Gwent Healthcare NHS Trust

Discharge Policy
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1 Executive Summary

Discharge is an essential component of the patient pathway and minimising delays associated with it, are a key priority.

The development of Local Wanless action plans highlight increased emphasis on partnership and integrated working so that resources within both health and social care are maximised to improve performance.

It is essential to have a strategic and operational approach to discharge planning so that there is a clear understanding of roles and responsibilities between Health and Social care and the Voluntary and Independent sectors.

The policy clearly sets out the importance of:

- education and training - in equipping staff with the necessary skills and competencies to affect discharge
- the UACM process being used, where appropriate, to assess an individuals risk to independence using supporting documentation.

1.1 Scope of Policy

The discharge policy applies to all health care professionals and support staff working within Gwent Healthcare NHS Trust. The policy applies to all those staff working directly or indirectly with patients whether they are in a primary, community or a secondary care environment. The policy covers all clinical environments, incorporating the needs of both children and all adults.

1.2 Essential Implementation Criteria

To be measured by both Qualitative and Quantitative Methods:

- Uptake of training and level of competence achieved
- Review of training and competencies
- Annual survey of users and carers about their experience of hospital discharge
- Feedback from Trust Patient panel
- Time of day and number of patients discharged over the week
- Proportion of Estimated Date of Discharge (EDD) written in the medical notes and compliance meeting the actual EDD
- Clinical audit of patient discharge documentation relating to nursing/therapy and medical notes to ensure that they reflect the guidance within the policy
- Evaluation of the Unified Assessment and Care Management Process (UACM) process and completion of supporting documentation
- Review of complex discharges to ensure needs were planned and met
- Feedback from primary, community and social care staff
- Number of Delayed Transfers of Care (DTOC), reduction in length of stay and numbers of EDD met
- Analysis of complaints and compliments and other feedback mechanisms from users and carers about their experiences of hospital discharge
- Review of re-admission rates associated with failed discharges

2 Policy Statement

Gwent Healthcare NHS Trust is responsible for implementing a safe, effective and timely discharge of patients into an environment which is appropriate to the individuals needs and which will have been assessed and communicated to the patient, parent, family and/or carer.

Successful discharge will be based upon a multi-disciplinary approach involving the patient/parent and their carer(s) as equal partners.

A whole systems approach will be adopted as part of the discharge process through the effective commissioning and provision of services which are fit for purpose.

3 Aims

- To provide a safe and effective discharge of patients reflecting their assessed needs.
- To provide guidance for all clinical staff working within Gwent Healthcare NHS Trust involved in the discharge process.

4 Objectives

- To understand that discharge is not an isolated event and it must involve the development and implementation of a plan to facilitate the transfer of an individual from hospital to an appropriate setting.
- To ensure that discharge is planned at the earliest opportunity across the primary, community, intermediate, secondary and social care services.
- To provide continuity of care through effective communication across all professionals and teams.
- To ensure all healthcare professionals understand their roles and responsibilities associated with effective safe and timely discharge.
- To fully understand the role patient, parents, families, carer’s and persons appointed under the terms of the Mental Capacity Act play in the planning and implementation of safe discharge. This is to ensure that
the arrangements for discharge are least restrictive on the patients’ rights and freedom.

- To understand the range of services provided within health and social care to facilitate the effective and timely discharge of patients.

- To ensure all healthcare professionals receive training associated with discharge planning to include unified assessment and care management.

- To reduce the delays associated with discharge.

- To understand the importance of communication and information sharing between different organisations involved in the discharge process.

- To ensure discharge is person centred, planned and seamless across primary, community and secondary care.

- To understand the links between other policies and how they impact upon the discharge process.

5 Discharge Care Pathway

5.1 Preadmission

- The discharge care pathway begins before admission whether it is in primary care, social or community services or at preadmission clinic.

- It essential that any discharge needs identified at this early stage are communicated to the appropriate professionals so that the discharge plan can be developed. For example the need to involve an IMCA at an early stage where the patient is known to lack capacity and has no one to represent them. (An IMCA can be commissioned via the Local Health Board).

