Northern Health and Social Care Trust

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Reference No:	**NHSCT/15/926**		
Title:	**Reluctant Discharge Protocol** **(Protocol for situations where the patient (relative/carer) is reluctant for discharge**		
Policy Author(s):	Helen McClurg - General Manager Patient Pathway Anita White - Service Lead for Acute Care of Elderly and Hospital Social Work		
Responsible Director:	Olive MacLeod – Director of Nursing & User Experience		
Policy Type:	Trust Wide ☒	Directorate ☐ Specific	Clinical ☒
Policy Replacement:	Yes ☒ No ☐	Patient Discharge Protocol - NHSCT/09/106	
Directorates policy to be issued to:	Finance ☐ Medical & Governance ☒ Children's ☐ Mental Health & Disability ☒ Human Resources ☐ Acute Hospital Services ☒ Primary & Comm Care ☒ Nursing & User Exp ☒ Planning, Performance Management & Support Services ☐		
Target Audience, ie, specific staff groups	This policy is directed to medical, pharmacy, social work and nursing staff working with adult patients in both the acute and sub-acute hospital setting and community based staff who are involved in discharge arrangements and/or meetings		
Approved by:	 Co-chairs, Policy, Standards and Guidelines Committee	13 May 2015	
Operational Date:	20 August 2015		
Review Date:	31 October 2017		
Policy Library Categories: (Please tick as appropriate)	<u>Clinical & Social Care</u> Hospital (incl Comm Hosp) ☒ Children's Hospital & Community ☒ Mental Health, Learning & Physical Disability ☒ Community ☒ Finance ☐ Estates ☐ Health & Safety ☐ Human Resources ☐ Palliative Care ☐ Major Incident Plan ☐ Infection Control ☐ Information Management ☐ Family Planning ☐ Allied Health Professions ☐ Maternity & Gynae ☒ Trust Wide ☒		
NHSCT Mission Statement **To provide for all the quality of services we would expect for our families and ourselves**			

Northern Health and Social Care Trust

PATIENT DISCHARGE PROTOCOL FOR SITUATIONS WHERE THE PATIENT (OR RELATIVE/CARER) IS RELUCTANT FOR DISCHARGE

Contents

1.0 Summary of Policy

The aim of the protocol is to reduce the delays in the acute and sub-acute settings in NHSCT at the point where patients are assessed as medically ready to leave hospital and a suitable alternative facility, resources or service is available.

The protocol is applicable to patients within Antrim, Causeway, Whiteabbey and Mid-Ulster Hospitals. Input will be required as appropriate from relevant staff groups within the Acute Hospital Services Directorate as well as those staff from other Directorates who would be involved in discharge arrangements and/or discharge related meetings.

2.0 Responsibilities

Directors are responsible for the dissemination and implementation of this guidance within their directorates.

Line managers are responsible for ensuring that staff have a working knowledge of and adhere to the guidance and that any amendments are disseminated.

All staff to whom the policy applies are responsible for familiarising themselves with and adhering to this guidance.

3.0 Policy Statement

3.1 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 has been assessed by the responsible medical officer, in consultation with the multi-disciplinary team as appropriate, as medically fit to leave.

3.2 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 preferred choice of residential / nursing home placement is not available and they are unwilling to consider an alternative option.

Such delays could relate to patients awaiting transfer

- from an acute bed to a sub-acute bed e.g. for in-patient rehabilitation
- from an acute bed or sub-acute bed to an intermediate care facility
- from an acute or sub-acute bed to a temporary or permanent placement in residential or nursing home or
- from an acute or sub-acute bed to home

3.3 Guiding Principles

3.3.1

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 with 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.

3.3.2

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 and has been assessed as meeting the patient's needs. 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 at a later date.

A named worker will follow this up in the community after discharge

3.3.3

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.

3.3.4

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 preferred option can be accommodated as soon as possible.

3.4 Process

3.4.1

The information leaflet "Getting Ready to Leave Hospital "(Appendix 1) will be given by the nurse on admission to the patient /carer. The leaflet will have the initial Estimated Date of Discharge (EDD); this can be changed, depending on the clinical status of the patient throughout the period of acute/sub-acute intervention

3.4.2

The ward nurse will explain the EDD to the patient /carer. The patient/carer will be advised that the initial EDD is a guide only, will be revised daily by medical staff, and they will be updated accordingly. The nurse will explain the need for patient, carers, and multi-disciplinary team to work together to prepare for discharge on the EDD date.

