ADMISSION AND DISCHARGE POLICY

The attached jointly developed District Admission and Discharge Policy has been formally adopted for use within Portsmouth HealthCare NHS Trust.

Local admission and discharge procedures may need to be amended to reflect the standards within this policy.

The Trust clinical audit programme for 2000/01 will include audit against key standards within the policy.

Policy Produced by: The Quality Partnership Panel

Policy Produced: July 2000

Review Date: July 2001

For Review by: Lesley Humphrey, Quality Manager
in conjunction with the Quality Partnership Panel

PORTSMOUTH AND SOUTH EAST HAMPSHIRE DISTRICT WIDE ADMISSION AND DISCHARGE POLICY

1. Introduction

Good discharge planning is fundamental to the provision of efficient and effective health care and helps equip patients and carers with the knowledge, understanding and support to prevent or minimise further episodes of ill health. The costs of poor discharge planning include: inefficient use of beds; longer waiting lists; re-admission to hospital; increased patient and carer distress; increased work loads for community nurses and general practitioners.

The Patient's Charter states *"The Charter standard is that before you are discharged from hospital a decision will be made about any continuing health or social needs you may have. Your hospital will agree arrangements for meeting these needs with Agencies such as community nursing services and local authorities social services departments before you are discharged. You and, with your agreement, your carers will be consulted and informed at all stages."* This policy has been jointly developed by the local health services, in consultation with local Social Services Colleagues, and is based on the Health Service Accreditation Standards for Discharge Care.

Discharge planning should begin, where-ever possible at the first point of contact with the patient; e.g. outpatient clinic, pre-admission clinic, at the time of admission for elective admissions or within 24 hours for emergency admissions (in the early stages this may simply consist of information gathering about the home situation). Delayed discharge in the case of people who no longer need specialised services is an issue of great concerns for a number of reasons. The patient may understandably wish to go home as soon as possible. A delay may mean that access to the specialist services is denied to someone else, constituting inefficient use of scarce resources. Discharge planning is therefore essential.

The standards within this policy are based on agreed best practice. It is recognised, however, that there may be circumstances when some standards cannot be met (e.g. notice of discharge during a bed crisis). Exceptions should be rare and should only be made in agreement with all parties. If a discharge is arranged in a hurry, the need for good communication is even more important.

The patient's wishes are paramount, even when his/her preference for care on discharge places them at risk (unless he/she is formally assessed by a psychiatrist as mentally unfit to make judgements on their care)

2. Purpose

To ensure patient centred care through effective communication between health and social care teams, when patients are discharged from hospital or transferred from one service to another by:

- Ensuring that patients are discharged from hospital in a timely fashion to a clinically appropriate and safe environment.
- Ensuring that the receiving health or social care services are prepared to meet the patient's needs.
- Providing appropriate information, medication, equipment and minor environmental adaptations to enable independence for the patient and carer.
- Involvement of and consultation with the patient and relatives/carer at all stages of the discharge process. (It should be remembered that relatives and/or carers can only be given information with the agreement of the patient)

3. Scope of Policy

This policy applies to all care groups and sets the general principles for planning discharge care. Where particular services require more specific guidance this should supplement, not replace this policy. The policy refers to the discharge of patients to their own home, to other accommodation in the community or from one hospital to another. The principles should apply to all discharges but especially to those with complex needs. The following people may be at risk unless adequate arrangements are made:-

- people who are frail or elderly
- people who live alone, including those in sheltered housing and warden assisted accommodation
- people living with carers who may have difficulty coping
- people with a serious illness who may be returned to hospital for further treatment
- people being discharged for a trial period
- people who are terminally ill
- babies and children, particularly those at risk of abuse
- people who usually care for others at home
- people who are confused, have a mental illness or impairment
- people with special needs requiring equipment, training or supplies
- members of travelling families or the homeless
- people with language difficulties, including those for whom English is not their first language
- people with temporary or permanent disability

4. Responsibility

Managers are responsible for ensuring that all staff who are involved in the discharge process (including medical, nursing, professions allied to medicine and some clerical staff) are familiar with the requirements of this policy. Within each service the service manager is responsible for ensuring that the requirements are met or for reporting problems which need to be addressed. Clinical managers and

team leaders are responsible for ensuring that action is taken in individual cases so that people receive the right amount of care at the right time.