- The UACM process where appropriate must be used to assess an individuals risk to independence with the supporting documentation. It is essential that whatever health and social care setting the patient accesses, that the appropriate information is transferred with the patient’s consent.

5.2 Assessment Units

- Where a patient presents or is referred to an assessment unit but does not require admission, it is essential that any discharge needs are identified before they leave.
A named person will be allocated to assess, co-ordinate and put in place any discharge arrangements which will be documented in the patient care record and communicated to the patient and other health and social care professionals.

5.3 On admission

On admission an assessment of the patients needs will be undertaken and a care and treatment plan will be developed within 24 hours in association with the relevant health care professionals.

The patient, parent, carer and or IMCA (as appropriate) will be fully involved in this process as an equal partner.

An expected date of discharge will be set as soon as possible – in most cases within 24 hours of arrival or at a multi-disciplinary team meeting or in many cases before admission for elective patients and communicated to the patient and all health and social professionals involved with the patient.

The expected date of discharge will be proactively managed against the patient care plan to reflect when they will be fit for discharge, in conjunction with the multi-disciplinary team and any changes communicated to the patient/carer.

Diagnostic tests and other interventions will be planned to avoid delays in treatment and local response times for radiology and pathology referrals should be set

Patient’s response to treatment will be reviewed on a daily basis and the likely impact upon the EDD should be documented.

When an EDD is not achieved the reasons should be coded and entry made on the PAS record.

5.4 Discharge Plan

Discharge will take place seven days of the week and where possible arranged for the morning to release bed capacity for those patients requiring admission.

The decision to discharge will be based upon a multi-disciplinary approach against agreed criteria, where key actions and responsibilities will be identified and documented in the patient care/medical record.

There will also be those situations in which nurse and allied health care professionals can discharge using agreed criteria.
• A named person will be responsible for affecting the discharge plan and communicating with the appropriate health and social care professionals.

• It is essential whether the discharge is simple or complex that all the necessary arrangements are in place prior to discharge, which has been documented and communicated to the appropriate health, and social care professionals together with the patient/parent and/or carer/IMCA.

• A copy of the discharge plan must be given to the patient, parent, IMCA and or carer, together with the respective health and social care professionals involved in their continued care. A record must be kept in the patient care/medical record.

• For complex discharges a multi-disciplinary team meeting between health and social care will take place to identify the care needs associated with the patient, parent, IMCA and/or carer, where possible. The assessment using the UACM process will determine whether the patient will be discharged home supported by a package of care, transfer to an intermediate, residential or specialised care or nursing home facility. It is essential that this process is actively managed by a care co-coordinator in accordance with the local choice and local agreements (See local authority choice and local agreement policies).

• Those patients assessed as requiring Continuing NHS Health Care will follow the Continuing NHS Care guidance.

• Those patients eligible for free home and NHS funded nursing care will be assessed by the appropriate health and social care professional but this will not affect the discharge date of the patient (See policy on NHS funded nursing care and Local Authority eligibility criteria for free home care).

• Where it is considered appropriate (for example patients with mental capacity issues) an Independent Mental Capacity Advocate (IMCA) must be appointed. It is essential that the patient wishes are expressed through the advocate, this will lead to greater participation and understanding of the discharge plan.

• Patients who are detained under the relevant sections of the Mental Health Act 1983 and its amendments can only be discharged in accordance with the statutory requirements.

• Patient’s, who are homeless, should be identified as soon as possible on or before admission, so that the appropriate agencies in both health and social care are involved at an early stage. This will ensure that appropriate and timely needs assessment have been actioned in order to develop a discharge plan proportionate to individual need. Where
placement and discharge has been affected it is essential that primary care services continue to oversee their clinical care, where appropriate.

5.5 Discharge against medical advice or refusal to be discharged

- Where a patient is determined to be discharged against medical advice every reasonable steps should be made to ensure that any continuing care needs are met.

