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Quality and Patient Safety Division

Integrated Care Guidance:
A practical guide to discharge and transfer from hospital

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Overview

Overview

This practical guide to integrated care is designed to support healthcare providers to improve their discharge and transfer processes from the acute hospital setting back into the community and thereby, support the delivery of high quality safe care. The National Integrated Care Guidance has been developed by the National Integrated Care Advisory Group under the auspices of the Quality and Patient Safety Division. The guidance is based on feedback received following extensive national and targeted consultation with service providers in both the acute and community healthcare settings and on review of Version 1.0 of the HSE Integrated Discharge Planning Code of Practice (2008). The Integrated Care Guidance (2014) replaces the existing HSE Integrated Discharge Planning Code of Practice (2008).

This guide will support service providers in demonstrating how they are meeting the National Standards for Safer Better Healthcare (NSSBH), (HIQA, 2012) and the High Impact Changes required to Improve Performance with Unscheduled Care (SDU, 2013).

This document currently pertains to discharge and transfer from the acute hospital setting to the community and consequently may be followed by service specific guidance e.g. palliative care discharge guidelines, other relevant clinical care pathways.

Structure of the guide

The National Integrated Care Guidance begins by outlining and explaining the nine key steps required for effective discharge planning and transfer from the acute hospital setting (see figure 1). The steps are based on good practice previously identified, used and evaluated by service providers in the HSE Integrated Discharge Planning Code of Practice (2008) and incorporate the key lessons learned during implementation of the Code of Practice for IDP (2008). It also reflects discharge processes used in other jurisdictions e.g. Ready to Go, Department of Health UK[1].

The second section outlines and explains the eight underpinning principles of the healthcare charter – 'You and Your Health Service' which aims to ensure a positive health experience for service users.
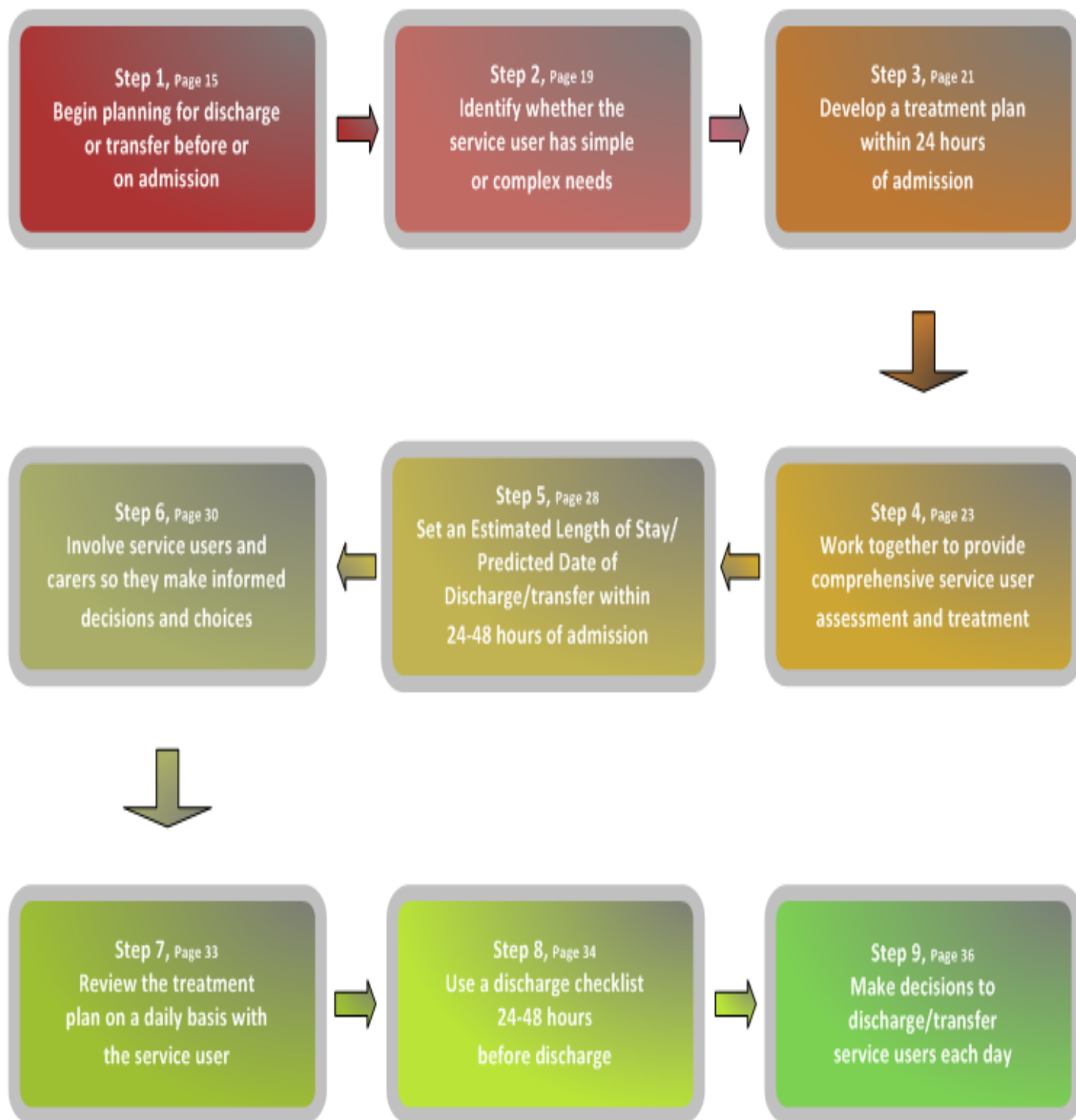
The third section provides essential guidance regarding medication safety and medication reconciliation which when undertaken at key stages of the service user's journey of care facilitates and supports safe admission, discharge and transfer.

