**PATIENT DISCHARGE PROTOCOL**

<table>
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<tr>
<th><strong>Reference Number:</strong></th>
<th>NHSCT/09/106</th>
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<td><strong>Responsible Directorate:</strong></td>
<td>Emergency, Primary Care &amp; Older Peoples' Services</td>
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<tr>
<td><strong>Replaces (if appropriate):</strong></td>
<td>Legacy Homefirst Trust’s Reluctant Discharge Policy – (ID 927) and legacy Causeway Community Hospitals Patient Choice Protocol – Delayed Discharges (Ref CHSST/06/477)</td>
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</tbody>
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**NHSCT MISSION STATEMENT**

*To provide for all the quality of services we would expect for our families and ourselves*
PATIENT DISCHARGE PROTOCOL
Protocol for the Management of Delays in Discharge Related to Unavailability of Resources /Patient Choice (Excluding Mental Health Facilities)

1.0 Aim of the Protocol

The aim of the protocol is to reduce the delays associated with the unavailability of resources linked to assessed need at the point where patients are assessed as medically fit to leave hospital as well as addressing delays associated with patients choice of residential/nursing home placement being unavailable at the point the patient is declared medically fit to leave hospital .The protocol relates to patients in Antrim, Causeway, Whiteabbey, MidUlster, Braid Valley, Inver, Robinson and Dalriada Hospitals.

2.0 Definition of Delays

2.1 Definition of Delayed Discharge

A delayed discharge is defined as a delay in discharge from hospital of a patient whose treatment episode in an acute, rehabilitation or intermediate care bed is finished and who have been assessed by the responsible medical officer, in consultation with the multi-disciplinary team as appropriate, as medically fit to leave.

2.2 Definition of Delays Related to Unavailability of Resources

Delays related to unavailability of resources occur when the care package based on the assessed need is unavailable in total or part and the patient has been declared medically fit to leave hospital.

2.3 Definition of Delays Related to Patient Choice

Delays relating to patient choice occur when the patient or their relative or carer is reluctant to accept any of the following:

- the assessment of need and/or the identified resource to meet that need
- an available bed/facility for further assessment or to wait for their appropriate care option
- their choice of residential / nursing home placement is not available

Such delays could relate to patients awaiting transfer from an acute to an intermediate care bed, transfer from an acute or intermediate care bed, transfer to a residential or nursing home of choice or a care package to return to their own home.
3.0 Guiding Principles

3.1

As far as possible decisions about future care needs and how these can be met, such as the choice of a permanent residential or nursing home placement should be made outside of the hospital setting. Where possible assessment and rehabilitation options outside the hospital setting will be maximised to provide patients and their carers or relatives further time to make informed decisions about the patient’s continuing care needs. This will also facilitate patients requiring admission to an acute hospital bed to have access to such a bed.

3.2

It is recognised, however, that sometimes the assessment of care needs will indicate that the patient should move directly from a hospital setting to a long-term residential or nursing home placement. In these circumstances patients do not have the right to wait in a hospital bed for a vacancy in their home of choice if a suitable interim placement is available. In such circumstances the patient is required to move to the suitable alternative placement pending the availability of a place in the home of their choice.

3.3

Alternative arrangements should meet the needs of the individual and where possible, sustain or improve their level of independence. In identifying alternatives, due regard should be given to the suitability of alternative arrangements in relation to the individual’s assessed needs. Where an interim placement is required, the Trust will endeavour as far as possible to arrange this within the patient’s local area. This is dependent on the bed availability on the date of discharge and may not always be possible.

3.4

The Trust has considered its obligations under the Human Rights Act 1998 and in particular under Article 8 of the European Convention on Human Rights and therefore requires Trust staff to consult with the affected patient and his/her relative or carer in respect of future care arrangements following discharge from hospital. The Trust acknowledges that where patients are placed in residential and nursing homes outside of their chosen geographical area, that this may cause additional difficulties in terms of visitation particularly for older and disabled relatives and those using public transport. Trust staff will monitor and review the interim arrangement to ensure that the patient’s choice can be accommodated as soon as possible.
4.0 Protocol

4.1

All staff involved in the treatment and assessment of patients should familiarise themselves with a patient’s expected date of discharge and the medically fit date when known.

4.2

When the patient is declared medically fit, they must be ready for discharge within 72 hours. Treatments, assessments and care planning should commence as early as possible in the patient’s admission in order to avoid delays in discharging patients.

