HYWEL DDA UNIVERSITY HEALTH BOARD

DISCHARGE AND TRANSFER OF CARE POLICY

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1.0	December 2014	Carol Cotterell		CPRG	16/05/2016	16/05/2018

Brief Summary of Document:	This policy provides guidance to all those involved in in-patient care provision and community care and should be adopted for all discharges of care from and transfers between hospitals across Hywel Dda University Health Board.

To be read in conjunction with:	141 - Multi Agency Policy of the Independent Mental Capacity Advocate Service 163 - Deprivation of Liberties Safeguards Policy 196 - Escort Policy for Adult In-patients Policy 374 - Mental Capacity Act (2005) Policy 289 - Record keeping for Nurses and Midwives Policy 295 - Protection of Vulnerable Adults from Abuse Policies & Procedures 309 - Continuing NHS Healthcare (CHC) Operational Policy to support the National Framework for Implementation of CHC 341 - Prescription and Administration of Emergency Oxygen in Adults Policy & Procedures

Classification:	Clinical	Category:	Policy	Freedom Of Information Status	Open

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HYWEL DDA UNIVERSITY HEALTH BOARD

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Scope	**ORGANISATION WIDE**	✓	**DIRECTORATE**	✓	**DEPARTMENT ONLY**	✓	**COUNTY ONLY**	✓

Staff Group	Administrative/ Estates	✓	Allied Health Professionals	✓	Ancillary	✓	Maintenance	✓
	Medical & Dental	✓	Nursing	✓	Scientific & Professional	✓	Other	✓

CONSULTATION	**Please indicate the name of the individual(s)/group(s) or committee(s) involved in the consultation process and state date agreement obtained.**			
	Individual(s)	Ward and Department Nursing , Therapy and Medical Staff, Community Teams Mental Capacity Act Administrator	**Date(s)**	February 2014 2016
	Group(s)	Acute Services Management Team Community Services Management Team Paediatric Team	**Date(s)**	February 2014 2016
	Committee(s)	Senior Nurse Management Team County based Safety and Quality Management Groups	**Date(s)**	February 2014

RATIFYING AUTHORITY (in accordance with the Schedule of Delegation)	**KEY**		**COMMENTS/ POINTS TO NOTE**
NAME OF COMMITTEE	A = Approval Required FR = Final Ratification	**Date Approval Obtained**	
Clinical Policy Review Group	A	16/05/2016	

Date Equality Impact Assessment Undertaken	21.8.2014 Reviewed : 21.03.15	**Group completing Equality impact assessment**	C Cotterell J Hooper

Please enter any keywords to be used in the policy search system to enable staff to locate this policy	Discharge, Expected Date of Discharge, Transfer of care, Complex discharge, Delayed discharge, Transport, Equipment on discharge, Local discharge, Discharge planning

Document Implementation Plan			
How Will This Policy Be Implemented?	Dissemination through clinical service managers and Acute Services and County Community Teams Professional nurse forums Local awareness raising and training events Staff focus group in consultation phase		
Who Should Use The Document?	All clinical ward/departmental areas (nurses, allied health care professionals, doctors)		
What (if any) Training/Financial Implications are Associated with this document?	Awareness raising within Hospitals, with the Welsh Ambulance Service and within primary care and the community resource teams		
What are the Action Plan/Timescales for implementing this policy?	**Action**	**By Whom**	**By When**

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1. INTRODUCTION

Hywel Dda University Health Board (HDUHB) is committed to providing safe, evidenced based health care which meets with national standards of best practice.

Discharge is a process not an isolated event (DOH 2003). The Welsh Government Circular 2005/17 – Hospital Discharge Planning Guidance highlights that people being discharged from hospital are entitled to expect and receive a smooth transition from one stage of care to the next. A lack of coordinated and person centred planning for discharge can lead to poor outcomes for patients possibly jeopardising health and safety or leading to inappropriate readmission to hospital

This Policy sets out the strategic direction and detailed procedures for discharge and transfer of care arrangements in Hywel Dda University Health Board.

It gives an opportunity to impact on the whole system improving the patient journey and patient experience by re-enforcing what needs to be done to make discharge safe and effective

2. POLICY STATEMENT

This policy clarifies the Health Board's core responsibilities - corporately, clinically, professionally and externally with key partners. It should be read in conjunction with the list of national and local documents as listed on page 1 of this policy. The Acute and Community Services Management Teams, through the Acute and Community Management Structures, are responsible for the development and delivery of the Service Implementation Plans which are the operational vehicles to fulfil this policy and will adhere to the key strategic principles laid out in this policy for discharge and transfer of care working.

3. SCOPE

The Discharge and Transfer of Care Policy application is the responsibility of all health care professionals and support staff working in the Hywel Dda University Health Board care environment. The policy covers all clinical environments where care is received and incorporates the needs of children, young people and adults, but excludes neonates.