5. Requirements

The standards for the different stages of discharge planning, listed below, should be followed:

5.1 Pre-admission/admission

5.1.1 Referral letters should contain the locally agreed referral information (see appendix A)

5.1.2 Where pre-admission clinics are held, discharge planning should commence through; a) documentation of relevant information about the patients social circumstances and b) providing the patient/carer/relative with information on length of stay, mobility restrictions, possible environmental adaptations, e.g. rails, height of bed/chair etc., c) referral to social services where needs are complex and likely to need a care management assessment.

5.1.3 GPs, district nurses and care managers etc have a responsibility for sharing information on social circumstances, to facilitate discharge planning. Information contained in the referral letter should be confirmed with the patient/carer/relative at the time of the pre-admission clinic or admission to a ward.

5.1.4 The admission care assessment should highlight the need for referral to other services e.g. Occupational Therapy, Physiotherapy, Specialist Nurses Social Services etc.

5.1.5 When a high level of community support will be required on discharge (e.g. district nursing, social services etc.), contact should be made with the relevant service, within two working days of admission or the medical condition being stabilised, to gather information and facilitate early planning for discharge.

5.1.6 Where community services are already providing care prior to admission, they have a responsibility for sharing information (with the patient's permission) which would inform discharge planning.

5.1.7 The anticipated length of stay should be documented and shared with the patients/carer within 24 hours of admission and regularly reviewed there after. (This is an estimate to be used as a planning guideline and is not a fixed date).

5.2 **Inpatient Episode**

5.2.1 The named nurse or key worker is responsible for co-ordinating the plan of discharge and ensuring that all necessary actions and/or assessments take place.

5.2.2 Where a need for community care assessment is identified, social services will appoint a care manager in line with the local agreement. (see appendix B)

5.2.3 Each patient's care plan should include information on discharge planning, including completion of a discharge checklist (see appendix C for suggested content).

5.2.4 Patients/carers/relatives should participate in the developments of the discharge plan and be kept informed at all stages.

5.2.5 Where it is perceived that a patient may need a package of care following discharge a referral should be made to the relevant social work department, with the agreement of the patient/carer. Referral will be necessary when:

- The patient is unlikely to be able to return to his/her previous place of residence
- The patient can only return to his/her previous place of residence with new or enhanced support form community services provided through social services
- The patient has an existing package of care which needs re-starting (Appendix B contains a summary of the Joint Health Social Services hospital discharge arrangements).

5.2.6 The patient/carer/relative should be informed of the final planned date of discharge at least 48 hours in advance.

5.2.7 Any service providing support following discharge should be informed of the planned date of discharge at least 48 hours in advance.

5.2.8 Patients/carers/relatives should have a clear understanding of what services are to be provided post discharge and by which service and when.

5.2.9 Patients/carers/relatives should be given information and consulted on:

- future self care and life style
- medication and treatment
- transport arrangements
- use of equipment

5.2.10 When a home visit is deemed necessary, carers and relatives should be involved.

5.2.11 When equipment or home adaptations are needed patient/carer/relatives should agree with the choices made and be provided with suitable training.

5.2.12 The joint arrangement for the care programme approach should be followed for those people with a mental illness.

5.2.13 When a patient has an infection such as MRSA or C. DIF, the relevant infection control policy should be followed.

5.2.14 If a patient takes self discharge, the GP (and other community services as appropriate) should be informed as soon as possible and no later than 12 hours when there is concern for the person's safety; otherwise on the next working day.

5.3 Discharge from Hospital

5.3.1 Discharge should not take place until the responsible clinician states the patient is medically fit for discharge, in consultation with the multi disciplinary team, and all essential support services/equipment are in place.