- Where a patient declines to be discharged following a multi-disciplinary decision, every effort should be made to affect the discharge. Although patient choice is considered extremely important, patients who have been assessed as not requiring NHS continuing care, do not have the legal right to occupy an NHS bed (with the exception of a very small number of cases where a patient is being placed under Part 11 of the Mental Health Act 1983).

- Where difficulties are experienced in discharging from a NHS care facility into a care home, the hospital, social services and community staff should work with the patient and his or her family to find a suitable alternative. This should be done in accordance within agreed timescales.

- If there are continued difficulties then the Senior Nurse, Borough/Directorate Manager should become involved and meet with the patient and or their representative to expedite the discharge, confirming in writing the expected date of discharge. This should be communicated to the General Manager and Chief Executive if there are continued problems with legal advice provided through the corporate services manager (See discharge tool-kit escalation procedure)

5.6 Facilitating Discharge

- To effect the discharge it is essential that all the necessary arrangements are put in place prior to discharge and communicated to the patient, parent, IMCA and/or carer. This should be supported by the completion of the discharge checklist.

- Any follow up appointments for further diagnostic, outpatient or day hospital attendance should be made and discussed in advance of discharge. Where this is not possible, the patient should be advised that they will receive confirmation through an appointment letter.

- A completed discharge document will be sent to the patient’s GP on discharge outlining the diagnosis, treatment, ongoing medication and any continued health and social care services. A copy will be kept in the patient clinical record.
• If referral to district nursing services have been made a copy of the discharge document will be given to the patient to give to the district nurse. **A copy will be kept in the patient clinical record.**

• Transport arrangements should be discussed in advance with the patient and/or their family. Every effort should be made by the patient to arrange their own discharge transport with their family, friends and relatives, taxis or voluntary transport organisations. If that is not possible then patient transport services can be used to facilitate the discharge. This must be booked through Ambulance Patient Transport Services 24 hours in advance of discharge. Unexpected on the day discharges can be booked through bed management at the RGH. For further information see The Trust Ambulance/Transport Booking for Patient Discharge and Transfer Policy.

• Where appropriate a patient who is ready for discharge should be transferred to the discharge lounge from where their family, relatives, friends or hospital transport will collect them. This will assist in freeing up bed capacity.

5.7 **Medicine Management**

• Medicines management plays an important role in preparing patients/parents and their carer(s) for transfer/discharge, which has an impact on the recovery and/or maintenance of their conditions following discharge.

• Any medication or dressings required by the patient on discharge should be requested from pharmacy at least 24 hours in advance

• The nurse has the responsibility of ensuring the patient/parent and/or carer understands the importance of the medication being taken to ensure compliance.

• An assessment of their ability to self medicate must also be made and if the patient requires assistance on discharge this must be communicated to the appropriate health and social care professionals. This will include any domiciliary care agencies.

• For further information please see GHNT Medicines Management Policy and Code of Practice

5.8 **Equipment**

• Any equipment requirements should be assessed in advance of discharge and arrangements put in place to secure delivery in alignment with the date of discharge.
• Patients/parents and carer(s) should be trained in the use of any equipment. Follow-up arrangements should be made as necessary to check equipment provided is adequate and - being used correctly. Information provided to the patient will cover the procedure for return.

• Patients/parents may require equipment or adaptations to help them manage at home, or for their carer(s) to be able to care for them safely. Traditionally, responsibility for providing equipment has been split between the NHS and Local Authority Social Service Departments. It is important that all health and social care professionals understand the processes to follow in those situations.

5.9 Equipment or adaptations fall into different categories:

• Simple and easily transportable equipment which only requires minimal instructions for use, e.g. walking frame or stick.

• Wheelchairs (manual and electric). Patients will be assessed by occupational therapists in advance of discharge and arrangements made for delivery by specialist provider.

• Specialist hoists, which are processed through social services, beds through medical loans (new Huntleigh contract) and grab rails through Occupational Therapy.

• Care and repair schemes ensure equipment and minor adaptations are installed in a person’s home within a few days of referral.