Treatments, multi-disciplinary assessments and care planning should commence on the day of admission to avoid delays in discharging patients. When medical staff, in conjunction with the multi-disciplinary team decide that the patient has finished their acute/ sub-acute episode and no longer require an acute/sub-acute bed they must be ready for discharge.

3.4.3

Assessment and rehabilitation within the community setting 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 required. If a direct return home is not appropriate the Trust has access to intermediate care settings where the patient could transfer for a temporary period .Patients will be advised of the option appropriate to meet their assessed needs.

3.4.4

If the patient is unwilling to accept the option offered the Ward Sister/Deputy and, if appropriate, the social worker should work with the patient, carer or relative to explore any concerns they may have and should seek to reach an informal resolution. Discussions with the patient, carer or relative regarding options discussed, the discharge plan and agreements/disagreements to the discharge plan should be properly documented in the patient's ward notes.

3.5

Action to be taken when patient/ carer/relative are non - compliant with the protocol.

3.5.1

The senior hospital social worker will set up a meeting with the patient/relative/carer, Consultant (or medical representative) and ward manager. This will be to agree a date and time for discharge or transfer to an alternative facility which meets their needs. It is essential that the patient's consultant or medical representative chairs this meeting and takes forward this stage of the protocol. This should be held within one day of the patient/carer/representative indicating they are not willing to accept the option offered by social worker.

3.5.2

The patient's Consultant or their medical representative will at this meeting advise the patient and carers of the need to immediately comply with the discharge arrangements.

3.5.3

If agreement for discharge is still not reached the patient's Consultant or their medical representative, Senior Manager, Hospital Social Worker, Ward Sister, Lead Nurse/ community representatives (if necessary) and Patient Flow Coordinator (where applicable) will have a further meeting with the patient and carers to formally advise of a discharge date. This should be held within one/two days of the first meeting and will be chaired by the consultant.

3.5.4

If agreement to discharge is not reached the Ward Sister will issue the letter from the Director of Acute Hospital Services (Appendix 2) and explain the rationale around the need for discharge.

3.5.5

On the day of discharge if the patient/carer/relative refuses to comply with discharge, the ward manager will notify the relevant lead Nurse/General manager who will contact the relevant Director/Assistant Director who will request the Chief Executive to issue the Chief executive's letter to the ward manager to give to the patient. The Director may wish to seek legal advice in particular situations.

4.0 Monitoring

This policy will be monitored through implementation and evaluation by the users of the policy. The authors will audit its effectiveness during periods of implementation and amend as necessary.

5.0 Evidence Base/References

Legacy Homefirst Trust's Reluctant Discharge Policy – (ID 927) and Legacy Causeway Community Hospitals Patient Choice Protocol – Delayed Discharges (Ref CHSST/06/477)

6.0 Personal & Public Involvement (PPI)/Consultation Process

Consultation involved Trust Senior Management Acute and Community, Consultant Medical staff, Lead Nurses and General Managers, Ward and Department Managers, Patient Flow, Hospital and Community Social Services, the Trust's Legal Team and the Policy Standards and Guidelines Committee, Northern Health and Social Care Trust.

7.0 Equality, Human Rights & DDA

This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the 9 equality categories and no significant differential impacts were identified, therefore, an Equality Impact Assessment is not required.

8.0 Alternative Formats

This document is available, on request, in accessible formats, including Braille, CD, audio cassette and minority languages.

9.0 Sources of advice in relation to this document

The Policy Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

10.0 Policy Sign Off

Helen McClurg &

Anita White

Lead Policy Author s Date: 29th April 2015

Olive MacLeod

Director, Nursing & User Experience Date: 17th August 2015

11.0 Appendices/Attachments

APPENDIX 1 – LEAFLET "GETTING READY TO LEAVE HOSPITAL"

APPENDIX 2 – LETTER FROM RELEVANT DIRECTOR ACUTE SERVICES

APPENDIX 3 – LETTER FROM CHIEF EXECUTIVE

What will happen if my hospital treatment is completed and the particular support best suited to meet my needs is not available?