4. AIM

The aim of the policy is to ensure a safe, timely, efficient patient centred discharge and transfer of care.

5. OBJECTIVES

The objective of the policy is to set out the framework to ensure that all individuals and teams are aware of their roles and responsibilities in the implementation and application of this Discharge and Transfer of Care Policy, incorporating the six core principles as detailed in 6.

6. THE DISCHARGE AND TRANSFER OF CARE PROCESS

6.1. Key Principles

The following principles are the drivers for delivering effective and timely discharge planning arrangements.

i. **Communication:** Patients and their designated representatives are to be fully involved and engaged in the discharge process at the outset and encouraged to fulfil their responsibility within the process. There must be appropriate consultation and involvement of the patient and their/family/carer/ advocate in the discharge process. Appropriate

communication to other professionals involved in the on-going care of the patient following discharge is mandatory.

ii. **Coordination:** The discharge process will be coordinated by a named person, and a deputy will be identified when the named person is absent, to ensure continuity of plans.

iii. **Collaboration:** Liaison and communication with and between the multi disciplinary team/appropriate agencies in order to arrange the provision of appropriate services will take place, including timely referrals and assessments.

iv. **Consideration:** A comprehensive assessment of the patient's home circumstances will take place in line with the principles of the Integrated Assessment, identifying the support required to achieve the best available way of meeting the care needs of the patient.

v. **Creativity:** Consideration of the range of services that most appropriately meets the patient's needs that will promote and sustain their optimum level of independence.

vi. **Integrity:** Displaying a moral and ethical duty to secure the best possible outcome for the patient.

vii. **Partnership:** Effective communication and collaboration between all agencies, ensuring clear lines of responsibility and accountability for the process.

6.2. Discharge or Transfer from Care

The Department of Health (2003) identifies that a patient is ready to be discharged from care when:

- A clinical decision has been made that the patient no longer requires care and is ready for transfer and/or;
- A multi-disciplinary team decision has been made that the patient is ready for discharge/ transfer and;
- The patient is safe to discharge/transfer.

These three criteria are not separate or sequential stages; all three should be addressed at the same time where ever possible.

Discharge planning should begin during any needs assessment or following the decision to admit and should consider the whole continuum of care, until such time that the responsibility for health care can be resumed by the primary care team. In complex cases it is a multidisciplinary/inter-agency process that necessitates close liaison between hospital and community based staff. The continuum may include transfer from acute hospital care to community hospital or from acute hospital to a tertiary care facility and visa versa with the needs of the patient aligned to the level of care provision within each setting.

The discharge planning pathway should be commenced from the outset or within 24 hours of admission and be an actively managed process. Wherever the patient is on the pathway and in whichever healthcare environment, discharge planning should be evident.

Patients who are ready for discharge but cannot be discharged out of an acute setting to their own home; either through choice or a delay in discharge arrangements, will be transferred to an appropriate facility. Patients do not have the right to remain in an acute hospital bed while these arrangements are being realised: (ref: Welsh Government (WG) ministerial statement 23rd April 2013).

6.3. Expectations at Acute and Community Services Level:

Acute and Community Directorate Management Teams are responsible for supporting the clinical areas with the implementation of 6.3 and 6.6 below.

Acute and Community Directorate Teams have a clinical escalation process in place to support ward staff and departments in the event of a failing discharge process.
Each Acute and Community Service Team should ensure the implementation of the following:

- All patients to have an assessment within 24 hours of arrival, which should include consideration of discharge/transfer processes;
- The expected date of discharge (EDD) or transfer will be pro-actively managed against the plan on a daily basis by a named professional or designated deputy;
- The plan will be formally reviewed at each multi-disciplinary ward round/meeting;
- Changes to the plan should be agreed by the patient and communicated to the family/carer/or advocate;
- Effective communication processes must be in place between medical staff, the patient and family/carers, medical, nursing and allied health professional staff and all staff involved in the patient's treatment and care;
- Family members and carers play an important part in a patient's continuity of care following discharge from hospital. Therefore it is important that as part of the discharge plan any practical or emotional support they as individuals may require should be addressed. This is particularly pertinent in the event of any major change in the patient's condition to that preceding the need for the individual's hospital admission and may necessitate transfer of care to an alternative care environment, all of which will have an impact on the family member/carer.