5.3.2 Patients should not be discharged after 5pm, without agreement by patient/carer, or any community service needed to provide care on the day of discharge.

5.3.3 Patient's with complex support needs must not be discharged at the weekend/bank holidays unless there is prior agreement with the supporting services.

5.3.4 The discharge checklist should be fully completed prior to discharge.

5.3.5 Medication/Dressings/Treatments

- TTO's should be prescribed, where ever possible, 24 hours in advance of discharge
- TTO's should arrive on the ward no later than one hour before the planned discharge time
- Medication should be supplied for seven days, unless the course is shorter
- Dressings, (including all materials, lotions, bandages etc. required incontinence products, and any other medical supplies required should be supplied at least for three days and in sufficient quantity to cover weekends and holiday periods.
- Discharge letter to GP/district nurse should advise regarding need for ongoing supply of dressings
- Patients/carers/relatives understanding of treatment and medication should be checked

5.3.6 Where applicable a DSS medical certificate should be supplied for the period the patient is expected to be unfit for work or two weeks, whichever is the shorter.

5.3.7 Hospital transport should only be provided where there is clinical need. Information on patient needs must be explained when transport is ordered: e.g. stretcher, wheel chair, walking frame, two man lift etc.

5.3.8 Prior to discharge patient/carers/relatives should be given information on:-

- Ongoing care arrangements; Out Patient Appointment, further supplies medication, service visit to the home etc.
- Whom to contact in case of problems or emergencies
- Anticipated time of transport
- Package of care arranged
- Where applicable written information should be provided

5.3.9 The provider spell discharge summary should be completed and sent to GP with 24 hours of discharge and a copy given to the patient (see appendix D for information to be included).

5.3.10 When a patient is being transferred to another care environment a nursing transfer letter should be completed and accompany the patient on transfer (see appendix E for information to be included).

5.3.11 Care programme approach documentation should be given to the patient/relative/carer.

6. Monitoring/Audit

6.1.1 Monitoring/audit will take place through the Quality Partnerships Group.

6.1.2 Where applicable complaints will be harnessed to improve future practice.

6.1.3 Through compliance with the Health Authority requirement for regular census of delayed discharges.

Policy Produced by: The Quality Partnership Panel

Policy Produced: July-2000

Review Date: July 2001

For Review by: Quality Partnership Panel

Key Organisational contacts:
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Portsmouth Hospitals Trust: Ursula Ward, Nursing Director
Haslar: Barbara Smith, Quality Manager

APPENDIX A

INFORMATION TO BE INCLUDED IN THE REFERRAL LETTER

The referral letter should be legible and as a minimum contain the following information; where available.

- The patient's name and marital status
- Date of birth
- Address (with postcode) and telephone number
- NHS number - (if known)
- Identifying reference (if the patient has been seen by the hospital before)
- An outline of case history
- Treatment to date, including details of any medication or investigation
- An indication of what the general practitioner expects by way of response from the consultant
- Suggested diagnosis/reason for referral
- An indication of any special needs the patient may have
- Social factors which may influence inpatient care, discharge planning and management
- All available information affecting the patient's health which is likely to affect discharge needs and decisions.

APPENDIX B

JOINT HEALTH/SOCIAL SERVICES AGREEMENT HOSPITAL DISCHARGE ARRANGEMENTS

A Joint Community Care Agreement was produced by Hampshire County Council Social Services and Portsmouth and South East Hampshire Health Commission, in 1993 and is still in effect. This includes a Joint Policy for Hospital Discharge, copies of the full policy are held by Divisional General Managers. Key standards/requirements include:

Screening

- All patients will be screened at the earliest possible stage to establish if a referral to Social Services is necessary. Responsibility for ensuring this occurs rests with the Sister or Charge Nurse of the ward - although the screening may be done by other nursing, medical or paramedical staff and will draw upon existing knowledge of the patient from community staff.
- The patient must agree to a referral - unless the welfare of a child is concerned, or if there is doubt about the ability of the patient to make their own decisions.
- A referral to Social Services will be made in circumstances highlighted in para 4.4 of the main policy.
- Referrals should be on agreed forms and provide the information requested.