• Home adaptations: identified following assessment by an occupational therapist and provided by care and repair in the local authority, require assessment by the local authority housing department where a grant may be required to fund the enabling works. Delays in referral and in completion of any necessary works must not delay the patient discharge and in those situations interim accommodation will have to be discussed and agreed with the patient and/or their carer until the work is completed.
6 Responsibilities

6.1 Executive Nurse Director

The Executive Nurse Director will take the lead responsibility on behalf of the Trust for the strategic visioning, developing and implementation of the Discharge Policy. The Executive Nurse will be supported by the Lead Nurses, Chiefs of Staff and General Managers for the operationalisation of the policy.

6.2 Chief of Staff

It is the responsibility of Chiefs of Staff to support the implementation of the Discharge Policy by working with consultant colleagues and therapy managers to influence practice and improve processes to maximise bed capacity and reduce avoidable delays.

6.3 General Managers

The General Managers are responsible for developing the infrastructure support within their divisions to direct both financial and human resources to support the implementation of the discharge policy.

6.4 Chief Nurses

The Chief Nurses will support the Nurse Director in the strategic development and implementation of the policy. They will work with professional nursing staff across the Trust providing support particularly in relation to complex and difficult discharges where professional advice is required. They will also work with education and training to influence the development of competencies which ensure professionals are fit for practice. The Chief Nurses will support the development of an audit calendar which will include discharge, ensuring that its qualitative effect is identified within the patient experience.

6.5 Locality Managers/Service Managers

Locality Managers and Service Managers will be responsible for ensuring that the policy is fully implemented in their areas of responsibility. They will also be responsible for monitoring performance associated with discharge and how it impacts upon reducing delays associated with discharge, freeing up bed capacity, reducing DTOC’s and length of stay.

They will also be responsible for creating an environment in which multi-agency and partnership working flourishes to assist the process and patient experience.
6.6 Senior Nurse/Heads of Service

The Senior Nurse and Heads of Service will be responsible for communicating the Discharge Policy to their Managers and Staff so that it is fully implemented. The implementation of the discharge policy should be discussed in Heads of Department and Team Briefings.

The Senior Nurse will also respond to and support any operational difficulties taking direct responsibility when there are complex situations which require higher level intervention and resolving of issues associated with discharge.

6.7 Ward/Departmental Managers

Ward/Departmental Managers have a responsibility to ensure that all their staff have read and fully understand the discharge policy. They will take direct responsibility for ensuring that discharge is co-ordinated and that the multi-disciplinary team work together in an integrated way to secure discharge. They will be responsible together with their staff for ensuring that the Expected Date of Discharge (EDD) is facilitated and that all the necessary arrangements are in place prior to discharge. They will also ensure that all staff understand their responsibility and accountability associated with the discharge process. They will ensure that there is a named person identified for each patient's discharge plan. Where there are difficulties associated with discharge the appropriate escalation process must be used to inform the Senior Nurse.

6.8 Discharge Practitioners/Liaison Nurses/Case Managers

Discharge Practitioners/Liaison Nurses/Case Managers will assist the Ward Managers to drive and co-ordinate complex discharges; carry out appropriate person centred assessments using UACM. They will work closely between Health and Social Care and participate in multi-disciplinary team meetings.

6.9 Multi-Disciplinary Team

The patient journey is dependent upon the integrated working of the Multi-Disciplinary Team and how it works together. They will ensure that they follow the principles set out in the policy and communicate effectively with one another updating the patient and carer(s) with any changes associated with discharge.

7 Training

It is essential that all those involved in the discharge planning process understand their roles and responsibilities. Appropriate training in discharge planning will be provided according to the needs of different staff groups. (See discharge tool-kit)
Groups who will require training will include the following:

- Multi-disciplinary ward/department staff
- Specialist Nursing Staff
- Allied Health Professionals
- Social Services staff
- Community based staff
- Medical staff
- External organisations (e.g. CHC’s, voluntary organisations, voluntary hospital discharge services)

To maintain knowledge and ensure a proactive approach to discharge planning is maintained, staff training will be a continuous and ongoing process and a core element in the induction of new staff.

