Western Health
and Social Care Trust

POLICY FOR THE MANAGEMENT OF PATIENT CHOICE RELATED DISCHARGE DELAYS IN WESTERN TRUST HOSPITALS

January 2021

<table>
<tr><td>Policy Title</td><td colspan="3">Policy for the Management of Patient Choice Related Discharge Delays in Western Trust Hospitals</td></tr>
<tr><td>Ownership</td><td colspan="3">Assistant Director: Care & Accommodation – Primary Care & Older People's Services</td></tr>
<tr><td>Reference Number</td><td colspan="3">PrimCare12/002</td></tr>
<tr><td>Approval By</td><td>Trust Board</td><td>Approval Date</td><td>7 January 2021</td></tr>
<tr><td>Original Implementation Date</td><td colspan="3">August 2012</td></tr>
<tr><td>Version No</td><td>Supersedes</td><td colspan="2">Version 1 – August 2012
Version 2 – August 2014
Version 3 – September 2018</td></tr>
<tr><td>Review Date</td><td colspan="3">January 2023</td></tr>
<tr><td>Links to Other Policies</td><td colspan="3"></td></tr>
</table>

CONTENTS

SECTION		PAGE
	GLOSSARY OF TERMS	4
1	INTRODUCTION	5
2	PATIENT CHOICE RELATED DELAYS	5
3	AIMS OF THE POLICY	6
4	RIGHTS AND RESPONSIBILITIES	6
5	DISCHARGE PROCESS FOR PATIENT CHOICE RELATED DELAYED DISCHARGES	8
6	STEPS TO BE TAKEN IF PATIENT/FAMILY/MAIN CARER DISAGREES WITH THE DISCHARGE PLAN	11
7	EQUALITY STATEMENT	12
	APPENDICES	
Appendix 1	Getting Ready to Leave Hospital Leaflet	14
Appendix 2	Discharge from Hospital - Information for Patients Leaflet	16
Appendix 3	Useful Contacts	18
Appendix 4a	Checklist to assist in choice of nursing home	19
Appendix 4b	Sharing of Information Record	20
Appendix 5	Templates for Discharge Letters	21

GLOSSARY OF TERMS

Regional Rate: The Health and Social Care Board (HSCB) negotiates on an annual basis on behalf of Trusts, a regional weekly tariff rate with the independent sector for residential and nursing home care.

Top-Up Fee: A top-up fee is the amount of money requested by a nursing home over and above the agreed regional rate between nursing home and Trusts. These amounts vary, and payment of same is normally the responsibility of the patient/family in an agreement with the nursing home provider.

Estimated Discharge Date (EDD): An estimated date made by the consultant when a patient will be ready to leave an acute hospital setting.

Medically Fit for Discharge: Defined as: "a patient is declared medically fit when they no longer require care in an acute hospital bed, as decided by the responsible medical officer (Consultant, or designated other) in consultation with the multi-disciplinary colleagues as appropriate". (Source: Department of Health).

Multi-Disciplinary Team (MDT): A multi-disciplinary team is a group of health care workers who are members of different disciplines (professions, e.g., social workers, nurses, AHPs, etc.), each providing specific services to the patient. For the purposes of this policy, each member of the team co-ordinates their services and work together to facilitate the patient's discharge from hospital or other health care facility.

Delayed Discharge: Defined as: "a delay in discharge from acute hospital of patients whose treatment episode in hospital is finished and who have been assessed as medically fit to leave". (Source: Department of Health).

Self-Directed Support: is the way the social care system now operates to give individuals who are eligible for social care services, choice, control and flexibility over the support they receive. Self-Directed Support includes a number of options for getting support. The individual's personal budget can be:

1. Taken as a Direct Payment
2. A managed budget (where the Trust or a 3rd party organisation holds the agreed budget but the person is in control of how it is spent)
3. The Trust can choose and arrange a service on behalf of the individual (the provision of a domiciliary care package)
4. Or a mixture of all three above

Charging for Residential Accommodation Guide (CRAG) - provides guidance to local authorities on how to interpret and apply the regulations on completing financial assessments for individuals requiring nursing or residential home placement

1 INTRODUCTION

This Policy should be read in conjunction with the following publications:

- Getting Patients on the Right Road for Discharge (Department of Health, 2016) (www.health-ni.gov.uk)
- Self-Directed Support: User Guide (Western Health and Social Care Trust; www.westerntrust.hscni.net)
- Health & Social Care Board Commissioning Plan 2017/2018: with reference to Delayed Discharge target and Improving Mental Health Services (Health and Social Care Board; www.hscboard.hscni.net)
- Discharge of Hospital Patients, circular ECCG 1/98 (Department of Health) (www.health-ni.gov.uk)
- A Report into Unsafe Discharges from Hospital (Parliamentary and Health Service Ombudsman, May 2016) (www.ombudsman.org.uk)
- Good Practice in Consent; Consent for Examination, Treatment or Care (DHSSPS 2003) (www.health-ni.gov.uk)
- Safety and Quality Reminder of Best Practice Guidance - SQR-SAI-2020-065 - OPS & AS - Care Home Admission and Initial Review (www.health-ni.gov.uk)

These publications set out the principles and quality standards that underpin the approach to the practical application of this policy.

2 PATIENT CHOICE RELATED DELAYS

2.1 Discharge delays are defined as delays in the discharge of patients within the following Western Trust facilities:

- Altnagelvin Area Hospital
- South West Acute Hospital
- Omagh Hospital and Primary Care Complex
- Waterside Hospital (Rehabilitation and Older People's Mental Health Wards)
- Tyrone and Fermanagh Hospital (Oak and Ash Wards)

2.2 Patient choice related delays are a subset of all delays and mainly occur when the patient or carer has identified their choice of nursing or residential home that has no vacancies at the time they are ready for discharge and the patient is subsequently delayed in hospital beyond their medically fit date.

The terms of this policy will also be applied if the patient's assessed self-directed support option cannot be provided at the time they are medically fit for discharge.

2.3 A reduction in patient choice related delays will promote patient safety and ensure that patients ready to leave hospital are cared for in an environment that can safely and appropriately meet their assessed needs. The timely and effective flow of patients through hospital and other health care facilities ensures timely and appropriate access to specialist resources by those who require them most.

3 AIMS OF THE POLICY

3.1 The aim of this policy is to describe a process for managing situations where the patient's preferred choice of residential or nursing home placement or self-directed support option, wholly or partly, is not available at the time the patient is medically fit for discharge from hospital. It is designed to be in line with *Getting Patients on the Right Road for Discharge Guiding Principles 2016*.

3.2 The Policy recognises the importance of the safe care and treatment of patients being supported by a clear and equitable approach to discharge planning.

3.3 The Policy applies regardless of how the individual care package is to be funded; whether the package is largely self-funded in part or whole, or is wholly funded through the Health and Personal Social Services system.

4 RIGHTS AND RESPONSIBILITIES

4.1 All Health and Social Care Trusts have a responsibility to ensure that patients are discharged from hospital as soon as possible after they no longer require acute hospital care and appropriate after-care arrangements have been made. Aftercare will be provided within the Self-Directed Support Framework and agreement of a preferred personal budget option.

4.2 The patient leaflet *Getting Ready to Leave Hospital* should be shared with and clearly explained to the patient and/or family on admission to hospital by the ward staff. The Hospital and Community Social Worker should share and discuss this policy with the patient/family/carer.

4.3 Patients and their families/carers should be informed that they have a responsibility to work constructively with all staff involved in their care to ensure timely discharge from hospital.

4.4 Patients have a right to expect choice from within available options. However, the consultant with responsibility for the patient's care should advise the medically fit patient and/or their family/carer, that they do not have the right to

wait in hospital for a vacancy in their home of first choice, or if there is a delay in providing their self-directed support option, if a suitable interim placement is available. The role of the hospital/community social worker is to facilitate the medically fit patient's discharge from hospital to the interim placement, as well as providing reassurance about any concerns they may have.

4.5 In instances described in paragraph 4.4, patients have the right to expect that the Trust will normally identify one or more appropriate and affordable alternative homes, from which they will be expected to choose. The Trust will make every effort to identify those homes that are not subject to a "top-up fee". However, if this is not possible, the Trust will accept responsibility for paying top-up fees for the duration of the interim placement, to ensure patient flow through the hospital system. If and when the patient's first choice of placement becomes available and the service user wishes to remain in the home with the top-up fee they were transferred to as an interim placement, the patient's community care manager will discuss the payment of the top-up fee with the patient/carer/family in order to reach agreement.