6.4. **Local Discharge Planning at Ward Level:**

All wards will have a localised protocol for discharge which will include:-

- The identification of the staff role(s) that will take the lead for daily review of expected dates of discharge or transfer for individual patients;
- The identification of the staff role(s) that can make the decision to discharge patients (nurse or therapy-led discharge according to agreed policy for individual wards including provision for 7 day working);
- Reference to an expected date of discharge for adult patients being set within 24 hours of arrival by the multidisciplinary team for all unscheduled care admissions; and to initiate local procedures that reflect the Welsh Government Guidance relating to choice of accommodation in accordance with WHC (2004)/066 Choice of Accommodation Directions (National Assistance Act 1948) and communicate all of this to the patient/family/carer/ or advocate;
- The predicted length of stay for elective patients, as determined in their pre operative assessment which includes their discharge plans are to be pre arranged prior to the hospital admission with the patient/family/carer;
- Reference to the planning of ward rounds (in some areas the ward round will also be the MDT meeting) scheduled to allow a senior review of all patients at least daily;
- Daily MDT Board Rounds to establish progress on the patient's discharge plan and identify any potential difficulties that can be addressed;
- All Inpatient discharges should be planned to occur before 10:00am, on any day of the week, including weekends;
- Patients waiting for transport should be transferred to the discharge lounge before 11.00am;
- Completion of the discharge checklist documentation and discharge plan. The process for patients requiring ongoing health or social care support on discharge from hospital is described in the complex discharge section 6.8 on page 9**;**

- The ongoing care management of each patient should be communicated to the General Practitioner on discharge. Following the introduction of the Medicines Transcribing and e-Discharge (MTeD) process a complete discharge summary will be provided electronically;
- A nursing transfer of care discharge letter must be sent with the patient who requires district nursing input or is returning to, or being placed in residential homes, nursing homes or community hospitals;
- The community services will have a discharge protocol in place to guide the discharge process from hospital into the community services;
- In the case of children and young people, the discharge summary is communicated to the General Practitioner and Health Visitor or School Nurse.

6.5. Equipment and Environmental Adaptation

Assessment and advice regarding the need for equipment, non-consumables and medical equipment should be available prior to discharge. Supply should be sufficient to meet the risk assessment needs until continual supplies are obtained. Where equipment is essential for safe discharge, but the items are currently unavailable, short term temporary solutions must be considered to prevent a delay in discharge.

Assessment for equipment and/or adaptations should be timely to avoid delaying the discharge process. Where home adaptations are required before a safe discharge can take place, there may be a delay in the patient going directly home. In these cases it may be necessary to transfer the patient to another facility to wait for the work to be completed. This must meet the level of need required which may not necessarily be an NHS facility.

6.6. Nurse/ Therapist Criteria Led Discharge /Transfer

Where relevant clinical management criteria are in place or where medical staff have confirmed that a patient is medically fit for discharge, the decision for date of discharge will be made by a designated nurse practicing within the agreed criteria.

Criteria for nurse/therapist led discharge will include the following as a minimum:

- There is consensus with the MDT that criteria led discharge is appropriate for the particular patient;
- The proposed date and time of discharge;
- The lead clinician has signed off the protocol for the individual patient concerned;
- The agreed clinical parameters that will constitute medical fitness for discharge is clearly documented;
- The designation and grade of the practitioner with delegated responsibility for making the decision to discharge is documented;
- Confirmation that all planned discharge arrangements are in place;
- The person responsible for discharging the patient ensures and documents that all communication requirements are met;
- The discharging practitioners contact information is available in case of query (Passing the Baton p 64).

6.7. Simple Discharge/Transfer of Care

6.7.1 Criteria for a simple discharge

The patient has one or more of the following:

- Can be discharged to their own home or place of residence (no change to existing nursing / residential placement).

- Has simple ongoing care needs (e.g. Community Nurse/Acute Response Team, Community Children's Nurse) that do not require complex planning and delivery.
- Does not require multi-disciplinary team involvement / meeting.
- Is identified on assessment with length of stay (LOS) predicted.
- Can be discharged directly from ward areas or assessment units.

For simple discharges, an expected date of discharge (EDD) or transfer should be set within 24 hours of admission, based on the predicted length of stay. This should then be communicated to the patient/family and to all staff in contact with the patient.

The EDD must be documented on Myrddin and on the 'Patient Status at a Glance Boards (PSAG)' which are wall mounted within the vicinity of the Nurses Station in each ward area. A PSAG board details the patient's journey of care and those involved in that care.

The EDD should be proactively reviewed against the treatment plan on a daily basis by the Ward Sister or designated deputy, and any changes should be communicated to the patient/ family/ or advocate. Changes to the EDD must also be noted on Myrddin under the notes section for EDD.

6.8. **Complex Discharge**

6.8.1. Criteria for a complex discharge

The patient who:

1. Prior to admission, was already in receipt of social care/community services.
2. Has a restart care package of current services;
3. Is being discharged home with carer/residential or nursing home support (new placement / arrangements);
4. Has a history of recurrent admission linked to a chronic illness;
5. Has a length of stay (LOS) in hospital which is more difficult to predict;
6. Requires educational input, e.g. management of Insulin administration;
7. Requires rehabilitation, home visits or equipment;
8. Is a vulnerable adult ,child or young person, either due to circumstances or diagnosis (refer to The Interim All Wales Policy and Procedures for the Protection of Vulnerable Adults from Abuse Has experienced a recent life changing event/deterioration in functional ability;
9. Is being discharged with an "end of life" priorities package.

