Western Health and Social Care Trust

POLICY FOR THE MANAGEMEMENT OF PATIENT CHOICE RELATED DELAYED DISCHARGES ACROSS WESTERN TRUST HOSPTIAL FACILITIES

August 2014

Western Health and Social Care Trust

Title	Policy for the Management of Patient Choice Related Delayed Discharges across Western Trust Hospital Facilities
Reference Number	PrimCare12/002
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Review Date	August 2016
Responsible Officer	Mrs Geraldine Brown, Assistant Director Secondary Care

Western Health and Social Care Trust

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1. INTRODUCTION

The Policy should be read in conjunction with:

- "Delayed Discharges Related to Patient Choice Regional Policy November 2004" (P.F.A. Draft Priority 4)
- Guidance on Patient Discharge Western Health and Social Care Trust
- Priorities for Action 2012/13 – as determined by Department of Health annually with reference to Delayed Discharge Target and Improving Mental Health Services
- Discharge of Hospital Patients, circular ECCG 1/98 and standard for assessment and care management SSI (NI) October 1999.

These set out the principles and quality standard that underpin the approach to the practical application of the Policy.

Equality and Human Rights Screening carried out in line with duties under the Equality Legislation (Section 75 of the Northern Ireland Act 1998) Targeting Social Need Initiative, Disability Discriminations and the Human Rights Act 1998, the Western Health and Social Care Trust (WHSCT) has carried out an initial screening exercise. A full impact assessment is not required in relation to the Policy.

2. DEFINITION OF PATIENT CHOICE RELATED DELAYS

2.1 Discharge delays are defined as delays in the discharge of patient's within the facilities outlined above whose treatment episode in hospital is finished and who have been assessed as *"medically fit"* (*when the responsible consultant or other authorized individual agrees in conjunction with multi-disciplinary colleagues that the patient is clinically fit to leave acute care*) to leave.

2.2 Patient choice related delays are a subset of all delays and occur when the patient or carer has identified a preferred post-hospital care placement that is not immediately available. The patient then remains in hospital awaiting a place in their preferred placement setting and their discharge is delayed. Most patient choice related delays are associated with patients awaiting a place in their nursing home of choice however if patients are awaiting a domiciliary care package this Policy may also be used to facilitate their discharge home. This will be an interim arrangement until their domiciliary care package is available.

2.3 A reduction in patient choice related delays would promote patient safety and ensure that patients ready to leave hospital are cared for in an environment which 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 domiciliary care package 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 the fore mentioned Regional Policy and Regional Priorities for Action 2012/13.

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 & 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.

4.2 Patient Information: that is "Getting Ready to Leave Hospital" leaflet (Appendix 1) should be shared with the patient and family on admission and time set aside for explanation of returning home or to another care environment. When nursing home placement is first mentioned or if there are delays in accessing domiciliary care the Hospital and Community Social Worker should ensure that the patient/carer has a copy of the relevant leaflet and further discuss the Policy with patient/carer.

4.3 Patients and their families/carers have a responsibility to work constructively with hospital and community-based staff to ensure timely discharge from hospital.

4.4 Patients have a right to expect choice from within available options. Patients do not, however, have a right to wait in a hospital or health care facility for a vacancy in their home of first choice, or if there is a delay in their domiciliary care package if a suitable interim placement is available.

4.5 In instances where a patient's domiciliary care package, nursing or residential home of first choice is not immediately available at the point they are clinically fit for discharge, patients will be required to move to a suitable alternative placement in a nursing or residential setting. In these circumstances all patients who are awaiting placement have a right to expect that the Trust will normally identify one or more appropriate and affordable alternative homes from which the patient will be expected to choose i.e. the Trust can only

identify Residential/Nursing Home places that meet the patient's identified needs and are not subject to a "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 are the responsibility of the patient/family.)

4.6 Trusts have a responsibility to ensure that due regard is given to individual circumstances in identifying what is a suitable interim placement. Where possible, Trusts should also indicate to the patient/carer, the likely duration of any interim placement.

4.7 Patients have a right to expect the Trust, in identifying suitable interim placements, will have regard to relevant factors such as: the suitability of any alternative accommodation in terms of the patient's assessed needs; the affordability of any residential or nursing homes identified; the patient's spiritual and cultural needs and consideration regarding travel arrangements for carers and family within the Western Trust catchment area.

