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1.0 Introduction

For the majority of patients discharge from hospital is simple and uncomplicated. For a minority of patients their needs are more complex. However, all patients, regardless of their discharge type, need to be confident that the policies and procedures in place ensure that their discharge is effectively planned and is as uncomplicated as their circumstances allow.

Discharge planning is an essential component of quality healthcare for patients who transfer, or discharge home, from one care environment to another. Clear guidelines and procedures need to be in place to ensure a safe consistent process. Discharge can be a major life event for patients, their families and carers. It may also have substantial implications for the use of health and social care resources as well as for the voluntary sector and other support services.

1.1 Aim of the Policy

The aim of this policy is to provide a robust framework for Discharge Planning for all patients. The policy should be read in conjunction with NHS Lothian Discharge Procedures, Discharge Checklist and other appropriate NHS Lothian/national policies, procedures, standards and/or guidelines. See also 1.3.

The policy provides staff and the multidisciplinary team (MDT) with guiding principles and outlines roles, responsibilities and accountability for discharge planning throughout NHS Lothian. It provides a reference for staff of all agencies involved in discharge planning in order that they may understand individual and team responsibility, and will facilitate the safe and timely discharge of all patients in a dignified manner.

1.2 Policy Objectives

Implementation of the policy will:

- Achieve consistent high quality and safe discharge for all patients, and where appropriate their carers and relatives;
- Set the standards and procedures to be followed in the discharge process;
- Affirm the importance of joint (inter-agency) and multidisciplinary (intra-agency) team working, and meet legal, national standards;
- Provide a consistent, coordinated approach with multidisciplinary, multi-agency input while maintaining the individual's interests as central to the discharge planning process;
- Provide a systematic review process for discharge planning; providing staff, patients and their representatives with a voice in the review process;
- Ensure adherence to national and local quality standards

1.3 Scope

This policy applies to all persons (staff and patients), in all locations, who are involved in the discharge of NHS Lothian patients.

The term discharge also relates to the transfer of patients and patients with on-going care, either within or out with NHS Lothian and should be read in conjunction with:

- Policy on the assessment of eligibility for adult continuing NHS healthcare
- NHS Lothian management of patient’s funds and valuables policy
- NHS Lothian Policy for Meeting the Needs of People with Limited English Proficiency: Interpreting and Translation
- Procedure for the safe transfer/escort of patients within and out with NHS Lothian
- Principles and procedure of care management for Adult Patients (16+) with cognitive impairment within a generic hospital setting
- Caring for adult patients (16+) with learning disabilities within a generic hospital setting
- The Carers Information Strategy
- Moving on policy
- Adult Support and Protection: Ensuring rights and preventing harm
- NHS Lothian Child Protection procedures.

2.0 Philosophy, Principles and Objectives

2.1 Philosophy of Discharge Planning

Appropriate, timely discharge planning is fundamental to the provision of effective health care and enhances the patient's, and their relatives/carer's, experience. Poor discharge planning leads to the inefficient use of beds; increases in waiting lists; higher re-admission rates; patient and carer distress; as well as increased workloads for hospital staff and colleagues in the community. Discharge planning is a process and not an isolated event, and those involved should understand the various elements within this process (see NHS Lothian Discharge Procedure). This process needs to be managed seven days a week and should involve patients, relatives, carers, MDT members and inter-service agencies fully. It builds on the following guidance ‘Discharge from Hospital: Pathway, Process and Practice’ issued by the Department of Health in January 2003. Advanced and anticipatory care planning is to be used where appropriate. For more information please see Anticipatory Care Planning Frequently Asked Questions from the Scottish Government (2010).

The working of the MDT is also an important element in discharge planning and the aim of all members of the MDT would be to commence planning for discharge where possible pre-admission or at the point of admission. The information collated prior to or on admission is critical in providing a focus to enhance patient care and the patient experience.

2.2 Key Principles of Discharge Planning

Although discharge criteria should be relevant to the aims and objectives of each clinical area, the following principles and values must always be taken into consideration. Individual areas may produce more specific guidelines but these should reflect the overall principles outlined below.