6.8.2 Complex discharge and transfer

For complex cases, it is more difficult to anticipate the length of stay and requires detailed assessment and care planning by the MDT. In most cases the EDD should be set within 24 hours of admission, in collaboration with the patient// family /carer/ or advocate and be documented in the patient's record. Ensure that everyone involved in the patient's care is aware of the anticipated timing and works towards the discharge date.

6.9. **Continuing NHS Healthcare (CHC)**

Comprehensive guidance on assessment and eligibility for continuing NHS Healthcare (CHC), a Decision Support assessment tool will assist the decision making process, care planning and provision, dispute resolution and related issues is contained in the publication 'Continuing NHS Healthcare – the National Framework for Implementation in Wales'.

This guidance must be used whenever continuing NHS Healthcare is being considered as an option for the patient. Again, the objective in these circumstances must be to ensure a timely discharge to the appropriate care setting. Refer to Hywel Dda UHB Policy 309 - Continuing NHS Healthcare Operational Policy.

6.10. **Delayed Transfers of Care & Executive Escalation Including Home Of Choice**
A delayed transfer of care is experienced by a hospital in-patient, who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons.

The date on which the in-patient is ready to move on to the next stage of care is the ready-for-transfer-of-care date. This is determined by the clinician responsible for the in-patient care, in consultation with colleagues in the hospital multi-disciplinary health care team and all agencies involved in planning the in-patient's transfer of care (both NHS and non-NHS). Thus the in-patient is ready for transfer of care, but the transfer is delayed, for one or more of the following:

- Healthcare reasons;
- Social care reasons;
- Patient, parent /carer /family-related reasons;
- Lack of essential equipment for support in home environment;
- Difficulty in arranging appropriate transport.

The 'next stage of care' covers all appropriate destinations within and outside NHS, so delayed transfer of care applies to those in-patients who are unable to be discharged from NHS care, and those who are unable to be transferred within the NHS to a more appropriate bed that meets their level of need.

Delayed transfers of care are the subject of performance review for the Health Board and Local Authority partners. They are measured and reported on a national basis monthly using an agreed set of criteria to identify the delay. Community Management Teams (CMT) must ensure that arrangements are in place for the census to be undertaken on a monthly basis and the outcome validated in collaboration with Local Authority (LA) partners. Community Management Teams must also ensure that they have mechanisms to support and monitor the transfer of care arrangements in order that delays can be managed timely and escalated. CMTs should have guidance through local Accommodation of Choice on procedures which reflects the WHC National Assistance Act 1948 (Choice of accommodation Directions) 1993, which was further supported by Supplementary Guidance To WHC(2004) 066/NafW 46/2004 Procedures When Discharging Patients From Hospital To A Care Setting.

6.11. **Escalation of Discharges**
Reasons for the need to escalate a delay in discharge are as follows:

- Delay in treatment, investigation and/or medication;
- Access to care;
- Dispute by patient;
- Dispute by parent/family/carer;
- Technical advice (community provision);
- Dispute by Multidisciplinary Team (MDT);
- Dispute by Agency;
- Delay in assessment by an Allied Health Professional/Social Worker;
- Lack of availability of supportive equipment for home environment;

- Difficulty in arranging appropriate transport.

Local escalation procedures must be followed and documented within the Acute and Community Services Plans.

6.12. **Discharge against Medical Advice**

If a patient wishes to discharge themselves from hospital, the health professional involved must:

- Establish the reason for this intention;
- Attempt to resolve any issues;
- Advise the patient of the consequences of leaving;
- Encourage the patient to see a doctor;
- Assess the risks to the person and/or others and take any necessary action;
- Offer the patient the discharge arrangements that would normally have been planned for their aftercare;
- Document a full account of the events and the relevant discharge plan, together with the patient's responses;
- Encourage the patient to sign a "discharge against medical advice form" located in the designated stationary area generally on the Nurses Station on each ward;
- Inform the patient's GP, Community Nurse and other relevant community services by telephone;
- Complete the Datix incident reporting system.

Where there are reasons to doubt a patient's capacity to make a decision about discharge against medical advice a formal assessment of capacity must be considered in accordance with the Deprivation of Liberty Safeguards assessment criteria as outlined and supported by legislation. Discharge against medical advice may be viewed as an 'irrational decision' but this does not necessarily mean that the patient lacks capacity to make it. As well as a concern about the decision being made, there *must* be some evidence of impaired or disturbed functioning of the mind or brain (e.g. stroke, dementia, mental illness, delirium, intoxication, etc.) before a functional assessment of the patient's capacity can be undertaken.

If the patient is found to lack capacity to make a decision about their discharge, the decision will need to be made following the best interests process. If it is concluded that it is in the patient's best interests to remain in hospital against their expressed wishes consideration must be given to making an application for authorisation under the Deprivation of Liberty Safeguards.