Assessment

- A Hospital based Social Worker will give an initial response to the referral, including meeting the patient within 2 working days.
- The assessment will normally be completed within 5 working days of referral.
- The completed assessment will include a health needs assessment. It is the responsibility of the doctor to complete this.
- The referral should indicate the estimated date of discharge and Social Workers will make every effort to prioritise their work to ensure assessment does not delay discharge.

Arrangements at time of discharge

- There will usually be at least 2 working days between the receipt of a request for service and the actual delivery of the service.
- The person who co-ordinated the care plan for discharge shall be responsible for reviewing the arrangement within 3 weeks of the patient beginning to use them.

Disputes

- The exception is that local managers will be expected to resolve any disputes that may arise. However in exceptional circumstances the situation may be referred to the Deputy Director or Social Services / Trust Chief Executive.

Monitoring Arrangements

At ward level continuous monitoring of any discharge delays (ie. where delay in excess of 10 working days occurs) should occur. This will be internally reported monthly and reviewed quarterly by the Trust/Health Commission and Social Service

THIS AGREEMENT NEEDS TO BE REVIEWED DURING 2000/2001

APPENDIX C

INFORMATION TO BE INCLUDED IN DISCHARGE PLAN OR CHECKLIST, AS APPROPRIATE

- Patient I.D.
- Named nurse
- Planned date of discharge
- Actual date of discharge
- Discharge destination
- Referral to Occupational Therapy; needed/made
- Referral to physiotherapy; needed/made
- Referral to S.A.L.T.
- Referral to Social Services; needed/made
- Referral to community nurse (CPA/HV/DN); needed/made
- Transport arrangements; needed/made
- Written/verbal advice to patient/carer/relatives on treatment/aftercare
- Discharge date discussed/agreed with patient/carer/relatives
- Equipment needed/in situ
- Aftercare arrangements needed/made
- Aftercare arrangements in place
- Clothes/keys etc. available
- Nursing transfer form needed/completed
- Spell discharge summary completed/copy given to patient
- Medication TTO's dressings, medical products etc. prescribed/issued to patient/carer/relative
- Patient/carer/relatives knowledge/skills checked
- Personal property returned
- Medical certificate issued
- Out Patient Department appointment needed/made
- Contact names/telephone numbers provided

All entries should be signed and dated

APPENDIX D

THE SPELL DISCHARGE SUMMARY PREPARED ON DISCHARGE, SHOULD CONTAIN THE FOLLOWING INFORMATION AS A MINIMUM

- The patients name
- Date of birth
- Address (with postcode) and telephone number
- NHS number
- Hospital reference number
- Consultant's name, speciality and ward
- Date of admission and discharge
- Discharge diagnosis; key investigations/findings; treatments
- Medication details to include ALL drug names, dosage and course length
- Follow up plan (including specific requests for primary health care team action, OPD arranged, OT, Physio, day hospital, specialist referral etc.)
- Whether elective or emergency admission
- No abbreviations, unless understandable by the patient
- Contact person

The information on the discharge summary must be clear, understandable and unambiguous.

(taken from Portsmouth & South East Hampshire Health Authority Quality Requirements for 1999/2000)

APPENDIX E

NURSING TRANSFER LETTER

On transfer of care, a Nursing Transfer Letter should accompany the patient, which includes as a minimum:-

- Name
- Address (or visiting address) including postcode and telephone number
- Date of birth
- Name of GP
- Next of kin (with telephone number)
- Diagnosis
- Information given to patient/carer/relative regarding diagnosis/prognosis and understanding of condition
- Treatment/intervention required
- Named nurse contact number
- Social Worker contact number
- Summary of care/treatment in hospital
- Date of discharge
- Other services involved
- Waterlow and/or Barthel score where appropriate

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