

Discharge Policy and Procedure

<p>Approved by: Ian Marshall, Chairman Originator: Catherine Power, Head of Clinical Services Date of approval: September 2017</p>	<p>Signature: </p>
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1. Introduction

Primrose Hospice has a responsibility to use its resources for the benefit of as many people as possible, and to ensure equity of access for all who meet our criteria (See Policy & Procedure for Referral and Admission to Care Services at Primrose Hospice).

This means that as well as working hard to open access to people who have a need that we are able to meet, we must also discharge those people who have benefited from our services but no longer need them.

People may be discharged from services provided by Primrose Hospice when their need for that service has been met, or their need for the service could be better met by an alternative service.

Occasionally an individual's perceived needs will not have been met by Primrose Hospice because the service is not able or resourced to address a particular issue. In this circumstance the Hospice will aim to signpost or refer the person on as above, to an alternative service that matches the individual need better, and will also aim to communicate clearly why the Hospice cannot help in this situation.

Primrose Hospice aims to ensure that discharges are safe and timely, and that people who use our services and are being discharged understand the reasons for the discharge and how to access alternative services and/or return to us to access further services in the future if the need arises.

Primrose Hospice acknowledges the changing needs of people living with life limiting illness.

Primrose Hospice will liaise appropriately with members of the wider health and social care teams; referring on to other agencies, with the person's permission, if indicated.

2. Purpose of Policy

The purpose of this policy is to set out those steps needed on the discharge of a person from any of the services at Primrose Hospice, including:

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- The internal process to be followed for the discharge of a patient or family member/carer to an external health or social care agency
- The need to share relevant information to facilitate discharge
- The need to ensure that other relevant health and social care agencies are aware of the discharge
- Documentation requirements
- Reporting structures

3. Roles and Responsibilities

Management Responsibilities

Chief Executive

The Chief Executive is responsible for determining the governance arrangements of the Hospice including effective risk management processes. They are responsible for ensuring that the necessary clinical policies, procedures and guidelines are in place to safeguard patients and reduce risk. In addition they will require assurance that clinical policies, procedures and guidelines are being implemented and monitored for effectiveness and compliance.

Clinical Lead Nurse

The Clinical Lead Nurse has overall responsibility for patient safety and ensuring that there are effective risk management processes within the Hospice that meet all statutory requirements and adhere to guidance issued by the Department of Health.

Line Managers

Line managers are responsible for ensuring that:

1. This policy is made available to all staff within their department
2. The staff they are responsible for implement and comply with the policy
3. That staff are updated with regards to any change in the policy

4. Process

Setting of Expectations

In all areas, people will be told when they first attend Primrose Hospice how long they might expect to attend:

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- i. Day Hospice patients are informed that attendance is usually for 8 or 12 weeks initially, and depending on the circumstances might expect a review towards the end of that period with an extension of that period if indicated by their changing condition.
- ii. Outpatients are told that the frequency and regularity of future appointments will be agreed with them at each appointment.
- iii. The Therapy team (Physiotherapist and Occupational Therapist) provide problem-based support as and when it is needed.
- iv. People accessing Counselling Services will receive up to 6 sessions initially, and a formal written contract is drawn up at the outset of the service (**appendix 1**). This may then be extended if it is felt to be necessary but always in such a way that is very clear to both parties.
- v. People accessing Complementary Therapies will understand at the outset of therapy how many sessions they can have. The number of sessions is strictly limited to carers and family members but palliative patients can usually have ongoing therapy limited only by the resources available. Patients undergoing treatment aimed at cure will generally be offered a limited number of sessions which may be increased where a specific need has been identified on review.
- vi. People accessing bereavement groups are provided with clear information both written and verbal as to how long they will have access to a specific group. Following assessment they will then be supported to move on as appropriate, providing a seamless service which encourages independence and reduces dependence on one aspect of the service.
- vii. People accessing other Family Support Services, including the Children's Service are aware from the outset that their service is tailored to individual need. This will be determined by the input required both pre and post bereavement. All workers within the Family Support Service receive supervision and within this process cases are evaluated and discussed, and the timing of discharge is agreed, on a needs led basis.

Key Workers

Each service has a key worker who takes responsibility for the length of care episode and together with the person receiving the service will decide when the person's needs have been met or could be better met by an alternative service.

The Decision

That decision may involve other members of the multidisciplinary team (MDT) and may be discussed at the weekly MDT meeting; however this is not essential.

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It is essential that the person to be discharged is involved in discussions.

Referral on

Where appropriate and agreed by the person, referral may be made to external agencies.

Clinical records will be used to record the transfer of all relevant information to the external agency to facilitate a smooth progression from one service to another. This may include SystmOne and it may also involve writing a letter where the agency does not use that system.

People should be made aware of and consent to this sharing of their healthcare records.

If there is any question about the legitimacy of sharing of records the Caldicott Guardian can advise.

Setting a date

A discharge date will be agreed with the person and if appropriate their family.

Communication with other professionals

For all Day Hospice patients and Outpatients a discharge summary will be issued, setting out the current situation and including assessed problems and goals achieved, together with any forward planning.

As above, patients are offered a copy of their discharge summary. Their response to discharge is recorded in their healthcare record.

For all other services a discharge summary may be issued at the discretion of the clinician.

5. Review

This policy and procedure will be reviewed every 3 years or sooner if required by changes in legislation or local or national guidelines.

6. Policy Area

Patient Treatment and Care.

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7. Staff Training Requirements

This policy will be introduced to staff on induction.

Clinical staff will be qualified to make appropriate assessments and decisions on whether goals have been achieved and needs met. Training in these areas will be provided if needed.

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