This guide seeks to help service providers to embed these principles consistently into daily discharge and transfer practices so that they become habitual. Small things done consistently can and do have a significant impact on providing person centred, safe and effective care for service users.

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[1] Department of Health (2010) *Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care.* DH

Structure of the guide

Figure I: The nine steps in effective discharge and transfer of care from hospital to community

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Begin planning for discharge or transfer before or on admission

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## 1.	Introduction

The majority of people spend relatively short periods of time in hospital. It is estimated that approximately 80% of all discharges are simple in nature i.e. are straightforward and follow a predictable series of events. However, achieving safe and effective discharge or transfer of care can become complicated by a number of internal and external factors in the hospital e.g. pressure to discharge to release beds, shorter lengths of stay, accuracy of information available on admission regarding use of services in the community. Ensuring service users are discharged or transferred safely and on time requires full assessment of their individual healthcare needs, planning and co-operation of many health and social care professionals. The challenges and barriers to effective timely discharge or transfer of care are well documented, so too are the potential benefits for service users and services providers in terms of healthcare experience, health outcomes and efficiency of service provision and management.

### 1.1	What is Integrated Care?

It is the 'processes, methods and tools' of integration that facilitate integrated care. Integration involves connecting the healthcare system (acute, community and primary medical) with other service systems such as long-term care, education or housing services (Leutz, 1999: p77-78).

### 1.2	What is the purpose of integration?

The purpose of integration is to improve service user experience and outcomes. In its most complete form, integration refers to a single system of needs assessment, service planning and service provision. This is done by using a whole systems approach. Whole system working takes place when:

- Services are organised around the service user.

- All stakeholders recognise they are interdependent and understand that action in one part of the system has an impact elsewhere.

- Vision, values, objectives and actions (including redesign of services) are all shared.

- Users experience services that are seamless, in other words the boundaries between service providers are not apparent.

This method requires all stakeholders to agree an approach and then to act flexibly to deliver it.

