declare that in spite of the explanation referred to above, I still insist upon my right to discharge myself from the hospital and that I propose to leave on

the and will go to

PATIENT

Signature

Date

WITNESS

Signature

Date

Name in Block Capitals

Address

.....

.....

GUIDELINES FOR RESPITE CARE DISCHARGE CHECKLIST

Local checklists should include the following:

Details

1. Hospital Ward/Home/Unit
2. Name and address of patient
3. Discharge address (if different).
4. Next of kin name and address.
5. Date of admission/discharge

Communications

6. Community Nurse informed/name
7. Social Worker informed/name
8. Day Care booked, date and location
9. Transport booked.

Discharge

Arrangements

10. Medication returned
11. Property checked and returned
12. Physical check completed
 - by whom
 - weight recorded
 - bruises, condition of skin noted
13. Information to carers including any incidents.