Discharge training will be driven corporately which will reflect a strategic approach with each division taking responsibility for its implementation.

A range of learning materials will be developed to include on-line learning to support discharge training. This will reflect all those services available which facilitate admission avoidance, early discharge and maintenance of patients in their own environments of care. This will include the Wanless developments, redesign and remodelling of services being undertaken in each Borough.

Multi-agency discharge training will be developed to build on the success and joint training associated with the Protection of Vulnerable Adults (POVA) and the Unified Assessment and Care Management processes.

Training is essential for:

- The delivery of service plans
- Meeting patients needs and improving the patient experience
- Clarifying roles and responsibilities of team members
- Understanding other organisations, other professions and other services
- Making the best use of resources and enabling highly skilled personnel to focus on their areas of expertise and what they do best
- Delivering a joined up service across the NHS, Local Authorities, Social Services and Independent sector.

8 Implementation

The policy will be approved by the clinical forum and will then be forwarded by the policy manager to the intranet manager and risk management team who will upload the policy onto the intranet and disseminate the policy to key staff for cascade dissemination. General Managers, chiefs of staff, chief nurses, and
service/locality managers will be responsible for drawing the attention of all their staff to the implementation of the discharge policy.

Training utilising the discharge tool-kit will be implemented at divisional level.

9 Audit

Monitoring and evaluation will be an essential part of the discharge process. It will enable the key players to know whether or not they are meeting performance targets, improving the patient experience and taking corrective action where required.

Monitoring will happen at each stage of the discharge process (from pre-admission through to leaving hospital).

10 References


Gwent Healthcare NHS Trust Ambulance/Transport Booking for Patient Discharge and Transfer Policy

Gwent Healthcare NHS Trust (2005) Delayed Transfer of Care Policy


Social Services (2005) Local Choice and Local agreement Policies. Local authority

Mental Capacity Act, 2005


WAG (2003) NHS Funded Nursing Care, Welsh Assembly Government, Cardiff


WAG (2002) Unified Assessment and Care Management


11 Bibliography


Emergency Care Collaborative www.modern.nhs.uk/scripts/default.asp?site_id


12 Appendix 1 - Key Principles

The key principles for effective discharge are:

- Planning for discharge should be undertaken before or as soon as possible following admission.

- Where it is anticipated that an individual will have specific needs which will affect their discharge, referral should be made as soon as possible prior to or on admission to the appropriate health and/or social care professional so that those arrangements can be commenced.

- Patients, parents, relatives, IMCA’s and carers must be involved at all stages in the planning of their discharge and be kept fully informed following regular reviews and updates of the care plan.

- All patients, parents, relatives, IMCA’s and carers must be provided with written discharge information prior to or on admission, advising them of the importance of seamless services, choices and minimising delays. This information will be provided in a range of media formats to take account of any sensory or spoken language needs.

- Each patient or parent will on or shortly after admission be provided with an estimated date of discharge (EDD) which will be documented and communicated to the multi-disciplinary team, family and their carers.

- The referral process between primary, secondary, community care, social services and the independent sector will be streamlined (See Inpatient Placement Policy).

- There will be locally agreed response timescales associated with medical, nursing, therapy and social services referrals.

- Identified discharge needs must be documented and reflected in the patient’s care plan and communicated to the multi-disciplinary team, including comprehensive transfer information.

- A comprehensive range of discharge checklists and patient care records will be used to support and record the process.

- A named person must take responsibility for co-ordinating all activities associated with the discharge process.

- The unified assessment and care management process will be used for those complex patients in acute areas and for all patients transferred to a community hospital/intermediate care setting.
• Effective and timely discharge requires the availability of alternative, and appropriate, care options to ensure that any rehabilitation, transitional and continuing health and social care needs are identified and met.

• All healthcare professionals will work within a framework of integrated multidisciplinary and multi-agency team working to manage all aspects of the discharge process.

• All staff involved in the discharge process will be fully aware of the patient’s care and care options provided in the community, statutory and independent sectors and how to access them.