4.6 There may be instances when individuals are transferred to an interim nursing/residential home placement whilst waiting on their self-directed support option and their condition deteriorates or other circumstances alter to such an extent that their assessed needs change to requiring a permanent nursing or residential home placement. The individual's community social worker will identify this through the care monitoring and review process and will conduct updated assessments and changes to the original care plan. This will include the completion of a financial assessment if necessary.

4.7 The Trust has a responsibility to ensure that due regard is given to individual circumstances in identifying a suitable interim placement that will take into consideration the following issues:

- the patient's assessed needs
- the patient's spiritual and cultural needs
- travel arrangements for carers and family within the Western Trust catchment area
- the likely duration of the interim placement

4.8 Patients who have been moved to an interim placement have the right to receive the active support of their key worker in transferring to their first choice of nursing/residential home as soon as a bed becomes available or returning home as soon as their self-directed support option is in place.

5 DISCHARGE PROCESS FOR PATIENT CHOICE RELATED DELAYED DISCHARGES

5.1 As already stated at paragraph 4.2, ward staff should provide the patient and/or family with a copy of the leaflet *Getting Ready to Leave Hospital* on their admission to the ward. This leaflet should contain details of the patient's estimated discharge date (EDD).

5.2 Any member of the multi-disciplinary team involved in the patient's care has a responsibility to inform the hospital social worker as soon as possible, if it becomes known during the assessment process that the patient's first choice of nursing/residential placement, or self-directed support option, may not be available when the patient is ready for discharge.

5.3 The consultant with responsibility for the patient's care will advise the patient and/or family when they are medically fit for discharge and that they may have to move to a different nursing/residential home until their first choice of home becomes available, or until their self-directed support option is available. All members of the multi-disciplinary team involved in the patient's care and discharge should refer to *Good Practice in Consent*, to ensure those patients (and/or family) who have difficulties in making their own choices are given sufficient opportunity to discuss the most suitable options available to them.

5.4 The hospital/community social worker will immediately arrange for a pre-admission assessment from the nursing/residential home provider. A copy of the multi-disciplinary assessment and the outcome should be available to the patient and/or family.

5.5 The team of staff planning the patient's discharge will identify and communicate a planned date for discharge and they will work to discharge the patient on the date identified. If the patient is unable to be discharged on that date, his/her name will be placed on a delayed discharge list. Once the date has been recorded on the Patient Administration System (PAS), monitoring will begin against the 48 hour standard for complex discharge.

5.6 The hospital/community social worker must get approval from the Head of Service/Locality Service Manager/Assistant Director, before any commitment is given for a residential/nursing home bed to be booked. Following approval, the hospital/community social worker will secure funding for the agreed care plan. Prior to discharge, the Care Home Manager will be required to confirm that they have read all pre-admission documentation and that they can meet the particulars of the care being commissioned, the Care Home Manager will be required to sign Sharing of Information Record for retention in Social Work Records (See Appendix 4b).

5.7 It is important that the community social worker provides reassurance to the patient/family/carer, that their first choice of placement/self-directed support option will be actively pursued and that they will not be disadvantaged because of the interim arrangements. It is the responsibility of the community social worker to ensure that their client's name is on the waiting list of all suitable nursing homes within the Trust area if there are no immediate suitable vacancies within the patient's home area. The community social worker should provide a regular report to their line manager on the progress being made to secure the patient's first choice of nursing/residential home or full implementation of their self-directed support option.

5.7 All available information, including the interim placement's latest Regulation and Quality Improvement Authority (RQIA) inspection report; contact details for RQIA; a checklist of points to look for in assessing the suitability of a nursing/residential home (Appendix 3), should be made available to the patient/family/carer.

5.8 The Trust will undertake to fund the costs associated with interim residential/ nursing home placements for those patients awaiting self-directed support options. Patients who are assessed as requiring residential/nursing home care and whose first choice of home is not available will be required to have financial assessments completed. Patients transferred to a nursing/residential home whilst waiting on their self-directed support option to be provided, will be prioritised as urgent for securing their entire option to enable them to return home.

5.9 The Trust will only transfer patients to alternative nursing/residential homes that are covered by the regional rate. The Trust will only place a patient in a home that requires a top-up fee if the patient/family signs a written agreement with the nursing home provider to pay the top-up charge. In circumstances where the only interim placement is available in a home with a top-up fee, the Trust will pay the top-up fee.

