Choice on Discharge Policy

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Version Control Sheet

Version	Section / Para / Appendix	Version / Description of Amendments	Date	Author / Amended by
1	New Policy		August 2016	Sarah McKown
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Choice on Discharge Policy

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Procedural Document Statement

1. Background

Lincolnshire Community Health Services (LCHS) strives to provide high quality care to patients in their own home. When patients needs require them to be cared for in an alternate environment such as a community hospital or a short term community care (transitional) bed (assessment and treatment, transitional care, reablement or rehabilitation), LCHS teams manage this change but continue to aim for their patients to return to care provided in their own home as soon as possible. When ready for discharge (This means assessed by LCHS as safe and ready to be moved on from their present place of care) services remain committed to the principle of Home First which recognises the importance of discharge into patients own homes where this can be done safely.

Patients will be cared for in a place of safety with care, compassion and competence from staff. This also applies when the assessment of their needs shows that they are considered ready for transfer or discharge from a community bed. The decision to discharge is based upon an assessment of the patient's health and adult care needs.

On admission the care pathway documenting the expected care to be followed will be discussed with the patient and their relative or friends. An estimated or predicted discharge date will be agreed on admission, or shortly after admission (within 24 hours), and documented by the admitting nurse or doctor. The discharge date and destination will be regularly reviewed, updated and discussed with the patient, and those close to the patient. This key step is linked to arranging timely discharge from a community or hospital bed. The patient will have received written information about their discharge and the process to be taken (see Appendix 2 Community Hospitals Ticket Home)

It is essential that community beds are used appropriately. We have a duty to ensure patients are getting the right treatment in the right place at the right time. It is also clearly the wishes of patients to be able to return to a familiar environment once safe to do so. Care needs may continue, but if they can be provided safely outside a hospital and community bed, this is our clear aim. If patients occupy community beds when this is not clinically necessary, it effectively denies other patients the care they require. The consequence of this can be other patients not receiving the care they need, a poor patient experience or issues with safety.

In addition to the above it is rarely in the patient's best interest to remain in a community or hospital bed longer than is clinically required. The risks attached to prolonged stays can be exposure to hospital acquired infections, loss of functional independence, decrease in social skills and increased risk of depression and various other complications associated with prolonged hospital stay.

In summary – All health and social care services should only be used for delivery of appropriate care and not the delivery of services than can be better provided elsewhere in the health and social care system.

This document covers the patient's choice in selecting a nursing or residential care home to which they agree to be discharged or transferred on a long term or permanent basis.

The policy sets out the procedure for resolving a delay in the discharge or transfer due to the patient not having made a choice, or not having put in place arrangements as to which nursing or residential care home to go to. This policy should be read in conjunction with the Discharge Planning Policy and Process.

2. National Guidance on Choice on Discharge

- **Guidance on choice of accommodation** (LAC (2004)20) Where patients have been assessed as no longer requiring NHS continuing inpatient care, they do not have the right to occupy indefinitely an NHS bed. If an individual continues to unreasonably refuse the interim care home or care package, the council is entitled to consider that it has fulfilled its statutory duty to assess and offer services, and may then inform the individual, in writing, they will need to make their own arrangements. This position also applies to the unreasonable refusal of a permanent care home, not just the interim care home or care package LAC(2004)20

- **The choice directions guidance** ('Ready to Go', DOH 2010) "Discharge or transfer from hospital is frequently delayed when an individual's preferred accommodation is not available. While it is entirely reasonable for a person to exercise choice at an extremely difficult and vulnerable time in their lives, the guidance makes it clear that, as long as an interim placement meets the needs of the individual, it is acceptable for a person to move from an acute hospital to an interim placement until the permanent or alternative choice becomes available. It is important that consistent messages and information are given to patients and carers by all staff about the likely length of stay in hospital, and the need to move on to more appropriate care when they are ready to do so. This will avoid misunderstandings and surprises later in the process".
- **Patient choice (NHS constitution 2015) –** clearly places the patient at the heart of the NHS and upholds the views that patients need to be consulted and involved), offers guidance for patients on the choices they can make**.**

3. Statement of purpose

- To ensure the concerns and anxieties of the patients and their carers are discussed without prejudice.

- To ensure the patient and their chosen representative are invited to be full participants in the decision making process from the time of admission.

- To ensure that during the patient's admission or length of stay and throughout the decision making process they will continue to receive a high standard of care which is safe, competent and compassionate.

- To ensure the patient receives information related to their admission aligned pathway of care and an identified ongoing plan post admission.

- To ensure the patient's identified levels of care and need for placement is kept under constant review during their admission.