2.2.1 Multidisciplinary/multiagency approach

The discharge process should be a multidisciplinary, inter-agency progression during which the needs and resources of patients and carers are assessed. Where assessment records that care or service is required, this will be clearly identified, agreed and documented as a responsibility of health and/or social services. These actions will be completed within agreed timescales.

2.2.2 Patient/Care/Family Involvement: Person Centred Care

This process will involve the patient and carer who are central to decision making, and who will be engaged, informed and communicated with at all stages. It is crucial that for every individual patient, and where appropriate their carers, they are at the centre of a customised pathway and not made to ‘fit’ into a process.

2.2.3 Planning and Communication

Effective discharge of patients from, acute and non-acute, inpatient facilities is a process which secures the successful transition of our patients from secondary to primary or community care.
Planning and good communication between every person involved in making those arrangements is required. Further advice and information on communication support can be found in the NHS Lothian Interpreting and Translation Policy: Meeting the Needs of People with Limited English Proficiency.

2.2.4 Dignity and Respect for Individuality
All patients will be treated with dignity and due consideration for their individual needs; the right to accept or decline care will be respected at all times. See NHS Lothian Policy and Guidance for Obtaining Consent (2010).

NHS Lothian recognises and values the differences in people. In carrying out our duties as an employer and service provider, we will act to promote equality for all regardless of age, disability, ethnicity, religion, gender, socio economic status or sexual orientation. The right of individuals to the lawful expression of these differences should be respected and their rights upheld.

3. Roles and Responsibilities

3.1 Patients

Patients will be fully involved in planning for their discharge and will be kept informed of any change affecting agreed plans.

3.2 Carers and Relatives

With the patient’s agreement, and with due regards to relevant legislation and individual circumstances, relatives and carers will be fully involved in both the discharge process and arrangements. Their contribution to aftercare and support will be both acknowledged and recorded. This policy will follow the principles outlined in the Carers Rights, which are to:

- Inform carers of the process and procedures of hospital admission and discharge and ensure carers are fully involved in the decisions taken at these key stages; and
- Recognise carers as integral to the pathway of care of the person being cared for.

This policy requires staff to share NHS Lothian’s duty to include carers and relatives, as appropriate.

3.3 Patients Who Refuse To Be Discharged or Reluctant Discharges

No one has a right to remain indefinitely in a NHS bed. If a patient refuses to be discharged from hospital, all efforts should be made to secure resolution by exploring all options.

The MDT will identify potential ‘reluctant’ discharges and discuss these within the MDT. For further information please refer to the NHS Lothian moving on policy and the NHS Lothian policy on the assessment of eligibility for adult continuing NHS healthcare.

If all options have been explored and there is still no agreement, the hospital may begin to implement discharge in an appropriate and sensitive manner. All discussions and decisions must be accurately and legibly documented.

3.4 NHS Lothian Staff

All staff are personally responsible for ensuring their actions comply with this policy.
NHS Lothian, its staff and its partners should demonstrate commitment to the following principles and values for the effective discharge, transfer of care and on-going care of our patients:

- Discharge is a process and not an isolated event. It has to be planned for at the earliest opportunity across the primary, secondary and social care services, ensuring that individuals and their relatives and carers understand and are able to contribute to care planning decisions as appropriate;
- Unnecessary admissions are avoided and effective discharge is facilitated by a ‘whole system’ approach to assessment processes and the delivery of services;
- The process of discharge planning should be co-ordinated by an appropriate member of the MDT who has responsibility for co-ordinating all stages of the ‘patient journey’. This may involve liaison with the Primary Care Team and/or Out-patient/Pre-admission clinics at the earliest opportunity and the transfer of those responsibilities on discharge;
- The engagement and active participation of individuals and, as appropriate, their relatives and carer(s) as equal partners is central to the delivery of care and in the planning of a successful discharge;
- Excellent communication and information sharing to ensure a smooth, effective, safe and prompt transition for our patient and/or carer, from hospital to home setting or further care facility; and
- A collaborative multidisciplinary and multi-agency approach, with a clear allocation of roles and responsibilities.
4 References