5.10 The Care Manager/Hospital Social Worker will work with the patient/carer to discuss any concerns and to seek a mutually agreed outcome, consistent with the terms of the Policy. It is recognised that some patients or their family/ carer may wish to seek the involvement of an independent advocacy or support service. In these circumstances, they should be facilitated in accessing such services.

5.11 The Trust will endeavour to secure placement as close as possible to the area identified by the patient/family/carer. If this is not possible, the Trust will make every effort to secure placement within a 35 mile radius of the patient's local

area. It should be noted that in exceptional circumstances, the Trust may need to place the patient in a home outside the 35-mile radius area.

5.12 In instances where patients have to be placed outside the 35-mile radius, this situation will be monitored closely by the care manager involved and as soon as a placement is available nearer to the person's home, transfer arrangements will be made. Information as at paragraph 5.7 will be made available to the patient/family/carer.

5.13 If patient/family/main carer disagrees with the patient being deemed medically fit/multi-disciplinary fit, the decision will be revisited by the medical staff and the multi-disciplinary team. Consideration is given to patient/family/main carer comments and concerns and the senior staff meet with the patient/family/main carer to further explain the rationale for decision.

5.14 The patient's family member(s)/friend(s) should be advised of their right to an assessment of their needs by a social worker (known as a Carer's Assessment), if they have a regular and substantial role in caring for the patient

5.15 Patients will be expected to make their own travel arrangements on discharge, in conjunction with their family/main carer. An ambulance is arranged only if there is a medical need. However, it is recognised that most patients transferring to a nursing home will require an ambulance for transfer.

6 STEPS TO BE TAKEN IF PATIENT/FAMILY/MAIN CARER DISAGREES WITH THE DISCHARGE PLAN

If a member of the MDT becomes aware of any issues regarding agreement with the patient discharge plan, they should escalate this to the Social Worker to commence Step 1 of the following plan.

STEP	TIMEFRAME	ACTIONS TO BE TAKEN
Step 1	Within 24 hours	The Social Worker and the Ward Manager or their deputy, jointly meets with the patient/family/carer to resolve any issues regarding the discharge plan. If this meeting does not resolve the issue, then step 2 is initiated immediately.
Step 2	Within 24 hours of previous step	Appropriate members of the MDT and community team members (e.g., the Hospital Social Worker and other programmes of care) meet with the patient/family/carer to try to reach a resolution. This is arranged for the earliest opportunity. If this meeting does not resolve the issue then step 3 is initiated immediately by hospital social worker.
Step 3	Within 24 hours of previous step	If family/MDT meeting has not been successful, senior medical staff and appropriate members of the MDT meet with the patient/family/main carer to inform them that the patient is fit for discharge and detail the care package/care home arrangements that can be provided to meet their assessed critical and substantial needs. If this meeting does not resolve the issue then step 4 is initiated immediately
Step 4	Within 24 hours of previous step	If discharge still cannot be facilitated, the appropriate Assistant Director(s) /Director(s) will be advised. The appropriate Assistant Directors of Acute and Community Services will liaise to agree a plan, which may include one or both of the Assistant Directors meeting with the patient/family/carer.
Step 5	Within 24 hours of previous step	If the discharge still has not been facilitated, the Director of Acute Services or the appropriate Director of Community Social Services will inform the patient/ family/main carer *in writing* of the discharge decision.
Step 6	Same day as written communication of decision to family.	The appropriate Director liaises with the Chief Executive and the Department of Health, outlining the steps that have been taken to facilitate patient discharge. Reference will be made to the HSSPS Circular HSC (ECCU) 1/2010; Care Management, Provision of Services and Charging Guidance.
Step 7	Within 48 hours of previous step	The Chief Executive informs the patient/family/carer in writing of the discharge decision (see Appendix 5) NOTE: In cases where the patient resides outside the Western Trust, the case will be escalated, following the above principles with the appropriate personnel within the patient's locality
Step 8	At the same time as Step 7	In situations where resolution has not been achieved and patient discharge has not happened, the case will be referred to DoH and legal bodies for support in proceeding to implement patient discharge out of the hospital setting.

See Appendix 5 for all letters

7 EQUALITY STATEMENT

In line with duties under the equality and human rights legislation (Section 75 of the Northern Ireland Act 1988), targeting Social Need Initiative, Disability Discrimination and Human Rights Act 1998, an initial screening exercise was carried out to ascertain if this policy should be subjected to a full equality impact assessment. The outcome of the equality screening indicated that an equality impact assessment was not required for this policy as

8 Monitoring arrangements

The Hospital Social Work Service must ensure that an accurate, up to date record is available that reflects adherence of this policy.