Further information and advice on assessing capacity, best interests decision-making and Deprivation of Liberty Safeguards can be found on the Health Board's Mental Capacity Act intranet page: http://howis.wales.nhs.uk/sitesplus/862/page/48570. Also refer to Hywel Dda UHB Policy 374 - Mental Capacity Act 2005 and Hywel Dda UHB Policy 163 - Deprivation of Liberty Safeguards. The Mental Capacity Act Lead Officer and/or the Deprivation of Liberty Safeguards Coordinator (contact details are available on the webpage) are available for further advice and support.

6.13. **Communication and Information Sharing**

Good communication is a pre-requisite for a well co-ordinated patient journey from pre-admission through to discharge. Patients and their families/carers/or advocates will be given every opportunity to discuss their care, treatment and transfer/ discharge arrangements.

Information will be given as far as possible, in English or Welsh. Additional communication help is available on request, such as language line, interpreters, advocates and other communication aids for minority populations and patients, families/carers/advocates with special needs.

6.14. **Documentation of Discharge and Transfer of Care Process**

Documentation provides the evidence of the active process of planning discharges and transfers of care. It must capture all elements of the planning in relation to the discharge/transfer and evidence the multi-disciplinary/inter-agency, partnership working and joint decision making with the patient with their /family and/or an advocate.

Record keeping is an integral part of professional practice and is essential to the provision of safe and effective care and seamless discharge. This must adhere to Hywel Dda UHB Policy 289 - Record Keeping Nurses and Midwives and profession specific record keeping procedures and guidelines.

Contemporaneous record keeping, whether at an individual, team or organisational level in relation to discharge planning must:

- Demonstrate how decisions related to discharge process were made.
- Document the delivery of care and discharge.
- Document effective clinical judgements and decisions regarding discharge.
- Documents the plans for continuity of care.
- Documents patient/ family/ carers/advocates' involvement and communications regarding the discharge.
- Provides documentary evidence of the care delivered and discharge planning process.
- Document the equipment, medical consumables and other needs.
- Document the transport home arrangements and criteria.
- Document the Do Not Resuscitate Status (DNAR)status clearly
- Ensure the Community DNAR's are completed if appropriate.

In addition, accurate, contemporaneous records assist in the investigations of enquiries, complaints and untoward events. Good standards of record keeping at every stage of the discharge process are essential- including an individual patient case-notes, records of MDT meetings, ward rounds and case conferences.

6.15. **Medicines Management**

Medicines management plays an important role in preparing patients and their families/ carers/advocates for discharges and transfers, which has an impact on the recovery and/or maintenance of their conditions following discharge.

Information regarding medicines must be provided to all patients on their discharge or transfer by a member of the multi professional team. .

Medication and non-consumables should be arranged in a timely manner prior to discharge.

A minimum of seven days supply of medication must be given to the patient on discharge. This will allow sufficient time for the patients to obtain further supplies form their GP.

Requests for existing patients who use Dossette/Nomad cassettes must be arranged at least 48 hours prior to discharge; however those new patients who require Dosette boxes must be referred to their local community pharmacy.

The provision of oxygen on discharge will require advanced planning. Refer to HDUHB Policy 341 - Prescription and Administration of Emergency Oxygen in Adults.

6.16. **Non Emergency Patient Transport (NEPT)**
Over the last two years there has been considerable change to non emergency patient transport across the region and indeed Wales. The Griffiths review identified the need for change and this was initiated with the establishment of four pilot projects. One of these was the Hywel Dda Pilot – ICARHS (Improving Customer Access to Rural Health Services). Prior to the project starting, there was very little knowledge or understanding within the Health Board about planned patient transport and there were no performance monitoring procedures in place with WAST.

Engagement with stakeholders has enabled a vast amount of information to be gathered and analyzed in order to provide a better understanding of the current system and the changes required to ensure that an efficient patient focused service is delivered. A number of interventions have been implemented in order to address some of the identified issues, but there is still significant change required.

The NEPT for 2013-14 was developed to identify the work streams required in order to achieve the initial project objectives, implement the actions identified in “Time to Deliver in Hywel Dda” and ensure that the National Programme Board’s Priorities for Delivery were met.

6.17. **Non-Emergency Transportation**
These guidelines are based on the current patient needs assessment introduced by the Welsh Government in 2007 (Welsh Health Circular WHC (2007) 005. These guidelines should be considered with reference to the Hywel Dda UHB Policy 196 - Escort Policy for Adult In-Patients (section 16).

Ensure that the family have taken home excess patient’s property and the transport will only take one bag on discharge.

For patients medically fit for discharge and deemed eligible for ambulance transport the Welsh Ambulance Service Trust (WAST) liaison supervisor is to be contacted in the first instance. Prior to requesting transport a decision will need to be made as to what category of transport will be required:

T1 - Patient can go by ambulance car (single manned) and patient - walks with minimal assistance;
C1 - Patient can go by ambulance but not by ambulance car – patient walks with minimal assistance.
C2 - Patient can go by double crew;
C3 - Patient in own wheelchair, can be conveyed by single crew;
C4 - Patient in own wheelchair, to be conveyed by double crew;
C5 - Patient in own electric wheelchair, to be conveyed by double crew;
C6 - Stretcher case, to be conveyed by double crew.