4.3

Assessment and rehabilitation within residential/nursing home placements will be maximised for those patients who are assessed as suitable for these options. This will encompass patients who will benefit from further assessment and time prior to making decisions as to their long term care requirements and also those for whom a period of rehabilitation or re-enablement is appropriate. Patients will be advised of the vacancies within the identified homes for assessment and rehabilitation in order to maximise appropriate placements and Trust funded placements.

4.4

The social worker and ward manager should work with the patient, carer or relative to explore any concerns they may have and should seek to identify a mutually agreeable outcome consistent with the terms of the protocol and DHSSPSNI delayed discharge requirements.

4.5

Discussions with the patient, carer or relative regarding options discussed, the discharge plan and agreements/disagreements to the discharge plan should be properly documented.

4.6 Community Care Package not available

The social worker should establish the availability of the care package (based on the assessed need) from the range of providers and also establish the source of funding. The social worker will ensure that patient, carer or relative is made aware of the current situation including which aspect(s) of the resource are unavailable at the point the patient is medically fit to leave hospital. The social worker will, based on a risk assessment, advise as to whether discharge with the available element(s) of the care package is appropriate. In the event where discharge with the available element(s) of the care package is inappropriate, the social worker will explore alternatives with the patient, carer or relative. This may require the patient’s transfer to a residential or nursing home placement to facilitate hospital discharge. The patient, carer or relative will be offered a “booked” bed in the first instance – these are beds contracted for this purpose (currently in Abbeylands PNH and Moneymore PNH). If there is no availability in these booked facilities, or a patient, carer or relative refuses, the patient, carer or relative will be asked to choose from the list of
 vacancies available. However, before any commitment is given, or any bed is booked on an 
adhoc basis, approval must be sought from an Assistant Director. This must be followed 
by a progress report to the AD, who approved spot purchase, on each placed client until 
they are allocated a package of care and have returned home. 
Information regarding the placement of a patient to any nursing bed (booked or adhoc) 
must be shared with community team on, or before, the time patient is physically 
transferred. This may initially involve a simple telephone call to the community team, but 
must be followed up, in writing, before the end of that working day. 
The social worker should make the multidisciplinary team aware of such interim plans and 
seek the Consultant’s support for such a plan so the patient, carer or relative can be 
supported in the interim discharge plan. The social worker will inform the patient, carer or 
relative that the patient will, with the support of a community named worker, transfer to the 
care package as soon as this is available and will not be disadvantaged in terms of their 
prioritisation for their care package. Assurance to this effect will be provided by the Trust to 
patients, carers and relatives. The Trust will also undertake to fund all costs associated with 
these interim residential and nursing home placements. 
The named worker will ensure that any patient awaiting a package of care, who has been 
transferred to Nursing Home beds (booked or adhoc), is reviewed at weekly interface 
meetings. They must provide this information to their Assistant Community Manager one 
day in advance of weekly meeting (or in AM of meeting if a patient placed late the previous 
evening). These clients must be prioritised at the interface meeting as urgent to ensure that 
the flow through booked beds is optimised and that the use of any other beds is kept to a 
minimum. Optimising flow will free booked beds for hospital discharge, whilst reducing 
length of stay (and bottlenecking) of patients temporarily placed in booked nursing beds. 
This will minimise the need for booking beds on an adhoc basis. 

4.7 Permanent Residential Home Placement not available

Where the assessed need is for residential care and this is unavailable, the social worker 
will explore an interim nursing home placement. The social worker should make the 
multidisciplinary team aware of such interim plans and seek the Consultant’s support for 
such a plan so the patient, carer or relative can be supported in the interim discharge plan. 
The social worker will inform the patient, carer or relative that the patient will, with the 
support of a community named worker, transfer to a residential placement as soon as this is 
available and will not be disadvantaged in terms of their prioritisation for the residential 
placement. Assurance to this effect will be provided by the Trust to patients, carers and 
relatives. The Trust will also undertake to fund any additional costs associated with these 
interim nursing placements.

4.8 For patients where the assessment of need is for permanent 
residential/nursing placement and the patient’s choice of permanent 
residential/nursing placement is unavailable.

Patients requiring residential or nursing home care will be asked to choose from the list of 
vacancies available. Where a patient, with the involvement of carer /relative, is discharged 
to an alternative interim placement, they should be able to revert to their first choice as 
soon as the preferred placement becomes available and should not be disadvantaged in 
their prioritisation for this. They will receive the active involvement of a community named 
worker in pursuing a placement in their home(s) of choice. Assurance to this effect will be
provided by the Trust to patients and their carers or relatives. The social worker should ensure that the Consultant is aware of these interim arrangements and seek their support for such a plan so the patient/relative/carer can be supported in the interim discharge plan. Patients will undergo financial assessment in line with Trust policy. The Trust will fund the “going rate” vacancy, the definition for the lowest price available to place the patient in suitable accommodation within the Trust locality at that time, (Trust Placement Policy - Nursing Home and Residential Home Accommodation). Patients who choose a more expensive vacancy to the “going rate” vacancy must be advised that this will incur a third party contribution.