4.8 Patients have a right to revert to their first choice placement/to return to their home, should that become available, after they are discharged. Therefore, they should receive the active support of the Care Manager in pursuing their domiciliary care package/first choice placement if that is their wish.

5. PROCESSES

5.1 The information leaflet 'Getting Ready to Leave Hospital' should be given by the nurse on admission to the patient/carer. When nursing home placement (or a delay in care package) is first mentioned the Hospital Social Worker and Community Social Worker should ensure that the patient/carer has a copy of the relevant leaflet and patient choice Policy is discussed.

5.2 Trust staff through their hospital discharge teams and their community teams should ensure the efficient operation of Discharge Policies. Patients/carers should be advised of/and explained the Estimated Date of Discharge (E.D.D.). This should be carried out by the hospital and the appropriate community team, actively working together in harmony. At this stage, the care manager/hospital team should actively discuss with the patient/family/carer, the care options that are available as per the care plan that has been developed for discharge home or to an alternative care setting.

5.3 When the Comprehensive Assessment Care Plan points to the need for a move directly from hospital to a nursing or residential home the Care Manager supported by the Hospital Social Worker should arrange for the Nursing/Residential Home Manager to carry out their assessment in a timely and efficient manner. A record of the Comprehensive Assessment and the outcome should be available to patient/carer/family. A list of nursing home names and contact numbers should be made available.

5.4 On completion of the assessment process, the care manager will establish the availability and source of funding to support care outside hospital. He/she working with the Hospital Social Worker will advise the patient/carer of the available placement options and assist them in identifying the most suitable option in the context of the terms outlined above under Rights and Responsibilities. In reviewing needs and choices for patients who have difficulty making their own choices, staff should have regard to the DHSSPS Guide to Good Practice on Consent.

5.5 Once the consultant in charge of the patient's care has determined that the patient is medically fit for discharge, he/she will communicate this to the patient/carer. The team of staff planning the patients discharge will clearly identify and communicate a planned date for discharge, they will actively work to obtain the discharge 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.

5.6 The term *medically fit for discharge* has been defined as "when the responsible consultant or other authorized individual agrees in conjunction with multi-disciplinary colleagues that the patient is clinically fit to leave hospital".

5.7 Where carers take a regular and substantial caring role, they should be advised of their right to a separate assessment of their needs by social services i.e. a Carers Assessment.

5.8 The Hospital Social Worker actively working with the community staff should establish the availability of the care package (based on assessed needs). The social workers will ensure that the 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/sub acute facility. 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 discharge. The patient carer or relative will be asked to choose from the list of vacancies available. However before any commitment is given for a residential/nursing home bed to be booked, approval must be sought from an Assistant Director. This must be followed by a progress report from the community social worker to the nursing home panel (Assistant Directors) on each placed client until they are allocated a package of care and have returned home. The hospital social worker should make the multi-disciplinary team aware of such interim plans and seek the consultants support for such a plan so the patient carer or relative can be supported in the interim discharge plan. The hospital social worker/discharge co-ordinator will inform the patient carer or relative that the

patient will, with the support of the community social 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 patient's carers and relatives.

The Trust will also undertake to fund all costs associated with these interim residential and nursing home placements. These clients must be prioritised as 'urgent' for domiciliary care services to ensure that the flow of clients through ad hoc residential and nursing home beds is optimised and kept to a minimum.

Clients who have assessed needs some of which are categorised as 'unmet needs' will only have Trust funding until their assessed 'met' needs can be delivered.

The Trust can only consider Residential Nursing Home Placements that are covered by the agreed Regional Rate (i.e. the Western Health and Social Care Trust will not be in a position to place a delayed discharge patient in a home that requires a top up fee unless families/client have agreed to pay the top up charge).

5.9 Information leaflets in user-friendly formats should be available to patients and carers at an early stage. This information should outline the processes involved in discharge planning and the terms included in this patient choice Policy (Appendix 2). Discussions with the patients and carers should be properly documented and supported by the availability of user-friendly information on placement options. This may include enabling the family/patient/carer having access to the latest inspection report on the residential or nursing home. Families/carers or patients should also be able, if required, to contact RQIA directly (Appendix 3). A checklist of points to look for in assessing the suitability of a nursing/residential home will be made available to the patient and their family (Appendix 4).