- To ensure the patient (where able) is involved in the choice of their transfer or discharge destination. Where they are unable, their chosen representative will be consulted. However, where the placement is short term the decision around choice will not be used to delay discharge.

- To ensure all discussions concerning assessment and the decision making process will be noted in the patient's medical and nursing notes.

- To ensure at all times, Health and Adult Care staff act in the best interest of the patient.

- To ensure the patient does not remain in hospital unless it is clinically indicated.

- To ensure community hospital and transitional care beds are made available for patients who need them.

- It is the responsibility of the Doctor/ Advanced Nurse practitioner (ANP) or Nurse in Charge (NIC) to ensure that all patients in his/her care have a clinical management plan within 24 hours of admission and a predicted discharge date (PDD) and that this is reviewed daily.

- The Ward Sister/Charge Nurse has responsibility for the coordination of a high standards of discharge planning and that staff report any examples of non-compliance to the policy through the hospital adverse events reporting system

- The Multidisciplinary team (MDT) have responsibility for agreeing the patient is ready for transfer and that this is recorded in the medical notes

- The ward staff on each site has responsibility for ensuring that appropriate multi-agency decision making is in place when deciding on the discharge pathway.
- It is also to bring about sustained improvement in discharge planning by:
    1. The development, implementation and evaluation of policies, standards and guidance on discharge planning.

2. The implementation of an effective inter-agency and multidisciplinary communication strategy, internal and external to LCHS.
3. Ensuring a programme of audit to monitor effectiveness of discharge tools and practise and identify areas of improvement
4. Influencing strategic planning to achieve national and local performance targets.
5. Monitoring the patients experience with discharge planning within the Trust.
6. Monitoring weekly delayed discharge data and identify areas of improvement to achieve Trust target for delayed transfers of care.

- The Deputy Director of Operations for LCHS have responsibility for aligning discharge process across all services ensuring that systems are in place to escalate and resolve discharge delays in a timely way.
- The Medical Director and Director of Nursing have overall responsibility for directing the quality of medical and nursing intervention to support the policy.
- The Director of Operations has overall responsibility for ensuring that there are effective arrangements for discharge planning within the trust and that they are implemented in a timely way.

The policy applies to patients in the following situation:

- Patients who require discharge to a care home, irrespective of funding arrangements.
- Patients who have identified a care home of choice that is not available at the point of discharge.
- Patients who are awaiting care packages to be arranged, and/or completion of aids/adaptations to their home.
- Patients who are declared “homeless”.
- Patients who are refusing to leave hospital despite the availability of an appropriate discharge location.
- Patients for whom an interim placement has been identified which meets their assessed physical or mental needs.
- In exceptional cases a patient can be excluded from this policy at the discretion of a Director. Individual cases will be presented by the Clinical Director or relevant Consultant.

This policy does not apply to patients who have been informed that they require a community hospital or community bed or care home in order that their assessed needs may be met, but have clearly expressed a wish to return to their own home or to alternative accommodation, with or without an assessed package of domiciliary care.

This policy would however apply in such circumstances should the patient be assessed as lacking capacity to decide matters of residence and/or care and/or treatment.

4. Safeguarding concerns/ vulnerable patients and patients who lack capacity

Health Services have a duty to safeguard all patients, but provide additional measures for patients who are less able to protect themselves from harm or abuse. Multi agency procedures apply where there is concern of neglect, harm or abuse and concerns at discharge must be addressed to facilitate a safe discharge.
Safeguarding Adults is shaped by 6 principles, Empowerment, Protection, Prevention, Proportionality, Partnerships and Accountability. Duties to empower people to make decisions and be in control of their care and treatment is underpinned by the Human Rights Act 1998, the Equality Act 2010 and the Mental Capacity Act 2005.

- Patients have the right to make choices about their care and treatment – this includes making decisions about their safety, even where those decisions may seem to others to be unwise.
- Empowerment is enabling the person to control decisions about their care to the extent that they are able.
- Any actions that do not have the person's full and informed consent must have a clear justification, be permissible in law and the least restrictive of the person's rights to meet the justifiable outcome.
- Mental Capacity (detailed below) is a key concept in safeguarding and needs to be considered from the outset.
- Person led safeguarding does not override the duty to protect others from harm
- Duty of care involves taking reasonable steps to identify and reducing risk while respecting the person's right to make choices.
  Safeguarding Adults: The Role of Health Service Practitioners (DoH, 2011)

Safeguarding multi agency procedures needs to be supported by working in partnership with patients and with partner agencies through

The patient (where able) has the right to decide and be involved in the choice of their transfer or discharge destination.