4.9

Once the Consultant has determined that the patient is medically fit for discharge, they should remind the patient and carer/relative that the patient will be discharged as soon as an appropriate placement have been identified. The Consultant should at this time advise the patient and carer/relative that if required, the patient will be transferred to an alternative Trust facility or interim residential or nursing placement to await the home(s) of choice. After this stage has been reached every effort should be made to ensure that any delay in discharge is minimised and is as close as possible to the recorded expected date of discharge.

4.10 For patients where there is disagreement with the assessed need and/or the identified resource to meet the need.

The social worker will establish that the patient, carer or relative understands the assessment of need and identified resources to meet these needs by ensuring user-friendly information is made available. The social worker will establish in consultation with multidisciplinary colleagues that the patient has the capacity to make informed decisions and where there are concerns in this respect advise referral for mental capacity assessment.

4.11

The social worker will, based on a risk assessment, advise the patient, carer or relative of any risks associated with non-compliance with the resource identified to meet the patient’s needs.

5.0 Action to be taken when patient/relative is non-compliant with the protocol.

5.1

The Senior Social Worker will set up a meeting with the patient/relative/carer, Consultant, Ward Manager and Social Worker to agree a date and time for discharge or transfer to an alternative facility.
5.2

If agreement to discharge is not reached the patient’s Consultant, General Manager or Assistant Director, Ward Manager and Senior Social Worker are required to have a further meeting at which a discharge/transfer date will be set and discharge/transfer plan implemented. This should be within 5 working days of the first meeting. At this time a letter from the Chief Executive should be issued to give notice to the patient’s imminent discharge/transfer (see appendices 1 & 2).

5.3

On the day of discharge if the patient/carer/relative refuses to comply with discharge, the General Manager or Assistant Director will notify the appropriate Director. The Director may wish to seek legal advice in particular situations.
Appendix 1

Dear

Now that your medical care in hospital is completed, arrangements will be made for your discharge from hospital.

I understand that your choice of care home does not have a vacancy at this time. When this happens, it is the policy of the Northern Health and Social Care Trust that a patient should then move on a temporary basis to an alternative home/Trust facility, until a vacancy in their home of choice becomes available.

This action is necessary to ensure that patients who need to be admitted to hospital have access to a hospital bed.

I understand that the choice of a suitable care home is a vital decision for you, but it is not appropriate for patients to remain in hospital when they no longer require medical treatment.

Alternative care home arrangements have been made for you at ____________
I wish to give you notice that your discharge/transfer to________________ will take effect on ____________

I would like to reassure you that a Community Named Worker will be informed of your circumstances and will support you in securing a place in the home of your choice. I would also like to reassure you that moving to another home will not disadvantage you in terms of the priority given to ultimately securing your home of choice.

Thank you for giving your support to these alternative interim arrangements.

I wish you well following your hospital stay.

Yours sincerely

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Norma Evans
Chief Executive
Northern Health & Social Care Trust
Appendix 2

Dear

Now that your medical care in hospital is completed, arrangements will be made for your discharge from hospital.

I understand that your care package/residential home (delete as appropriate) is not available at this time. When this happens, it is the policy of the Northern Health and Social Care Trust that a patient should then move, on a temporary basis, to an alternative placement, until their care package/residential home (delete as appropriate) becomes available. In these circumstances the Trust will fund any additional costs incurred as a result of the alternative placement.

This action is necessary to ensure that patients who need to be admitted to hospital have access to a hospital bed.

I understand that a care package is necessary for you to return home, but it is not appropriate for patients to remain in hospital when they no longer require medical treatment.

Alternative care arrangements have been made for you at ________________
I wish to give you notice that your discharge will take effect on ________________
I would like to reassure you that a Community Named Worker will be informed of your circumstances who will continue to support you in securing your care package. I would also like to reassure you that moving to an interim placement will not disadvantage you in terms of the priority given to ultimately securing your care package.

Thank you for giving your support to these alternative interim arrangements.

I wish you well following your hospital stay.

Yours sincerely

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Ms N Evans
Chief Executive
Northern Health & Social Care Trust