Hospital Social Work records must also be updated regularly throughout the process to record relevant dates of each meeting or correspondence, under this policy, in relation to progressing discharge from hospital.

The Hospital Social Work service should undertake regular self-audit to ensure that this policy is being adhered to using the self- audit tool in Appendix 7 (minimum, once yearly) and where necessary to make recommendations for improvement. The audit should then be shared with the relevant Social Worker, Social Work Manager and Head of Discharge and Hospital Social Work. If necessary, a date for review of action around recommendations should be set at this time.

Appendices

Who can I talk to about my future care needs?

You should talk to the nurses caring for you in the first instance. If you need help or rehabilitation when you go home, we will discuss the options with you and your family. If you need any equipment, this will be arranged by the hospital team with the community staff. Further assessment for specialist equipment will be carried out after you have been discharge.

What if I am better, but not quite well enough to go home?

If the team caring for you feel you would benefit from a short period of rehabilitation, they will refer you on to the community team.
Your rehabilitation could take place either at home, in a care home or in a rehabilitation unit.
Wherever possible, and within resources, you will be offered a choice from a range of options, based on clear and accurate information.
Your first or second choice of care home or all/part of your domiciliary care package for example, may not be immediately available, but may be available at a later date.
In this event, you will be expected to accept placement in another care home until your domiciliary care package or your preferred choice of care home become available.
We can provide an interpreter while you are a patient in the hospital. If you need this service, please ask one of the nurses on the ward to arrange this

Thank you for your co-operation. If you have any other questions, please do not hesitate to ask.

APPENDIX 1

Western Health and Social Care Trust

GETTING READY TO LEAVE HOSPITAL

This leaflet provides information about your discharge arrangement

June 2017

Patient's Name	
Date of Admission	
Ward	
Consultant	
Your estimated discharge date is	

Who is in charge of my care?
You have been admitted under the care of a consultant and his/her team. If you need to be transferred to the care of a different consultant's team, this will be discussed with you.

LEAVING HOSPITAL
When can I go home?
A team of health care staff, including doctors, nurses, physiotherapists, occupational therapists, dieticians, speech and language therapists, podiatrists and social workers as appropriate, will be involved in caring for you during your stay in hospital. Their aim is to help you to get home as soon as you are able.
Early in your hospital stay, the team will discuss with you arrangements for leaving hospital and agree an estimated discharge date. This date is to help you and your family to plan ahead. Please ask if you are not sure what your estimated date is for going home.

What time can I go home?
The ward staff will let you know what day you can go home. You will normally be discharged in the morning on the day you are due to leave hospital.

My family won't be able to collect me until later. What shall I do?

If for some reason you cannot be collected in the morning, the ward staff will ensure you have a place to wait on the ward as your bed will allocated to another patient as appropriate.

Hospitals are the right place to be when you are in need of specific medical or surgical treatment. However, when your treatment has been completed, it is important that your stay is not delayed.

- Beds are required for people treated in the emergency hospital admission system.
- Beds are required for people needing ongoing medical attention.
- People also awaiting surgery may have their operations cancelled if a bed is unavailable.
- There is a risk of acquiring infections in hospital, so leaving at the earliest opportunity means this is less likely.

How will I get home?

You will be expected to make your own transport arrangements with your family/carer.

If your consultant feels that you need an ambulance due to a particular medical problem, this will be arranged for you.

What happens if I am not well enough to leave hospital?

You will only be discharged if the team caring for you feel that you are well enough. If you are not, they will agree a new discharge date with you.

Contact Details

Hospital Social Work Teams:

Altnagelvin Hospital	028 71345171
South West Acute Hospital	028 66382000
Omagh Hospital	028 82833100
Waterside Hospital	028 71860007

Community Teams:

Castlederg	028 81672840
Enniskillen	028 66321011
Irvinestown	028 66382702
Limavady	028 77761100
Lisnaskea	028 66324042
Omagh	028 82833100
Physical Disability Team	028 71354031
Community Mental Health Team for Older People, Cityside/Strabane and Waterside/ Limavady	028 71864384
Community Mental Health Team for Older People, Omagh	028 82235993
Community Mental Health Team for Older People, Fermanagh	028 66344048
Riverview	028 71266111
Sensory Support Team	028 71320167
Shantallow	028 71351350
Strabane	028 71384109
Waterside Urban Team	028 71321729
Waterside Rural Team	028 71321749

APPENDIX 2

Western Health and Social Care Trust

Discharge from Hospital

Information for Patients

June 2017

Introduction

This information has been produced to help you plan your discharge from hospital. The information in the leaflet is intended mainly for residents of the Western Health & Social Care Trust area.