Where there are concerns that a patient lacks the capacity to decide on his/her discharge destination, an assessment of capacity should be undertaken. If this finds that the patient does currently lack the capacity to take that decision, a best interests meeting will be undertaken prior to decisions regarding the choice of accommodation.

Another capacity assessment may be required when further decisions emerge regarding discharge destination.

The Mental Capacity Act (2005) will be adhered to at all times.

4.1 Patients who lack capacity

A patient should not be determined as fit for discharge without consideration of Mental Capacity. The following should be determined for any patient where there are concerns regarding capacity to make decisions:

- A capacity assessment in relation to discharge destination should be carried out and documented.
- Relatives should be involved in decision making where there is Power of Attorney in place, this may relate to Health and Welfare or Finance in some cases where there is a need to self-fund.
- An IMCA should be appointed when patients lack capacity and there is no-one identified who can represent the patient.
- If a patient lacks capacity then a best interest discussion should be organized by the responsible Social Worker and documented. If as a result of discussions all parties agree that a care placement is required, care planning for discharge can progress. However, if no agreement is reached then a formal best interests meeting will be arranged by the social worker (within 7 working days) and the patient's discharge planning will not progress until this meeting has taken place and agreements reached.
- Once the above is agreed the patient should be considered for continuing healthcare eligibility and a checklist completed.

5. Discharge planning

5.1 Informed Patients, Relatives and Carers (with the consent of the patient)

Sharing information everyday with patients about what is happening with them is essential if they are going to be an equal partner in decision making. We know that this improves flow as the patient or their family will ask why planned interventions and/or decisions are not happening.

All patients should be able to answer the following questions every day.

- What is wrong with me?
- What is being done to fix it, what am I waiting for next?
- What do I need to be able to do to go home, and has anyone asked me?
- When am I going home?

A patient is "ready to leave" when:

- A multi-disciplinary team decision has been made that the patient is ready for transfer or discharge. That is, they no longer require the type of care provided within a community hospital or community managed bed with care lead by LCHS services. A multi-disciplinary team in this context includes nursing, medical and other health and Adult Care professionals. The patient is safe and ready to go.

LCHS recognises the importance of the multi-disciplinary team in effective discharge planning. The following minimum standards apply to all discharge planning:

- Patients will be discharged to their own home with further assessment and support offered as appropriate. Where no community resource exists to facilitate discharge home safely, alternative arrangements will be made to avoid unnecessary delay in an acute bed.
- Discharge planning commences at the pre admission stage for elective cases and on admission for non-elective admissions. On identification of potential complex needs on discharge patients will be given Discharge advice which explains the possible need for short term placement where home first is not an option.
- All patients will have an estimated discharge date (PDD) recorded in their notes. The estimated discharge date will be discussed and agreed with patients/relatives/carers and any changes to this date discussed with all stakeholders.
- The patient and their relatives will be made aware of the need to protect community hospital or community beds for those requiring this level of care. Patient and relatives expectations will be informed through the use of the "Ticket Home" information sheet provided on admission, and through discussions held with the patient throughout their stay.
- All meetings, case conferences and discussions concerning assessment and discharge will be discussed with the patient and their chosen representative and documented in their notes.

Once it is agreed that the patient's condition cannot be improved by further intervention in a community hospital or community bed, the following process will be adhered to. This will be undertaken with the full involvement of the patient and their chosen representative.

- Following a multi-disciplinary team meeting which agreed and recorded the patient is ready for discharge, the patient will be verbally informed of the decision, the reasons why and the date of discharge agreed with the patient and their chosen representative. Written confirmation will also be provided.

Where appropriate an individual discharge planning meeting will be held to support discharge placement into a care environment:

- Once in receipt of an agreed outcome from the Discharge Planning Meeting, the patient and their chosen representative will be informed of the outcome verbally.
- The patient or their significant other may wish to visit care homes as part of their selection of a suitable environment but doing so must not extend their inpatient hospital stay.

6. Delayed Transfers of Care (DTOC)

6.1 Underpinning Principles

Across the whole system, our common aims are to:

- Improve services for patients by avoiding situations where, particularly older people are put at risk by remaining in the acute sector when they no longer need acute care.
- Encourage systems to invest together in an extended range of services to prevent delays occurring in the first place.
- Reinforce partnership working between acute trusts and local authority social care departments.
- Drive a better system of discharge planning encouraging the development of proactive planning for discharge rather than the reactive last minute planning for discharge that still exists in many trusts.
- Whether reimbursing or not the system of notification is necessary for alerting community and social services to the likely need for services post- acute discharge and the forward planning for discharge through expected dates of discharge (simple guide to DTOC)

DTOC covers patients occupying a hospital bed (this includes care homes with which we have a contract to provide care). It includes patients who are 'medically fit' for discharge who cannot be discharged for the various reason as specified in the DTOC guidance and they cannot be moved on owing to care not being available elsewhere, whether or not that is in their own home or other care setting. We do not class patients as DTOC if the patients are already in their own home, waiting a nursing or care home and we do not include patients who are not 'medically fit for discharge in to our community hospital beds.

