HSU

STRATEGIC INNOVATION & PEER LEARNING

In housing, health, care and support

TOOLKIT

AN ASSESSMENT

TASK LIST

DH Department of Health

Planned discharge of older people from an acute hospital setting "crisis" admission.

It is no longer necessary to use a "default" position of discharge to residential care and indeed this would not be the first choice of most older people. Up to date models of housing and community support can often enable older people to return home or move to more suitable accommodation that still enables independent living

Discharge planning should ideally start at admission stage at ward level and involve multi disciplinary integrated teams that have a good grasp of how all related service providers (in particular the housing and voluntary sectors) operate in their locality. There should be a named discharge co-ordinator and of course the views of the patient and their family and carers should be at the heart of every discharge plan

Key task for the care co-ordinator / discharge co-ordinator

- Co-ordinating patient assessment, care planning and daily review of the care pathway.
- To discuss with the patient a potential transfer/discharge date usually within 24 hours of admission and recorded in the patient's notes.
- Ensure that timely referrals are made, results are received and any delays are followed up.
- Identify, involve and inform the patient about all aspects of care planning, ensuring that the special needs of young carers are identified.
- Engage the carer and make arrangements for carer assessment if appropriate. Make arrangements to see the carer separately regarding their own needs.
- Keep the patient's documentation up-to-date.
- Liaise with and work as an integral member of the multidisciplinary team and care management services.
- Liaise with specialist nursing service and other specialist services as appropriate.
- Finalise the transfer/discharge arrangements 48 hours before discharge and confirm with the patient and carer/family.
- On day of transfer/discharge ensure the patient's condition remains as expected and confirm follow up arrangements.

The hallmarks of a high functioning multi disciplinary team: The team will have

- a well-developed understanding of the key roles and responsibilities of those involved in rehabilitation and discharge planning;
- a comprehensive knowledge of the care options available, the referral processes and criteria for admission to those services;
- information on what services are provided in the patient's own locality by the independent sector and housing organisations;
- The support of generic staff who take on the more routine administrative functions to enable

the skills and experience of the team to be targeted effectively. New roles can be developed such as home finder posts;

- Excellent communication and problem solving skills; the ability to work proactively to ensure patients receive appropriate care in the right setting

Job shadowing, mentoring, job swaps and secondments between differing disciplines can add real value for staff to really understand the bigger picture and the issues colleagues form another area have to consider

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Suggested decision tree for housing issues around discharge planning for older people

1 Have the views and wishes of the individual and his/her family and carers been taken into account? Are all consents obtained to discuss their situation with others?

2 If the individual already lives in supported/ sheltered / extra care housing, have these staff been involved and consulted?

3 Has a carer's assessment been carried out? (See below)

4 Has a full OT / telecare and reablement assessment been carried out? Can the individual return home with intermediate care and or longer term assistance at home?

5 What equipment, aids, adaptations and telecare is required in the home to facilitate discharge?

6 Is a DFG required as well as / in addition to the above?

7 If the answer is YES to any of numbers 4,5,or 6, have these requests been “fast=tracked” to the Handy person service/ DFG team/telecare team for fitting etc? (NB service standards should be in place re timescales etc)

8 Is short term intermediate housing required (e.g. sheltered or extra care) whilst DFG completed; if so has this been booked via the provider?

9 Has a six week “help at home” intensive care and support package been arranged to start on the day of discharge?

10 If current accommodation is not suitable for return even with equipment, adaptations and telecare, have all housing options been discussed with the individual?

11 If an Extra Care flat is best option, has this request been placed before the Allocations Panel with full assessment and report to enable fast track allocation of next empty flat (the allocations protocol should allow top priority for hospital discharge into extra care where appropriate and where the applicant fits the criteria)

12 If sheltered housing is more appropriate, has the individual been placed on the housing register with suitable priority ad assistance to bid via choice based lettings schemes

13 Is short term re-ablement and accommodation required whilst numbers 11 and /or 12 resolved?

14 What voluntary and community sector assistance can enhance any discharge arrangements and how is this being accessed?

15 Which organisation / individual staff member will take on the post discharge action plan following discharge from hospital?

16 Is the patient, his/her family and carers clear about the proposed course of action and timescales involved?

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A carer's assessment should be made covering the following areas

- Carers’ role.
- Breaks and social life.
- Physical and mental well being.
- Relationships and mental well being.
- Care of the home/s.
- Accommodation.
- Finances.
- Work (where carer is of working age).

- Education and training.
- Current practical and emotional support.
- Wider responsibilities.
- Future caring role.
- Emergencies/alternative arrangements.
- Access to information and advocacy.
- Personal safety and risk management.
- Agreed outcomes.

Discharge checklist 48 hours prior

Task Completed	By whom and any comments	Date	Signatures
Written and verbal advice given to patient			
Support worker / Scheme manager notified			
Patient care discussed with family/carer.			
Arrangements confirmed			
Family/carer advised of discharge date			
Carer understands how to use any specialist equipment provided			
Transfer of care co-ordinator responsibilities confirmed & note of new coordinator made			
GP letter written Discharge letter			

completed and signed			
Letter faxed or e-mailed to primary care			
Transport arranged: Own Hospital			
Arrangements for home equipment confirmed			
Training in use of equipment completed			
Relatives asked to bring outdoor clothes for patient to go home in			

Checklist to be completed on day of discharge with patient.

Task Completed	**By whom and any comments**	**Date**	**signatures**
House Keys			
Heating on			
Food available			
Medication instructions discussed with patient and/or carer			
Prescription arranged			
Prescription dispensed			
Community therapies informed			
Community nursing informed			
Out-patient			

appointment given			
Transport confirmed			

NB

Intermediate care is a range of integrated services that are intended to:

- promote faster recovery from illness;
- prevent unnecessary admission to an acute hospital bed;
- support timely discharge;
- reduce avoidable use of long-term care;
- maximise independent living.

This support can be delivered into an individual's own home, housing schemes, day centres and hospitals, as well as in more traditional care and rehabilitation settings such as community hospitals and care homes.

Transitional care

Transitional care refers to that care provided to a person who is not able to be placed in their home or the permanent setting of their choice but who still requires a supportive, and appropriately staffed, environment to live in. It can be used, for example, while someone is awaiting major adaptations to their own home. The essential feature is that the individual is there on a temporary basis, and there is an agreement that this is the case with the person, their carers, if relevant, and those administering the placement. All should be clear as to why the placement is needed and for how long. The care provided must be appropriate to the person's needs, including providing rehabilitation, support, confidence building and time for recovery.