In this event you will be offered alternative interim support to allow you to leave hospital. A community social worker or community nurse will be allocated to you to ensure you receive the support best suited to your needs when it becomes available.

If I have been given items of equipment to assist with my care will these be provided to me when I am discharged from hospital?

If you need any equipment to allow you to return home safely, this will be arranged by the appropriate member of the hospital team. Further assessment for specialist equipment may be carried out once you have been discharged.

How will I get home?

You will be expected to make your own transport arrangements with your family / carer.
If there is a particular medical problem and your consultant feels that you need an ambulance, this will be arranged for you.

If I have been discharged but my family won't be able to collect me until later on, what should I do?

You should notify the nurse finalising your discharge who will consider if alternative transport can be arranged.

Northern Health and Social Care Trust

Email: info@northerntrust.hscni.net

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Appendix 1

Getting ready to leave hospital

Information about your discharge arrangements.

Patient name

Northern Health and Social Care Trust

Ward

Consultant

Nurse

Estimated discharge date

Who is responsible for my care?

You have been admitted under the care of a consultant and their team. The hospital team includes nurses, physiotherapists, pharmacists, occupational therapists, podiatrists and social workers.
Appropriate members of the team will be identified who can contribute to your care. If you need to be transferred to the care of a different consultant and their team, this will be discussed with you.

Will I stay in the same bed/ward for all of my hospital stay?

Sometimes this may be the case, however, for some people, transfer to a more appropriate setting is necessary to meet their medical needs at that time. This may be a different bed in the same hospital, or a bed in a community facility. You will be informed by the doctor or nurse of any such transfers and the reason for this.

When can I go home?

Early in your hospital stay your consultant will inform you of an estimated date of discharge and we will keep you updated if this date changes. The date is to help you and your family plan ahead. Please ask if you are unsure about your estimated date of discharge.

You should also inform your doctor or nurse of any existing supports you have such as family support or any community services you already receive, so these can be taken into account when planning your discharge.

You will normally be discharged before 1.00 pm on the day you are due to leave hospital so that any support services that need to commence on the day of your discharge, can be arranged.
Please ensure that you have made plans to be collected before 1.00 pm.

What will happen if my hospital treatment is completed and I have concerns that I will need additional support to return home?

Your future care needs and the most appropriate support arrangements if required will be identified as early as possible in consultation with you and your family.
The majority of hospital patients continue to make progress after discharge so for this reason any home care services arranged by the Trust will be of a temporary nature and will be reviewed on an ongoing basis after you go home. This is to ensure that you continue to have the right amount of support and that you are assisted to become as independent as possible.

What will happen if my hospital treatment is completed and I still have concerns that it is too early to return home even with additional supports at home being made available to me?

If it is agreed that you should not return home immediately because you need further assessment or therapy, we will discuss other options for additional short term support with you such as input from the community intermediate rehabilitation and support team at home. In some cases it may be necessary for you to transfer to one of the Trust's non-acute beds if this is appropriate for your treatment needs, or to allow you and your family time to make decisions about future long term care arrangements. The hospital team will be able to advise as to which option is best for you.

Northern Health and Social Care Trust

Appendix 2 Director's Letter

Dear

I understand that you no longer require an acute/sub-acute hospital bed and your preferred option for discharge is not available (to be amended if appropriate)

Whilst I am aware that this choice is very important to you, I wish to advise you that it is not possible for you to remain in _____ Hospital to await your preferred option. Hospital beds are required for people who are in need of hospital care and any unnecessary extension of your stay will prevent our ability to admit other patients.

Therefore, it is essential that you accept alternative arrangements where your needs will be met until your preferred option becomes available. The Hospital Discharge Team and your Care Manager will facilitate your transfer if it is still considered necessary to meet your needs at that time.

If you have any queries or require further information, please raise them with your Ward Sister or Social Worker who will be happy to help you.

Yours sincerely

_____

Director

Appendix 3 Chief Executive's Letter

Dear

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

I understand that your preferred option 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 facility or service which meets their needs.

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

It is not appropriate for patients to remain in hospital when they no longer require medical treatment.

As alternative arrangements have been made for you which meet your assessed needs I wish to give you notice that your discharge/transfer will take effect on

_____

I would like to reassure you that a Named Worker will be informed of your circumstances and will support you in the temporary arrangement

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

If you have any queries or require further information please raise with your Ward Sister/Charge Nurse or social worker who will be happy to help you.