5.10 The Care Manager/Hospital Social Worker will work with the patient/carer to explore any concerns they have. They will seek to identify a mutually agreed outcome consistent with the terms of the Policy. It is recognised that some patients or their families/carers 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 In the event of the preferred choice of home or care package not being immediately available and the patient/family/carer not wishing to make an interim choice the following steps will be taken. Families will be advised they can seek independent advice if they feel it is necessary. The delayed discharge will be escalated to a Senior Manager. The Trust in the form of an Escalation Letter (Appendix 5/6) will request that an interim placement be facilitated to ensure the appropriate use of hospital beds. The Care Manager/Hospital Worker/Discharge Co-ordinator will explain the practicalities of escalation and an Escalation Letter will be delivered and explained to the

patient/family/carer by the Discharge Co-ordinator or Ward Manager. A list of Residential/Nursing Homes within the Western Health and Social Care Trust area that have vacancies and do not have a top up fee will be given. Every effort will be made to secure placement in the local area. If this is not possible the Trust will endeavour to secure accommodation within a 35 mile radius. In extreme circumstances clients may need to be placed in placements in a facility greater than 35 miles.

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, arrangements will be made to transfer the client. Information as at 5.9 will be made available to the patient/family/care. A date of discharge will be agreed with patient/family/carer. The care manager will be advised. During this time community and hospital staff will be available to answer any questions and to support patient/family/carer. Care Manager will ensure that up to date information re: Residential/Nursing vacancies within the care home sector is available to the patient carer family.

5.12 In the event of the family/patient/carer still refusing to make a choice and wishing to discuss the matter further, then an opportunity should be developed to facilitate a meeting with the Discharge Co-ordinator, a Head of Service and Care Manager if possible. The outcome of this meeting will be conveyed in writing to the family.

5.13 It is the responsibility of the care manager 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.

6. DEFINITIONS

6.1 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 are the responsibility of the patient/family.

6.2 Estimated Discharge Date

An estimated date made by the consultant when a patient will be ready to leave an acute hospital setting.

6.3 Medically Fit

This is when the responsible consultant or other authorized individual agrees in conjunction with multi-disciplinary colleagues that the patient is clinically fit to leave hospital care.

Appendices

Western Health and Social Care Trust

Who can I talk to about my future care needs?

In the first instance talk to the nurses caring for you. 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, 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 a care home other than your preferred choice until 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

January 2012

Western Health and Social Care Trust

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.
- Beds are required for people needing on-going rehab.
- 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
Tyrone County 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

Western Health and Social Care Trust

Discharge from Hospital

Information for Patients

January 2012

Western Health and Social Care Trust

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 to home. 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 4

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

a) Who are the registered owners of the home?

b) What are the criteria for admission?

c) How many resident places are in the home? Are they registered to meet the needs of your friend/relatives?

d) Do they have regular inspections from Regulation and Quality Improvement Authority?

e) Can you view the recent report?

f) How may 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 Advocates:

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

Dementia Advocate
Sevenoaks
Crescent Link
Tel: 02871348887

APPENDIX 5

Ref:

Dear

I understand that you no longer require a hospital bed and your first choice of nursing home is unavailable at present.

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 this place. 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 go to an alternative nursing home where your needs will be met until your first choice becomes available. The Hospital Discharge Team and your Care Manager will facilitate your transfer to an available nursing home.

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

Western Health and Social Care Trust

APPENDIX 6

Ref:

Dear

I understand that you no longer require a hospital bed and you have been waiting on part or whole of your domiciliary care package for __ weeks.

Whilst I am aware that returning home is very important to you, I wish to advise you that it is not possible for you to remain indefinitely in Hospital while we actively pursue securement of your domiciliary care package. Hospital beds are required for people who are in need of hospital care and any prolonged extension of your stay will prevent our ability to admit other patients.

Therefore, it is essential that you go to an alternative placement on a temporary basis where your needs will be met until your domiciliary package becomes available. The Hospital Discharge Team and your Care Manager will facilitate your transfer to an available placement.

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