6.2 Definition of a delayed transfer

A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:

a. A clinical decision has been made that patient is ready for transfer **AND**
b. A multi-disciplinary team decision has been made that patient is ready for transfer **AND**
c. The patient is safe to discharge/transfer.

A multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient in an acute setting.

7 Procedure if Patient is not discharged on the date highlighted on discharge due to patient choice

On confirmation that the delay is not due to discharge process issues but relates to patient or family choice (E.g. waiting for a specific care environment) then an urgent meeting is arranged to determine a new discharge date. This meeting will be arranged at the earliest opportunity, ideally 24 hours but not exceeding 72 hours. The Hospital Matron will be advised of the patient's refusal.

7.1 At the meeting

The ward manager/Lead Discharge Nurse/Matron will advise the patient that an acute hospital bed is no longer required and that alternative arrangements should be made for transfer of care or discharge. This could be discharge direct to home or as part of a step down process into a community.

The following points will be confirmed at the meeting:

- The patient does not require the type of care provided in a community hospital or community bed *and* there is no other required treatment that must take place prior to transfer.
- Remaining in the present environment may be detrimental to the patient's health and well-being and is not an option for their care needs.

The Ward Manager/Lead Discharge Nurse/Matron will ensure that:

- The patient and their representative have received all the information and have contact numbers for the relevant members of the multi-disciplinary team for seeking further advice.
- The patient and their chosen representative are given a new discharge date which will be no more than 72 hours from the meeting. The meeting will confirm discharge destination. This may be home or a community (transitional care) bed. In line with NHS guidance if the patients first choice of community bed is unavailable a temporary placement may be arranged. (NHS Responsibilities for meeting Continuing Health needs), this temporary placement may be outside the area of choice but consideration will be given as to suitability of visiting relatives. The patient and their representative are aware that alternatively, the patient could be discharged home (or to the home of a friend/relative) with a package of care based on their needs assessment they should be told there may be a charge for the care element of this package (this will depend on previous financial assessment carried out)
- The patient receives a written confirmation of the discussions of the meeting. A copy of the letter will also be send to the matron and other professionals present at the meeting and a copy placed in the patient notes.
- The Head of Clinical Service will be advised of the new discharge date and ongoing plan. The Deputy Director of Operations will be advised that a patient has been presented with discharge instructions following an escalation meeting including expected outcome.

7.2 In the event of further refusal to leave a community hospital or community bed

If after completing a meeting with the patient and setting a new discharge date, it is apparent that the patient and their chosen representative do not intend to find an appropriate placement or have a desire to return home, the matron and/ or Head of Clinical services will meet with patient and/or their representative to:

- Explore the issues that they have in relation to discharge, including any concerns they may have and make it clear that it is not appropriate for the patient to continue to occupy a hospital bed when they no longer have a clinical need to do so.

- Advise the patient and their chosen representative of the actions the Trust will take to ensure that the patient is transferred or discharged from a community hospital or community bed and address any concerns they may have. A written record of this meeting should be provided to the patient together with a new discharge date and time.

- Re-iterate to the patient and their chosen representative, they have the option of transfer or discharge to their own home or alternative community setting as suitable. Depending on need, Health and Adult Care package options and resources may be available. The lead Nurse or Adult Care worker will be responsible for coordinating such a package as appropriate in partnership with the patient and their family.

- If the patient still refuses to leave, a meeting will be convened with the Trust Corporate Assurance Manager, Trust Security Management Specialist, Deputy Director of Nursing and the Deputy Director of Operations to determine the next course of action

7.3 Action to take when a patient is reluctant to be discharged when patients and/or family do not agree they are ready for discharge

In first instance the ward staff will discuss the rationale for discharge with the patient and their family to ascertain the reason for disagreement and to agree a shared way forward.

If the patient continues to disagree this will be escalated to the ward manager

The Ward manager will chair a case conference comprising the patient, chosen representative, ward nurse member of the medical team, Principal Practitioner or a manager from Adult Care, and any other relevant member of the multi-disciplinary team.

The purpose of the conference is to agree an action plan to move the patient to alternative accommodation as soon as possible.