The WAST liaison supervisor is only available from Monday to Friday 08.30 hrs to -16.30 hrs, outside these hours transfers should only be undertaken when absolutely necessary. However when deemed necessary alternative transport arrangements will need to be pursued by the site manager and if identified, agreed by the relevant Service Delivery Manager.

It is the responsibility of the discharging hospital to deal with any transport requests for patients being discharged or transferred to another hospital. A patient's transport arrangements on discharge should be discussed with the patient upon admission. It is expected that all patients will make their own arrangements unless there is a medical need for non-emergency patient transport. If a patient is being discharged home consideration must be made to accessing the home, especially when there are codes or keys required that the patient does not have.

6.18. Escorts Arrangements & Transfer between hospital

An escort is defined as any member of staff who is involved with escorting patients and who has the relevant knowledge and skills required to provide a high standard of care during the transfer to ensure patient safety is not compromised.
An escort can be:

- Registered professionals, Doctors, Registered Nurses and Midwives, Operating Department Practitioners, Paramedics;
- Non-registered professional, Healthcare Support Workers and other clinical support workers;
- Family member.

6.19. Children and Young People

Refer to the Directorate/Hospital Site Service plans for specific details on the operational management of discharge or transfer of children and young people.

6.20. Vulnerable adults

There are two issues to be considered related to 'vulnerable adults'. There are those who may be deemed 'vulnerable' because of their condition, social circumstances, etc, but do not meet the definition of a vulnerable adult under the All Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (2010) and are not at risk of harm, abuse or neglect, but they may have specific needs in relation to discharge/transfer and their needs must be met in accordance with the principles of this strategy and Acute and Community Service Implementation Plans.

The All Wales Policy and Procedures for the Protection of Vulnerable Adults from Abuse refers to the Welsh Assembly Guidance, *In Safe Hands 2000*, to provide the definition of a vulnerable adult:

A vulnerable adult is a person over 18 years of age who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of himself or herself, or unable to protect himself or herself against significant harm or serious exploitation.

This definition may include a person who:

- has learning disabilities;
- has mental health problems, including dementia;
- is an older person with support/care needs;
- is physically frail or has a chronic illness;
- has a physical or sensory disability;
- misuses drugs or alcohol;
- has social or emotional problems;
- has an autistic spectrum disorder.

Adult protection is, in itself, a community care service. Vulnerable adults who are referred for adult protection and are not previously known (for example to Social Services) should have the benefit of adult protection services and referral should be made at the earliest opportunity so discharge planning is not delayed.

There will be situations where patients who meet the definition of a vulnerable adult under the All Wales Policy and Procedures for the Protection of Vulnerable Adults from Abuse may continue to be at risk if they are discharged back to the place where abuse occurred or into the care of the person alleged to be responsible for the abuse. In cases where a patient is/has been referred to or is already known to be under Adult Protection Procedures, discharge/ transfer of care planning must take place with close communication with the Adult Safeguarding Co-ordinator in the Local Authority Adult Safeguarding Team to ensure their needs are met in accordance with their adult protection plan. Contact and communication with the adult safeguarding team is essential at an early stage in discharge planning and regularly throughout the process to ensure proactive involvement in the discharge and individual protection planning process.

There are also patients who will meet the above definition and be at risk of harm, abuse or neglect as a result of a failed discharge/transfer or poor discharge/transfer planning. In these circumstances, the Head of Adult Safeguarding should be contacted for advice to consider a referral into Adult Safeguarding Procedures.

Good practice in safeguarding vulnerable adults who are referred to and/or under adult safeguarding procedures is to prevent unnecessary transfers between wards to prevent any communication breakdown in relation to the adult protection plan.

If there are reasons to doubt a patient's ability to make, or to consent to, a decision about discharge or transfer of care, refer to the guidance provided in section 6.12 above.

6.21. **Adults with Dementia**

In-patients with a diagnosis of dementia, specific considerations are required due to the detrimental impact 'change' has on patients with such disabling conditions; resulting in destabilisation and deterioration of their condition and a likely delay in their planned discharge or transfer.

It is beneficial to the care of such patients that moves or transfers of care are kept to a minimum and the National Audit of Dementia Care in General Hospitals Report December 2011 recommends:

- People with dementia should be moved only for reasons pertaining to their care and treatment.
- The move should take place during the day.
- Relatives and carers should be informed of any move and given adequate notice.

Mental Health Advocacy

Mental health advocacy has developed in the United Kingdom over the last twenty years. Advocacy in all its forms seeks to ensure that people are able to speak out, to express their views and defend their rights.

Having a mental health problem or experiencing mental distress can sometimes mean people feel that their opinions and ideas are not taken seriously or that they are not offered the opportunities and choices they would like.