Introduction

1.3   Key lessons learned

Comprehensive guidance was issued in the HSE in 2008[2] for the discharge and transfer of service users between acute care and other care settings. Key lessons have been learned through the evaluation of version 1 Code of Practice for Discharge Planning, for those who aim to improve service user care and experience through integration of care.

There are five key lessons:

1.   Services should be organised around the service user.

2.   All stakeholders recognise they are interdependent and understand that action in one part of the system has an impact elsewhere.

3.   Vision, values, objectives and actions (including redesign of services) are all shared.

4.   Service users experience services as seamless and the boundaries between service providers are not apparent.

5.   One size of integrated care does not fit all, it is service user centred.

[2.] HSE Code of Practice for Integrated Discharge Planning Version 1.0. November 2008

2.   How to use this guide in your organisation

To support compliance with the requirements of the National Standards for Safer Better Healthcare, (HIQA, 2012), and the High Impact Changes required to improve performance with Unscheduled Care (SDU, 2013) an organisation should share an agreed understanding of the discharge planning process in place and also should have an understanding of how they are performing in the area.

This guidance may be used by an organisation to establish their baseline position in relation to discharge and transfer practices and/or for audit purposes. To start the organisation should undertake a self-assessment of their own practice in comparison with the nine steps for effective discharge and transfer outlined. This will assist in identifying strengths, weaknesses and opportunities for improvement. The areas which require action may be developed into a quality improvement plan which when reviewed and monitored regularly should facilitate improved performance. Clarifying changes and actions required to improve outcomes in terms of effective discharge and transfer from the hospital will focus and drive improvement in the organisation.

The accompanying checklist and associated key performance indicators (Appendix I) may help establish the baseline practice in the organisation and also to measure progress through audit.

This guidance may also be used to support the development of supporting documentation and forms for use at local level.

2.1   At corporate/organisation level

1.   Agree a corporate/organisational approach to discharge and transfer that includes all relevant staff and stakeholders and reflects national policies and standards.

2.   Clarify roles and responsibility for discharge and transfer processes at all levels in the organisation to ensure effective leadership is in place and engaged.

3.   Ensure the organisation's approach to discharge and transfer is reflected in local departments' guidelines and procedures and communicated to all staff.

How to use this guide in your organisation

4. Undertake analysis of bed capacity demand and supply and align within a robust operational management system supported by appropriate policies, practices, procedures and organisational governance arrangements.

5. Monitor and evaluate service user flows in and out of your service to identify the causes and types of delays experienced by service users.

6. Consider the effectiveness of your services in comparison with the steps and principles as outlined i.e. undertake a self assessment.

7. Identify areas for improvement and provide staff with a training and development plan to enable them to support safe and effective discharge and transfer for service users.

8. There should be a named lead clinician responsible and accountable for the care of the service user at all times in line with National Standards for Safer Better Healthcare.[3] Responsibility for discharge and transfer may be delegated to members of the team.

9. Schedule ward rounds to allow at least daily senior clinical review of service users in acute hospitals.

10. Seek to maximise availability of diagnostic services to meet healthcare demands seven days per week.

11. Develop and provide written information for service users so they understand what your responsibilities and their responsibilities are while they are using the service.

12. Regularly review the organisations' overall performance with discharge and transfer processes through the monitoring of key performance indicators e.g. documented Estimated Length of Stay (ELOS), Predicted Date of Discharge (PDD), discharge and transfers effected by 11am (home by 11am).

[3.] Health Information and Quality Authority (2012) National Standards for Safer Better Health Care

2.2   At service provision level

1.   Ensure the corporate approach to discharge and transfer is reflected in local guidelines and procedures and communicated to all staff in your ward/department.

2.   Consider the effectiveness of discharge and transfer practices in association with the principles and steps as outlined using the checklist to review discharge and transfer practices e.g. audit of practice.

3.   Develop an action plan to make improvements at ward/departmental level.

4.   Ensure that local discharge and transfer policies and guidelines are up to date and accessible for staff.

5.   Ensure education and training is available to support all members of the multi-disciplinary team to understand their roles and responsibilities.

