INPATIENT UNIT DISCHARGE POLICY

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RATIFIED BY: Quality & Patient Safety Committee

FOLDER:Clinical

AUTHOR: Director of Patient Care

POLICY STATEMENT

This policy supports patients and their families in planning appropriate and timely discharge to an alternative place of care, once the care provided by the specialist inpatient unit is no longer needed. Rowcroft is registered with CQC to provide specialist inpatient care and cannot provide long-term care. The average length of stay is 10 days (2016). Rowcroft has a small number of inpatient beds to serve a population of circa 280,000 and therefore recognises the need to maximise the use of its specialist resources for the benefit of as many patients as possible.

The NHS standard contract (2016-17) and the law[i] does not require the hospice to continue to provide a service that in the professional's opinion is unsuitable for the individual person.

Planning for effective discharge or transfer of care should begin on, or before admission in partnership with the patient, their representatives and the relevant members of the MDT. The team recognises this may not be appropriate in cases where the patient is admitted specifically for last days of life care. This policy applies to all patients equally whether or not they require NHS or social care and whoever may be funding such care.

ROLES AND RESPONSIBILITIES

The Clinical director or Consultant in charge of the Inpatient unit is responsible for working with the MDT to determine if a patient is medically fit for discharge. When a patient is medically fit for discharge the medical team will communicate this to the patient and/or their representative and together with the MDT plan a timely date for discharge.

When a patients choice is to be cared for at home or an alternative care setting and they are not medically fit to be discharged, the risks will be discussed with the patient and where applicable their family or representative. Should a patient still wish to be discharged the appropriate documentation will be completed by the clinical staff.

Where there are difficulties in achieving the patients preferred option in a timely manner, the Clinical Director with support of the Director of Patient Care is responsible for discussing with the patient and/or their representative the requirement to agree an alternative temporary care setting.

Line Managers Responsibilities

All Line Managers are responsible for ensuring:

- Staff are aware of the discharge policy
- Staff are competent in communicating with patients and their representatives from the day of admission to plan patients discharge, unless the patient is in the last days of life.

Staff Responsibilities

All staff are responsible for:

- Supporting patients and their representatives by providing appropriate information about their options and support services available on discharge
- Where the patient's choice is for discharge to a Care Home, rather than home, staff will engage a hospice social worker or CCW to support the patient and their representative to find a suitable placement.
- Staff are responsible for completing the relevant CHC funding applications, where appropriate.
- Staff are responsible to ensure patients have the necessary take home medications, dressings, equipment and care package in place (where applicable and available), prior to discharge.

Corresponding Policies:

- Admission policy
- Policy for Informed patient consent
- Deprivation of Liberty Safeguards Policy
- Policy for Discharge against medical advice

AIMS AND OBJECTIVES OF RISK MANAGEMENT POLICY

The hospice inpatient unit resources are used fairly and equitably, maximising the benefit to all those in Torbay and South Devon who require specialist palliative care or require supportive care in the last days of life.

Objectives

- Patients are informed about their options and supported to be discharged home, where this is their preference, or to a suitable alternative care setting.
- Patients will be supported to be discharged to their choice of care setting, where possible; where this is not possible in a timely manner patients will be supported to choose a temporary alternative setting until their preferred choice is available.

PROCEDURE

- Every patient and/or their representative must receive the IPU admission leaflet which outlines that the hospice is a short-term specialist unit.
- The clinician in charge or another member of the medical team will initiate discussions about discharge home or to an alternative care setting as soon as practicable and appropriate.
- MDT members will agree who will lead the discussions about discharge planning with the patient and their representative
- When the patient is clinically stable this will be recorded in the patients record
- Staff must ensure the patient gives consent to involve their family or other representatives in planning discharge, including applications for CHC funding.
- Where there is a disagreement between the patient and the family about discharge plans the patient may wish to access an advocate to support them. For example a competent patient may wish to be discharged to their own privately owned home, but the family may not want to support this wish.
- Where applicable any unpaid carers of a patient who is being discharged home will be offered a carers assessment[ii] to support their needs in fulfilling this role
- Where the patient lacks capacity and they have no representative an independent mental capacity advocate will be consulted on the patient's behalf to support a best interest decision about onward care.
- All discussions and plans must be documented in the patient's electronic record.
- When the chosen care home or agreed care package is not available the MDT will discuss with the patient and/or their representative potential alternative interim available options for care and seek to gain agreement for the patient's preferred alternative option.
- Where the patient or their representative/s object to planning discharge or to the options available the Clinical Director, Consultant in Palliative Medicine or Director of Patient Care must be made aware at the earliest opportunity. The Director of Patient Care or Clinical Director will offer to meet with the patient and/or the family to discuss their concerns and seek to resolve these.
- Where there is a disagreement to transfer a patient to an alternative care setting and attempts to resolve concerns have failed the patient and or their family will be informed they have the right to complain using the organisations complaints procedure.
- Where the patient or family contest discharge from the hospice or inappropriately delay plans for discharge the Director of Patient Care will formally write to the

patient and or family as appropriate, to inform them that they will need to either choose a care package at home or choose an alternative care setting such as a residential or care home. They will be asked to notify Rowcroft of their decision within five working days from receipt of a recorded delivery letter.

- Legal, CCG and local council advice will be sought by the organisation, if required, should a resolution to discharge not be agreed.

REFERENCES

[i] R (Burke) v GMC (2005) EWCA Civ 1003; Aintree University Hospitals NHS FT v James (2013) UKSC 67
NHS Act 2006 (amended) s26, 63
Criminal Justice and Immigation Act 2008, ss 119-121) NHS Protect.
[ii] Care Act (2014)