In its simplest form advocacy can mean just listening respectfully to someone.

Advocacy is a process of supporting and enabling people to:

- express their views and concerns;
- access information and services;
- defend and promote their rights and responsibilities;
- explore choices and options.

Formal Advocacy (Independent Mental Health Advocacy IMHA)

An individual will be entitled to the support of an advocate as soon as they are admitted to hospital and will continue to be eligible for that support for as long as they are being assessed or receiving treatment as an inpatient. If further support were required following discharge, the patient would be referred on to existing non-statutory advocacy services. The support provided would only be in relation to issues connected to care and treatment of the patient's mental health disorder. This applies even where the primary purpose for the individual's admission was not for a mental health condition.

By expanding statutory advocacy statutory advocacy services to ensure that access is available to all inpatients receiving treatment for mental ill-health, whether subject to compulsion or not, the Mental Health Measure (Wales 2010) seeks to ensure that the rights of this vulnerable at risk group of patients are safeguarded. Statutory advocacy will assist inpatients in making informed decisions about their care and treatment, and support them in getting their voices heard.

- **Independent Mental Health Advocacy (IMHA)**

An **IMHA** is an independent advocate who is trained to work within the framework of the Mental Health Act to support people to understand and uphold their rights, to obtain relevant information, to participate in decisions about their care and treatment, to explore options and their consequences, to support people to have their views and wishes heard and to promote self-advocacy. An **IMHA** is independent of all services, professionals, family and carers involved in the care of an individual

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The Independent Mental Capacity Advocate (IMCA) Service

- **IMCA** is a type of advocacy introduced by the Mental Capacity Act 2005 ("the Act"). The Act gives some people who lack capacity a right to receive support from an **IMCA** in relation to important decisions about their care.

- **IMCA** services are free and provided by organisations that are independent from the NHS and local authorities.
  Contact them on telephone: 01437 762935
  A 24 hour answer phone is in operation. Calls will be returned within 72 hours.

6.22. **Concerns**

If a concern is raised by a patient/family/carer or advocate in relation to the discharge planning process, the concern should be dealt with using the guidance 'Putting Things Right' – Raising

a concern about the NHS from 1 April 2011. In the first instance, all efforts to resolve the issue should be made immediately, however if this does not resolve the issue, refer the complainant to the Concerns Team.

7. RESPONSIBILITIES

7.1. Chief Executive

The Chief Executive Officer and Board hold ultimate responsibility for assurance, safety and improvement within the Health Board and have a duty for setting Health Board priorities and requirements.

7.2. Executive Director of Nursing & Midwifery

The Executive Director of Nursing, Midwifery & Patient Experience will take the lead responsibility on behalf of the HDUHB for the strategic direction and development of the Discharge & Transfer of Care policy. She/he will also work with education and training providers to influence the development of appropriate training programmes to ensure professionals are competent and safe to practice.

7.3. Deputy Chief Executive / Director of Operations - Acute Services /County Directors of Community Services & Commissioning

The Director of Operations - Acute Services & County Directors of Community Services and Commissioning will be responsible for the localised implementation of the discharge and Transfer of Care Policy by working with consultant colleagues, nursing teams and therapy leads to influence practice and improve processes to maximise bed capacity and reduce avoidable delays.

Transfer of Care Policy by working with Consultant colleagues, nursing teams and therapy leads to influence practice and improve processes to maximise bed capacity and reduce avoidable delays.

The Director of Operations - Acute Services and County Directors of Community Services & Commissioning are also responsible for the development of the Service structures to direct both financial and human resources to support the Discharge & Transfer of Care Policy through the Service Delivery and Senior Nurse Managers

They will be responsible for ensuring that the Discharge & Transfer of Care Policy is fully implemented within their areas of responsibility. The Directorate Nurse Children's Health, Head of Specialist Child and Adolescent Mental Health Services, Heads of Mental Health Services, Heads of Therapies and Clinical Support Services will work in partnership with the Service Delivery and Senior Nurse Managers to ensure that the said policy is operationalised.

The Unscheduled/Scheduled Care/Hospital Site General Managers have overall responsibility for the monitoring of performance associated with the discharge and transfer of patients, how it impacts upon reducing average length of stay (ALOS), delayed transfers of care (DTOC), bed capacity and patient flows.

They will also be responsible for the full implementation of EDD, and for creating an environment in which multi-agency and partnership working flourishes to assist the process and patient experience.

7.4. Discharge Liaison Nurses

The Discharge Liaison Nurse (DLN) role is designed to support both patients and ward staff in the application of discharging patients with complex health and social care needs. The DLNs are responsible for providing effective communication between all members of the multidisciplinary team and associate departments and are responsible for identifying complex discharge issues and delays in the entire diagnostic, treatment and care process whilst being proactive in generating solutions which meet both the patients and carers needs in order to facilitate a safe discharge from hospital.