• Effective use will be made of transitional and intermediate care services, so that hospital capacity is used appropriately.

• Agreements will be in place with the bordering local authorities and primary care trusts regarding eligibility for home care, care home placements and for those requiring continuing NHS care and home equipment.

• The assessment for, and delivery of, continuing health and social care is organised so that individuals understand the continuum of health and social care services, their rights and receive advice and information to enable them to make informed decisions about their future care. In those situations where a patient does not have capacity to make decisions, it will be necessary to ascertain if there are decision making mechanisms in place as provided by the Mental Capacity Act. Where there are no such provisions their best interests must be acted upon, taking into account any previously known wishes and the views of their family or carers. This will be done in conjunction with the consultant responsible for the clinical care of a patient in conjunction with the multi-disciplinary team, parent/family and carer(s).
13 Appendix 2 – Benefits of Effective Discharge

13.1 Patient or Family (in the case of a child)

- Needs are met
- Able to maximize independence
- Feel part of the care process, an active partner and not disempowered
- Do not experience unnecessary gaps or duplication of effort
- Understand and sign up to the care plan
- Motivated in achieving goals towards reablement
- Experience care as a coherent pathway, not a series of unrelated activities
- Believe they have been supported and have made the right decisions about their future care

13.2 Carer/family/IMCA

- Feel valued as partners in the discharge process
- Consider their knowledge has been used appropriately
- Are aware of their right to have their needs identified and met
- Feel confident of continued support in their caring role and get support before it becomes a problem
- Have the right information and advice to help them in their caring role
- Are given a choice about undertaking a caring role
- Understand what has happened and who to contact

13.3 Health and Social Care Professionals

- Feel their expertise is recognised and used appropriately
- Receive key information in a timely manner
- Understand their part in the system
- Can develop new skills and roles
- Have opportunities to work in different settings and in different ways
- Work within a system which enables them to do so effectively

13.4 Organisations

- Resources are used to best effect
- Service is valued by the local community
- Staff feel valued which, in turn, leads to improved recruitment and retention
- Meet targets and can therefore concentrate on service delivery
- Fewer complaints
- Positive relationships with other local providers of health and social care and housing services
- Avoidance of blame and disputes over responsibility for delays
14 Appendix 3 - Whole System Working

A whole system approach is one that recognises the contribution that all partners make to the delivery of person centered care.

The whole system is not simply a collection of organisations that need to work together, but are a mixture of different people, professions, services and facilities which have individuals as their unifying concern.

Working together is essential to ensure the effective discharge of patients and all agencies must accept their inter-dependency responsibilities and the fact that the action of any one of them may have an impact on the whole system.

There must be agreement between the different agencies as to the vision of the service(s), the priorities, the roles and responsibilities, the resources, the risks and the review mechanisms associated with effective discharge.

There are three main areas where an integrated whole system working underpins the discharge care pathway:

- Capacity planning
- Reviewing performance
- Hospital discharge and inter-agency agreements
- Development of integrated care pathways

14.1 Capacity planning

This requires LHB’s, Trusts and local authorities to work together to ensure that the current capacity is used to best effect and which engages the independent sector.

Recent developments associated with the Wanless Local action plans and other services will increase capacity in services in order to avoid the need for admission to hospital and support earlier hospital discharge (See local Wanless action plans). These could include:

- The development of Intermediate care services
- Emergency care at home
- Carers’ support
- Prevention of admission to hospital(PATH)
- Rapid response teams
- Reablement teams
- Community Physician
- Domiciliary care
- Case managers/Discharge liaison/Discharge practitioners
- District Nursing services
- Children’s services
• Mental Health services
• Outpatient specialist services
• Therapy services
• Care and Repair schemes
• Telecare and Smart House technology
• Voluntary services

Please refer to LHB and Local Authority directory of services within each Borough

14.2 Reviewing performance

National targets have been set by the Welsh Assembly Government (WAG) through the service and financial framework (SAFF) and balanced scorecard to monitor performance, particularly in relation to delayed transfers of care (DTOC), reducing emergency admissions and the Unified Assessment and Care Management Process (UACM).