I wish you well following your hospital stay.

Yours sincerely

.....

Chief Executive
Northern Health & Social Care Trust

Northern Health and Social Care Trust

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Reference No:	**NHSCT/18/1260**		
Title:	**Contingency Placement Policy**		
Key words within policy (max 10 words):	Delays, Discharge, Temporary, Placement, Beds, Community		
Policy Author(s):	Colleen Morrison, Community Locality Manager Antrim / Ballymena Locality		
Responsible Director:	Phil Hughes, Interim Divisional Director of Community Care		
Policy Type:	Trust Wide ☒	Division Specific ☐	Clinical and/or social care ☒
Policy Replacement:	Yes ☒ No ☐	If yes state name and reference number of policy being replaced – NHSCT/12/611	
Directors/Divisions policy to be issued to:	Nursing ☒ Medicine ☒ Finance ☐ Medicine and Emergency Medicine ☒ Human Resources, Organisational Development and Corporate Communications ☐ Community Care ☒ Surgical and Clinical Services ☒ Mental Health, Learning Disability and Community Wellbeing ☒ Women, Children and Families ☒ Strategic Development and Business Services ☐		
Target Audience, ie, specific staff groups	Service Users and Carers, Hospital Social Work Teams, Community Discharge Coordinators, Community Discharge Facilitators, Acute Medical Staff, GPs facilitating the Community Beds, Northern Trust Senior Management Teams, Community Locality Managers, Community Area Managers, Community Team Managers, Multidisciplinary Team Members in Community Teams, Multi-disciplinary Team Members in Acute Services, Northern Trust Residential Unit Staff, Community Hospital Staff, Managers and Staff of Private Nursing Homes		
Approved by:	*Dr Kate Scott & Mrs Suzanne Pullins* Co-chairs, Clinical and Social Care Policy and Guidelines Committee	20 December 2018	
Operational Date:	20 December 2018	**Review Date:**	30 September 2021
Policy Library Categories: (Please tick as appropriate)	Clinical and Social Care - Hospital (incl Comm Hosp) ☒ Clinical and Social Care - Children's Hospital & Community ☐ Clinical and Social Care - Community ☒ Clinical and Social Care - Mental Health and/or Learning Disability ☐ Children's Nursing ☐ Maternity & Gynae ☐ Estates ☐ Health & Safety ☐ Human Resources ☐ Palliative Care ☐ Major Incident Plan ☐ Infection Control ☐ Information Management ☐ Family Planning ☐ Allied Health Professions ☐ Finance ☐ Trust Wide ☒ Safeguarding Children ☐		

NHSCT Vision
To deliver excellent integrated services in partnership with our community.

Contingency Placement Protocol

Contents **Page Nos**

1.0 Summary of Policy

It is vital that we provide high quality care at the right time, in the right place and by the right people, to reduce pressure on our hospital services.

Contingency placement is a temporary admission to a community bed. This placement is utilised to facilitate a service user's discharge from hospital within 48 hours of being assessed as medically fit to leave.

The overall aim of the policy is to prevent delays from the acute, subacute and community hospital facilities, when a package of care or item of equipment is not immediately available. Adherence to the policy will ensure bed flow can be maintained and services users are discharged in a safe, timely and co-ordinated way.

2.0 Responsibilities

The Community Director will maintain an overview of the policy and seek assurance of appropriate management of the contingency beds

The Community Assistant Directors will evaluate the contingency bed policy and guide and direct change as necessary.

Locality managers will oversee the implementation of the policy.

Area Managers will monitor and report the outcomes of the policy.

Community Discharge Co-ordinators (CDC) will be responsible for screening and allocating patients to an appropriate bed.

General Practitioners will provide medical cover as part of a service level agreement with the NHSCT. The decision to accept / decline patients will be the responsibility of the GP.

Dalriada Urgent Care will provide out of hours cover as part of a service level agreement with the NHSCT.

Ward Sisters / Person in charge of facilities will clarify points of care and ensure governance issues are met for their individual facilities before a patient is accepted.

A Community Discharge Facilitator will be assigned to each client to pursue an effective discharge pathway.