It explains the different services you may require and the arrangements that can be made for your care should you need it when you leave hospital. Your ward team will start to arrange your discharge from the day you come into hospital. Should you know of anything that may influence your ability to go home please let your nurse know as early as possible.

Planning to go home

Following the initial assessment process, you will be given an estimated date for your discharge (EDD). This estimated date of discharge will be reviewed every day. If you don't know the date, just ask a member of staff. This will help guide you and your relatives/carers as to how long you will be in hospital. This by no means implies that your treatment will be rushed; you will not be discharged until the medical team treating you has decided you are well enough.

Once you have recovered from your illness and no longer need the services of the acute hospital, it is important that your discharge home or your transfer to intermediate care services is arranged as speedily as possible. This is in your own best interests and also helps to ensure that beds in acute hospital are available for people who need medical care. Many people arrange the care they need themselves, by getting help from friends or family.

If you are unable to go to your own home without support, a member of the Social Work/Hospital Discharge Team will work with you to assess your needs, and will discuss this with you and your family so that appropriate services can be identified and put in place.

Checklist

During your hospital admission, the ward nurses will help you prepare for your discharge from hospital. Please include your family, carers and friends when making these arrangements and talk to them well in advance. Some of the things you may wish to talk about are:

- Is transport arranged for when I am ready to go home?
- Will the house be warm enough when I get home?
- Do people know I am coming home?
- Have I sufficient food in the house?
- Do I need to arrange to get some shopping delivered?
- Is the key available to gain access to the house?
- Are any services I might need organised?

APPENDIX 3

Useful Contacts

RQIA

Patient Client Council
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS
Tel: 0800 9170222

Complaints Manager – Western Health and Social Care Trust

MDEC
Trust Headquarters
Altnagelvin Area Hospital
Glenshane Road
Londonderry
BT47 2SB
Tel: 02871 345171 ext 214130

APPENDIX 4a

When researching the suitability of any Private Nursing Home the following checklist may be useful

a) Who are the registered owners of the home? Are they registered to meet the needs of your friend/relatives?
b) What are the criteria for admission?
c) How many resident places are in the home?
d) Do they have regular inspections from Regulation and Quality Improvement Authority?
e) Can you view the recent report?
f) How many qualified/unqualified staff they have (day & night)?
g) How is the food cooked/delivered to the client's (menu)?
h) Do rooms have en suite facilities?
i) Can personal items be used in client's room?
j) What laundry facilities are available?
k) Is there a relative/carer support group?
l) Are there opportunities for residents to use local community activities as part of their stimulation programme?

Other Useful Information:

RQIA
9th Floor Riverside Tower
5 Lanyon Place
Belfast BT1 3BT
Tel: 90517500

Patient Client Council
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS
Tel: 08009170222

As a relative/carer you are entitled to seek independent Advocacy

Patient Advocate:

Patient Advocate Office
Altnagelvin Area Hospital
MDEC
Glenshane Road
Londonderry
Tel: 71345171

Dementia Advocate
Sevenoaks
Crescent Link
Tel: 02871348887

APPENDIX 4b

Sharing of Information Record

Name of Residential/Nursing Home completing pre-admission assessment:

____

Patient details:

Name of Individual: ____

H&C Number: _______________________ D.O.B: ____________

Current Address: ____

____

I confirm that I have read all pre-admission documentation and have completed a pre-admission assessment which concluded that this facility is able to meet the assessed care needs of the above named person.

Name of Care Home Manager (BLOCK CAPITALS):

____

Signature of Care Home Manager:

___________________________________ Date: _________________

Copy to:
Independent sector provider/Care Manager
Hospital Social Work File
Community Social Work File

Western Health and Social Care Trust

APPENDIX 5

Our Ref:

Date

Address

Dear

We are pleased to hear that the Consultant responsible for you/your relative's **[Delete as appropriate]** care and treatment has confirmed that you/your relative is now medically fit enough to be discharged from hospital.