It is the responsibility of each organisation to work together to manage performance and to achieve these targets. Each member of staff within each organisation will accept their responsibility for the part they play in the discharge process and how it will impact upon the patient experience.

The Trust in partnership with each Local Health Board and Local Authority will establish performance management systems to monitor DTOC’s, emergency admissions and lengths of stay with specific timescales. In addition, local Corporate/Divisional/Directorate/Borough performance management groups will be established to monitor performance through:

• Validation of DTOC’s
• Management of complex DTOC’s (See DTOC Policy)
• Management of patient groups with lengths of stay of 24 hours, 7 days, 28 and 42 days
• Estimated Date of Discharge (EDD)
• Use of LEAN Methodology
• Application of Borough based choice and local agreement policies (See borough policies)
15 Appendix 4 - Involving Patients/Parents/IMCA’s and Carers

- The engagement and active participation of individuals and their carer(s) or IMCA’s as equal partners is central to the delivery of care and in the planning of a successful discharge.
- A person-centered approach must also recognise the important contribution made by parents, IMCA’s and carers. It is important to remember that young people also may be carers and that they should be offered a carer(s) assessment if they are under 16 years of age, when the adult receives a community care assessment.
- Person-centered care must be much more than just keeping the patient informed and up-to-date with decisions about their care as passive players in the process.
- Professionals bring the professional and technical expertise, patients/parents and carer(s) bring their individual experience, expertise and aspirations.
- The provision of information examined at their own pace, will allow any questions and concerns to be raised. Care must be taken to ensure that a patient who has communication difficulties, e.g. after a stroke, is involved as fully as possible in planning his or her care.
- Pre-admission assessment also helps the patient and carer plan for admission to hospital and to understand what to expect and prepare for on return home.
- The admission process is the critical time to explain to patients and their carer(s) what to expect and how they are to be involved in key decisions, remembering that they are the experts in how they feel and what it is like to live with, or care for, someone with a particular condition or disability. Any form of communication must take account of the individual’s ability to understand and absorb information.
- The same information will need to be available in plain language and in a variety of appropriate forms. This should include, for example, appropriate minority and ethnic languages and presentations in large print, Braille and British Sign Language. Other formats might also be appropriate including audiotapes and visual formats such as interactive CD-Rom. For some patients it will be necessary to involve an IMCA or interpreter to provide further assistance. Every effort must be made to ensure consistency and continuity of information from different personnel. The communication aids described may be accessed via the Patient Information Unit.
- Full information on the services available in the community relevant to their care must be provided to patients and their carer(s).
- Full information on short-or long-term nursing or residential care, including financial implications must be provided and discussed.
- The patient/parent/IMCA or carer(s) must be provided with an appropriate contact number where they can get help or advice on discharge.
• The patient/parent or carer(s) must be given a clear, legible discharge letter detailing the support services provided for them (where appropriate).
• The patient/parent/IMCA or carer(s) must be given full information on eligibility criteria for continuing care.
• The discharge planning team will be available as a point of contact to offer support and advice to patients, parents, carer(s), statutory and voluntary agencies.
• The patient/parent/IMCA or carer(s) will be provided with information on advocacy support.
• The patient/parent/IMCA or carer(s) will be informed of the trust complaints procedure and any complaint regarding their discharge arrangements and how it would be investigated with a full explanation given.
• If still not satisfied, then the patient/parent/IMCA and carer(s) will be given access to the health service ombudsman.
16 Appendix 5 - Discharge Policy Strategy

16.1 Introduction

The NHS plan “Improving Health in Wales” (WAG, 2001) emphasised together with “Designed for Life” (WAG, 2005) the challenges the service faces as it becomes more responsive to the needs of people. The NHS plan focuses on the enhanced role of primary/community care and its interface with secondary care. Maximising independence, promoting self-care, managing long term conditions, admission avoidance and timely discharge are key components of redesigning and remodelling services which need to be evidence based and resource effective.