3.0 Policy Statement

Contingency 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 individual's assessed needs. Where an interim placement is required, the Trust will endeavour as far as possible to arrange this within the service user's local area. This is dependent on bed availability on discharge and may not always be possible. Trust staff will endeavour to involve patients and carers throughout the discharge process.

The Community Discharge Facilitator (CDF) / Named Worker will monitor and review the interim arrangement to ensure that the package of care or equipment required is secured as quickly as possible to support the service user's return home.

Process for Contingency Placement from an acute hospital bed / sub-acute hospital bed / community hospital bed (including responsibilities):

- All usual hospital discharge care pathways should be explored in the first instance

- Service users will discharge from a contingency bed when the Trust is able to put in place reasonable care arrangements to facilitate the service user's return home

- On receipt of a referral for a contingency placement all community booked beds should be considered in the first instance by the Community Discharge Co-ordinator (CDC)

- Service Users should be offered a bed in the most appropriate environment that will best meet their needs. In the event of all booked beds being occupied an ad hoc placement may be required.

- Adhoc beds require Assistant Director approval. If an adhoc bed is required requests should be made to the relevant programme of care by the CDC. If there is a delay in response the CDC will escalate to their Line Manager.

- The CDC will ensure medical cover is sought for the service user transferring to a contingency placement

- Service users will not be financially assessed where the Trust has to implement contingency arrangements due to package of care or equipment not being available to facilitate the service user's discharge home

- Beds at tariff rate will be commissioned in the first instance, where these are not available the going rate will apply. Where a family indicate a preference

for a home which is above tariff or going rate this marginal difference should be met by the family.

- Once a bed has been arranged the CDC admin support will place the service user's details on Openward for follow up by the relevant CDF / Named Worker.

- The CDC will forward the discharge information to the appropriate GP (next on rota,) Community Team and Community Discharge Facilitator within 24 hours of referral to ensure timely follow up; for service users waiting on a package of care or equipment this will include - MDT assessments and screening sheets. Hospital Social Work will forward a Domiciliary Care Referral Form and copy of the care plan.

- In exceptional circumstances it may be deemed appropriate to place a service user in a bed with a third party contribution having given consideration to individual circumstances. Authorisation for such a placement at Trust cost must be secured by the CDC through completion of an escalation form signed by the appropriate Assistant Director. The escalation form should be completed by CDC when offering a bed.

- The Community Discharge Facilitator / Named Workers in the relevant Community Team will be responsible for ensuring that the service user is discharged as quickly as possible from the contingency bed. Community workers must contact the CDC when the bed is released to ensure maximum usage of Community Beds.

- On discharge from the contingency placement the CDF / Community Named Worker will be responsible for informing CPBU with 24 hours of discharge

- The CDF/ Community Named Worker is responsible for ensuring the care needs identified in the hospital are still appropriate to meet the service users' needs on discharge from the contingency bed

- The Community Team Manager / CDF will be responsible for updating Openward with progress plan.

- Openward will be reviewed daily by Community Managers.

NB: There may be times when the community nursing bed stock needs to be maintained for higher acuity patients. When this occurs there is a need to step patients down to a residential home (contingency bed.) It is vital on these occasions that the CDC are notified, via the CDC admin support, so they can retain their overview of available bed stock. On discharge from these facilities the CDF will send the updated reports, provide a care plan and organise transport.

This transfer will be dependent on the ability to secure GP cover, which needs to be within the GP catchment area.

4.0 Monitoring (including audit)

This protocol will be monitored through the recording of Openward reporting and daily performance meetings.

5.0 Evidence Base/References

- Bengoa (2016) Report Systems, Not Structures - Changing Health and Social Care.
- DHSSPS (2011) Transforming Your Care – A Review of Health and Social Care in Northern Ireland.

6.0 Personal & Public Involvement (PPI)/Consultation Process

The following internal and external stakeholders have been consulted in the development of this policy:

Representatives from the Community Care, Mental Health and Acute Divisions.

7.0 Equality, Human Rights & DDA

This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the 9 equality categories.

The policy has been '**screened out**' without mitigation or an alternative policy proposed to be adopted.

8.0 Alternative Formats

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

9.0 Sources of advice in relation to this document

The Policy Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

10.0 Policy Sign Off

Colleen Morrison

Lead Policy Author — Date: 25 June 2018

Roy Hamill

Assistant Director — Date: 20 December 2018