All of the necessary assessments by Health and Social Care staff have been completed and you/your relative's **[state name]** care needs have been fully discussed with you. I understand that this has identified that you/your relative no longer requires an acute/non acute **[Delete as appropriate]** hospital bed and that your/their needs could be appropriately met by a Care Home

I understand that your preferred place(s) of residence following discharge is **[insert names of chosen care facilities]** but that they are not able to accommodate you/your relative at this time.

I am sure you will understand that acute/non acute **[Delete as appropriate]** hospital beds are in great demand and that we need to ensure that they are available for patients who need them for urgent specialist medical and nursing treatment. It is therefore very important that those who have been assessed as medically well enough for discharge move to a more suitable placement promptly. It is also not in a patient's best interest to remain in hospital once they are ready for discharge.

You/Your relative **[insert name]** will not be able to remain in hospital whilst you continue your search or wait for your chosen care home(s). The intermediate care co-ordinator/hospital social worker will support you to find a care home that can offer a temporary room until a room becomes available at **{insert name of home(s)}.**

There may be an assessed charge and this will be explained to you.

If you have any queries or wish to discuss this further, please contact **[name of intermediate care co-ordinator/hospital social worker]** on **[insert contact details]**. If you would like a copy of this letter to be given to a relative or carer please let the intermediate care co-ordinator/hospital social worker know and we will arrange this for you.

Thank you for your co-operation.
Yours sincerely

____

Director

Western Health and Social Care Trust

Our Ref:

Date

Address

Dear

We are pleased to hear that the Consultant responsible for you/your relative's **[Delete as appropriate]** care and treatment has confirmed that you/your relative is now medically fit enough to be discharged from hospital.

All of the necessary assessments by Health and Social Care staff have been completed and you/your relative's **[state name]** care needs have been fully discussed with you. I understand that this has identified that you/your relative no longer requires an acute /non acute **[Delete as appropriate]** hospital bed and that your/their needs could be appropriately met by a Care Home

I understand that you have not yet advised us of you/your relative's preferred place of residence following discharge.

I am sure you will understand that acute /non acute **[Delete as appropriate]** hospital beds are in great demand and that we need to ensure that they are available for patients who need them for urgent medical and nursing treatment. It is therefore important that those who have been assessed as medically ready to be discharged from hospital move to a more suitable placement in a safe, effective and timely manner. It is also not in a patient's best interest to remain in hospital once they are ready for discharge.

You/Your relative **[insert name]** will not be able to remain in hospital whilst you continue your search. The intermediate care co-ordinator and hospital social worker will support you to find a care home that can offer a temporary room until you make a decision re your final choice of home.

There may be an assessed charge and this will be explained to you.

If you have any queries or wish to discuss this further, please contact **[insert name of intermediate care co-ordinator/hospital social worker]** on **[insert contact details]**. If you would like a copy of this letter to be given to a relative or carer please let the intermediate care co-ordinator/hospital social worker know and we can arrange this for you.

Thank you for your co-operation.

____

Yours Sincerely
Director

Our Ref:

Date

Address

Dear

We are pleased to hear that the Consultant responsible for you/your relative's **[Delete as appropriate]** care and treatment has confirmed that you/your relative is now medically fit enough to be discharged from hospital.

All of the necessary assessments by Health and Social Care staff have been completed and you/your relative's **[state name]** care needs have been fully discussed with you. I understand that this has identified that you/your relative no longer requires an acute /non acute **[Delete as appropriate]** hospital bed and that your/their needs could be appropriately met by a package of care in your own home.

I understand that a care package has not yet been found for you and that without a care package you would not be safe at home.

I am sure you will understand that acute /non acute **[Delete as appropriate]** hospital beds are in great demand and that we need to ensure that they are available for patients who need them for urgent medical and nursing treatment. It is therefore important that those who have been assessed as medically ready to be discharged from hospital move to a more suitable placement in a safe, effective and timely manner. It is also not in a patient's best interest to remain in hospital once they are ready for discharge.

You/Your relative **[insert name]** will not be able to remain in hospital whilst awaiting a start date for of your care package. The intermediate care co-ordinator/hospital social worker will support you to find a care home or suitable placement. A temporary room is available at **{insert name of home}** until a start date for your care package can be confirmed.

There may be an assessed charge and this will be explained to you.

If you have any queries or wish to discuss this further, please contact [insert name of Intermediate care co-ordinator/hospital social worker] on [insert contact details].