The Review of Health and Social Care (Wanless, 2003) made it clear that current systems and processes are unsustainable and new ways of working need to be adopted to improve, the patient experience. Resources should be targeted to improve performance and modernise both health and social care with a greater focus on co-operation and integrated working.

Crucial to the modernisation of health and social care is the redesign and remodelling of services. Discharge processes play a significant part in improving efficiency and the patient experience. It is clearly evident that effective discharge from hospital can only be achieved when there is joint working between the NHS and Social Care.

A strategic approach supported by a multi-agency discharge policy is an essential tool in supporting both health and social care professionals in performing their roles and responsibilities.

16.2 Discharge Policy

Modernising both health and social care is crucial to improving the patient experience and service delivery.

Gwent Healthcare NHS Trust Discharge Policy states clear aims and objectives focussing upon safe, timely and effective discharge, highlighting everyone’s responsibility associated with the process.

The policy stresses the importance of patients, parents/IMCA’s and carer(s) being equal partners and being fully involved throughout the process. Communication is seen as an essential vehicle for driving forward the process and keeping all stakeholders informed.
16.3 Discharge Tool – Kit

A discharge toolkit will be developed to assist all health and social care practitioners to facilitate discharge in a timely, safe and co-ordinated way which will bring together care pathways, supporting policies and documentation.

It will be a very practical tool which will be updated to assist practitioners in ensuring that each planning stage of discharge is accounted for with reference to the appropriate supporting policy, protocols, checklists, flow diagrams and transfer/discharge documentation.

16.4 Discharge planning

Eighty percent of patients discharged from hospitals are classified as simple discharges having minimal ongoing care needs and do not require complex planning. The timely and effective discharge of this large group will have a significant impact upon hospitals creating capacity and managing demand for both elective and emergency care. However, it is essential that all discharges are effectively planned with partners in both health and social care to minimise delays associated with discharge.

Discharge planning wherever possible begins before admission. Any needs identified should be communicated to the appropriate health and social care professionals so that appropriate planning begins.

Within 24 hours of admission or at a multi-disciplinary meeting, an Estimated Date of Discharge (EDD), where possible, should be agreed and documented in the medical/patient care record and communicated to all staff. This date and progress against it should be monitored on a daily basis and communicated to the patient/parent/IMCA and their family/carer(s).

16.5 Coordinating discharge

It is the responsibility of the ward/department sister/team leader to co-ordinate discharge, taking responsibility for organising where appropriate, multi-disciplinary team meetings and working closely with discharge nurses/practitioners/liaison/case managers/care co-ordinators to support individuals throughout the process.

16.6 Risk Assessment

Unified Assessment and Care Management (UACM) will, where appropriate be used to assess an individuals risk to their independence against a risk matrix and eligibility criteria.

It is essential that prior to discharge all the necessary arrangements are in place to secure a safe and effective discharge.
16.7 Monitoring and Effectiveness

16.7.1 Audit

The policy and discharge tool-kit will be audited to monitor the effect discharge has upon the patient experience and key targets.

16.7.2 Training

It is essential that all those involved in the discharge planning process understand their roles and responsibilities. Appropriate training in discharge planning will be provided according to the needs of different staff groups.

16.7.3 Communication

Good communication is a pre-requisite for a well co-ordinated patient journey from preadmission through to discharge. Staff involved in discharge planning are frequently working to conflicting pressures and priorities between organisations, professions and patients, IMCA’s, carer(s) and relatives.

It is essential that there is communication at all levels within a system if there is to be effective partnership working between organisations and between staff and the patients, carer(s) they are working with. This also needs to extend to communication with the wider public about service plans, priorities, pressures, access routes and the roles and responsibilities of different organisations.

Effective discharge can in most cases begin before admission and where this happens it is essential that appropriate assessments of needs are carried out by competent individuals and that information is communicated to professionals and carers.

Each patient discharged from hospital will have a discharge plan which will reflect where appropriate Unified Assessment and Care Management. In the case of children this will reflect the standards outlined in the National Service Framework, Carlile and Continuing Care Management for Children.