The DLNs provide a service in all the Acute General Hospitals across Hywel Dda University Health Board.

The Discharge Liaison Nurse should:-

- Co-ordinate discharge planning for patients with complex needs;
- Liaise with other relevant internal/external agencies to ensure optimum progression of care, completing assessments in a timely way;
- Work within the guidance of the Health Board's Discharge and Transfer of Care Policies;
- Work efficiently in coordination with the Hospital Bed Management Team in order to have effective patient flow and timely discharges;
- Attend multidisciplinary team meetings as required to progress complex discharge plans for the patient;
- Undertake audit and research as required in relation to the discharge planning process.
- Participate in and provide direct teaching in relation to the discharge process to multi professional groups;
- Chair discharge planning meetings as required;
- Be accountable for the accuracy of information collated and disseminated to the multidisciplinary team;
- Act as a resource point and role model for providing knowledge and advice to all staff working within the Health Board in relation to discharge planning;
- Be proficient in the assessment of patients for continuing health care applications;
- Be proficient in supporting staff in implementing local procedures relating to choice of accommodation as reflected in the WHC National Assistance Act 1948 - Choice Accommodation Directions 1993 and subsequent Supplementary guidance WHC 2004 Procedures when discharging patients from hospital and in providing relevant documentation /information to families;
- Be proficient in the assessment of patients for Reablement services and inputting data accurately onto the Carefirst IT System.

7.5. Medical Consultant /General Practitioner

Overall legal responsibility for a patient's medical care remains with the named consultant during admission, inpatient stay and discharge. On discharge the patients care returns to the patient's General Practitioner.

However, the Consultant can delegate responsibility to an appropriately qualified health professional. When a task is delegated the consultant/lead clinician assumes responsibility for delegating appropriately.

The Consultant should:

- Support the Expected Date of Discharge;

- Ensure that every patient has an EDD and discharge plan;
- Set clear goals of the discharge criteria for the MDT to follow.

8. MONITORING - KEY PERFORMANCE INDICATORS FOR DISCHARGE AND TRANSFER OF CARE

All Acute Service Hospitals / Directorates and Community Teams are required to provide evidence through key performance indicators (KPI's) that patients are receiving appropriate care. The KPI's include:

- Reducing the average length of stay;
- Reducing the delayed transfers of care;
- Increasing the percentage of wards using expected dates of discharge;
- Increasing the percentage of patients having an EDD in place within 24 hours of admission;
- Increasing the percentage of patients discharged before 1100Hrs;
- Percentage of patients discharged to usual place of residence;
- Reducing the hospital readmission rates within 28 days of discharge.

Completeness and timeliness of discharge letters are regarded as quality indicators.

9. TRAINING

The Hywel Dda University Health Board will ensure that all frontline staff has access to appropriate training in the management of patient discharge and transfer. This will be addressed through wide availability of the policy and through various training opportunities for example:-

- Internal training programme;
- Clinical induction and orientation;
- Appropriate E-Learning resources;
- Access to the effective Discharge Planning Module (University of Wales Swansea).

10. IMPLEMENTATION

The Acute Hospitals Services / Directorates and Integrated County Community Teams will set out the implementation process of the Discharge and Transfer of Care Policy within the areas.

11. REFERENCES

- CCQI/Royal College of Psychiatrists/ Royal college of Physicians (2011) Report of the National Audit of Dementia Care in General Hospitals.DOH (2010)

- Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care.

- DOH Continuing NHS Healthcare National Programme, (2010). 10High Impact Changes for Complex Care. NLIAH, Cardiff.

- NLIAH (2008) Passing the Baton. A practical guide to effective discharge planning.

- The Wales Interim Policy and Procedures for the Protection of Vulnerable Adults (2010)

- Welsh Health Circular WHC (2005)035: Hospital Discharge Planning Guidance

- WHC (2006)059: Emergency care – A report from the Delivery & Support Unit
- WHC (2004)066: Guidance on National Assistance Act 1948) Choice of Accommodation Directions 1993
- WHC (2004)024: NHS Funded Nursing Care in Care Homes Guidance
- WHC (2004)054: Continuing NHS Health Care: Guidance and Framework for Implementation in Wales
- Part 7 – Social Services and Wellbeing Act (2014)
- HIW Review of Adult Protection Procedures in Wales (2010)
- All Wales Child Protection Procedures
- www.wales.nhs.uk
- www.publichealthwales.org

12. GLOSSARY OF TERMS

Expected date of discharge	EDD
Multi-disciplinary team	MDT
Length of stay	LOS
Continuing NHS Healthcare	CHC
Do not attempt resuscitation	DNAR
Non emergency patient transport	NEPT
Average length of stay	ALOS
Delayed transfers of care	DTOC
Discharge liaison nurse	DLN
Deprivation of Liberty Safeguards	DOLS
Key performance indicators	KPI
Protection of Vulnerable Adults	POVA