The notes of the case conference which reiterates the agreement reached at the case conference will be sent to members of the MDT with a letter being sent to the the patient and their chosen representative within 24 hours of the action plan being formulated.

If NO agreement is reached the Ward Manager will notify the Matron and Head of clinical services who will discuss the situation with the Deputy Director of operations and the Deputy Director of Nursing

The Deputy Director of Operations will discuss this with the Chief Nurse, Director of Operations.

Appendix 1

Monitoring Template

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individuals/ group/ committee	Frequency of monitoring/audit	Responsible individuals/ group/ committee (multidisciplinary) for review of results	Responsible individuals/ group/ committee for development of action plan	Responsible individuals/ group/ committee for monitoring of action plan
Yearly	Audit	Community Hospital utilisation groups	Yearly	QSG	Community Hospital utilisation group	QSG

Appendix 2

Equality Analysis

Name of Policy/Procedure/Function* Choice Policy	
Equality Analysis Carried out by:	Sarah Mc Kown
Date:	8/8/16
Equality & Human rights Lead:	Rachel Higgins
Director\General Manager:	Lisa Green

***In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	Objective to ensure patients received clear discharge advice in a timely manner, to facilitate awareness and high involvement and self-management as appropriate		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	Yes policy public facing document		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No		
D.	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?	No		
		Yes	No	
	Disability		X	
	Sexual Orientation		X	
	Sex		X	
	Gender Reassignment		X	
	Race		X	
	Marriage/Civil Partnership		X	
	Maternity/Pregnancy		X	
	Age		X	
	Religion or Belief		X	
	Carers		x	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
Equality Analysis Carried out by:		Sarah Mc Kown		
Date:		8/8/16		

- Any community support appointment and when they will visit
- Your discharge summary and any special instructions you require
- Any outpatient appointment details you require
- Any contact telephone numbers or information leaflets you requested

Fit Notes and Claims
Please speak to a member of ward staff about this if required. They will be able to arrange fit notes and the signing of claims forms. You may be charged for some claim forms, but the ward will provide you with the information.

Friends and family test
LCHS staffs strive to take the best possible care of you while you receive services from us and routinely ask all our patients if they would recommend our hospital to family and friends as well as make any comments about the care received. You will be asked to complete a short questionnaire before/as you leave hospital. We value your feedback which helps us to improve our services.

Need further help?
If you are unsure about any part of the discharge process or who to contact after discharge, please ask your nurse or doctor who will be happy to help.

Hospital: _____	No: _____

Below are some useful numbers for patients, relatives and carers.

Lincoln County Hospital	01522 512512
Grantham Hospital	01476 565232
Pilgrim Hospital	01205 364801
Lincolnshire Community Health Services NHS Trust	01522 308686
Adult care customer services number	01522 782155
Citizens Advice Bureau	03444 111444
Age UK Spalding	01775 720305
Age UK Lincoln	01522 544635
Age UK Grantham	01529 302843
Age UK Lindsey (East and West)	01507 524242
Age UK Boston South Holland	01205 364161
Complaints Team	01522 309752
NHS 111 Service	dial 111
Patient Advice and Liaison Service	0845 602 4384
Red Cross	08450 547171
Addaction	01205 319920

Lincolnshire Community Health Services NHS
NHS Trust

Patients, Relatives and Carers

Please read

Shortly after being admitted to our hospital you will be informed of your Predicted Discharge Date (PDD). This is the date that your community hospital team feels you will be well and safe enough to leave hospital. Once your predicted date of discharge draws closer, you may no longer require the support of this ward and therefore the use of this bed and need to be in a more suitable environment for you. Our aim is to discharge you directly home or to your long term ideal place of residence, but it may be you have recovered enough to leave the community hospital but need further support to return home. On occasions we will step your care down to another setting, rather than going straight home. This will further your recovery, prior to returning home or ideal place of residence.

As you have been in hospital for more than two days this 'Ticket Home' information has been prepared with you and will remain at your bedside. The ticket includes your PDD, allowing you and your family or carers to make arrangements to ensure you are ready to leave the hospital.

Is there anyone we need to contact before you are discharged?
Please provide us with their details:

Name: _____
Telephone Number: _____

References

Department of Health (April 2016) part 7 – The NHS Choice Framework guidance for patients. DOH

LAC (95) 5: NHS responsibilities for meeting continuing Health Care needs.

NHS constitution (2015) Patients at the heart- Involved in patient care and evaluated. NHSC.

United Lincolnshire Hospitals NHS Trusts (2015) Choice on discharge from acute care policy. ULHT