Thank you for your co-operation.

____

Yours Sincerely
Director

Our Ref:

Date

Address

Dear

We are pleased to hear that the Consultant responsible for you/your relative's **[Delete as appropriate]** care and treatment has confirmed that you/your relative is now medically fit enough to be discharged from hospital.

All of the necessary assessments by Health and Social Care staff have been completed and you/your relative's **[state name]** care needs have been fully discussed with you. I understand that this has identified that you/your relative no longer requires an acute /non acute **[Delete as appropriate]** hospital bed and that your/their needs could be appropriately met by a package of care in your own home.

I understand that you are ready to leave hospital but your home will need cleaning or adaptation before you return or you will need a new home to be found.

I am sure you will understand that acute /non acute **[Delete as appropriate]** hospital beds are in great demand and that we need to ensure that they are available for patients who need them for urgent medical and nursing treatment. It is therefore important that those who have been assessed as medically ready to be discharged from hospital move to a more suitable placement in a safe, effective and timely manner. It is also not in a patient's best interest to remain in hospital once they are ready for discharge.

You/Your relative **[insert name]** will not be able to remain in hospital whilst you wait for your home to be made ready. The intermediate care co-ordinator/hospital social worker will support you to find a care home or suitable placement. A temporary room is available at **{insert name of home}** until your home is ready for occupation.

There may be an assessed charge and this will be explained to you.

Please discuss the discharge plans with the nurse in charge or the social worker on your ward to either confirm the transfer to temporary accommodation or to inform us of alternative arrangement to leave the hospital. We will make arrangements for the transfer to the temporary care home as soon as possible,

If you have any queries or wish to discuss this further, please contact [insert name of intermediate care co-ordinator/hospital social worker] on [insert contact details].

Thank you for your co-operation.

Yours Sincerely
Director

Our Ref:

Date

Address

Dear

We write further to the letter we sent recently in relation to the discharge arrangements for you/your relative. The hospital has offered you all the necessary support and advice to enable you to have a safe and appropriate hospital discharge. You have decided not to accept the arrangement which have been put in place for you.

We will instigate an appropriate transfer to the location below which has been assessed as suitable to meet your/your relative's needs and therefore the Trust will take legal advice.

We hope you will appreciate the importance of this discharge process being enforced to ensure the most effective use of NHS resources. If you have any queries relating to the content of this letter, please do not hesitate to contact **xxxx.**

For the avoidance of doubt, we confirm that the hospital bed you/your relative are currently occupying will no longer be available to you as of **[INSERT TIME]** ON **[INSERT DATE**]. Your discharge arrangement will be:
Discharge address:

____

Yours Sincerely
Director

Appendix 7

Self-Audit Tool: Policy for the Management of Choice Related Discharges

Period Audit Covers– From ______________ to ____________________

Name and Designation of Person Completing Audit:

____

Date Audit completed: ________________________

NOTE: If a discharge plan is agreed at an early stage please note this at that step on audit tool below

Stage of Process		Date of records on file/type of record on file
STEP 1	Meeting with Hospital Social Worker, Ward Sister, Patient, Family/Main Carer convened within 24 hours of issue being identified	
STEP 2	Multi-disciplinary members involved, Community Team, Hospital Social Worker meet with patient, family/ main carer within 24 hours	
STEP 3	Senior Medical Staff and appropriate MD Team members meet with patient, family/main carer.	
STEP 4	Appropriate Assistant Director will be advised. Assistant Director Community & Assistant Director Acute discuss issue to meet with patient, family/main carer – where possible, within 24 hours of escalation to this level	
STEP 5	Director of Acute or Director of Community will inform patient, family/main carer in writing of discharge decision.	
STEP 6	Appropriate Director liaises with Chief Executive and communicates with the Department of Health on same day as decision is communicated to the family	
STEP 7	Chief Executive informs Patient/Family, main carer in writing within 48 hours of step 6	

STEP 8	DHSS Legal Department will support in process of implementing patient discharge out of hospital setting.	

Self-Audit Tool: Policy for the Management of Choice Related Discharges (Cont'd)

Summary/Observations:

____

____

____

____

Recommendations for Improvement (if any):

____

____

____

Signed: ________________________________ Date: _______________________

Review Date: ____________________________

Copy to: Social Worker, Social Work Manager, Head of Service for Discharge and Hospital Social Work