The nine steps
for effective discharge
planning and transfer
from hospital

The nine steps for effective discharge planning and transfer from hospital

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Begin planning for discharge or transfer before or on admission

Planning for discharge or transfer of care should start before admission for elective admissions and on day one for all unplanned admissions. It is important to identify any potential challenges that would make a service users discharge or transfer problematic so that action may be taken early to plan care. Where specialist teams of staff are not available, responsibility for planning will rest with the ward team.

Assessing needs: The purpose of a needs assessment in healthcare is to gather information necessary to bring about change beneficial to the health of the individual by taking account of the physical, psychological, social and emotional needs of the person. Assessing the needs of individual service users ensures the care they receive is planned care that responds effectively, when required, and is most appropriate to their needs. Individual needs may change, sometimes very quickly, and best possible outcomes are associated with early recognition and prompt response to those changing needs.

A wide ranging assessment using the appropriate tool should be undertaken to ensure all care needs and services required for the service user are identified for the service user, e.g. services for older persons, disability services, mental health, primary care, etc.

<u>**Checklist**</u>

Assessment

- Service user assessment begins either prior to admission or on day one for all unplanned admissions. Pre-admission assessments are conducted for service users who have planned admissions to hospital, such as elective procedures.

- The service users best possible pre-admission medication list should ideally be identified before medication is prescribed for administration in the hospital. This is a proactive medication reconciliation process (See 5.1, Step 1 Medication Safety)[4].

[4.] Fitzsimons et al, (2011). Sources of pre-admission medication information: observational study of accuracy and availability

The nine steps for effective discharge planning and transfer from hospital

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- Prior history of colonisation with a multidrug resistant organism (e.g. MRSA) or healthcare associated infection (e.g. C. *difficile* infection) should be recorded in the healthcare record and healthcare staff informed as per local hospital policy.

- An anaesthetic assessment is performed where relevant (this may be performed in an anaesthetic clinic). The procedure, risks and expected outcomes are explained to the service user and carer.

- Options and preferences for hospital care and treatment and convalescence, as well as service user concerns are discussed.

- An assessment is carried out to identify:

  ◊ Rehabilitation, the presence of a carer, the home environment for convalescence and/or the requirements for home modifications.

  ◊ To identify vulnerable service users who may be homeless or living in temporary or insecure accommodation to ensure appropriate and timely referral to primary care services and homelessness services.

  ◊ Social issues which need to be attended to (such as financial arrangements, sickness benefits, and compensation requirement).

  ◊ The delivery of primary or community care services if required (including eligibility for access to services).

- Where care is provided by other healthcare professionals across the continuum of care, relating to the condition for which hospital admission is occurring, those practitioners are involved in the admission process.

- Standardised, up-to-date, service user healthcare records are readily accessible at pre-admission and throughout the service user's stay in hospital.

Note: Service user assessment should continue throughout the service user's hospital stay whenever the service user's condition changes.

The nine steps for effective discharge planning and transfer from hospital

Timely referral

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- Prompt referral is made to the other members of the multi-disciplinary team by the appropriate personnel and this is documented as appropriate e.g. to the diagnostic services and community care services by the appropriate personnel..

- Receipt of referrals is documented on an integrated discharge planning tracking form (see Appendix II) in the service user's healthcare record within 24 hours of receiving the referral.

Estimated Length of Stay/Predicted Date of Discharge (ELOS/PDD)

Each service user should have an ELOS/PDD:

- The ELOS/PDD should be identified during pre-assessment, on post-admission ward round or within 24 hours of admission to hospital (for simple discharges) or 48 hours (for complex discharges) and documented in the health care record..

- The ELOS/PDD should be based on the anticipated time needed for tests and interventions to be carried out and for the service user to be clinically stable and fit for discharge.

- The actual length of stay is dependent on the service user's condition and circumstances

- The ELOS/PDD should be discussed and agreed with the service user/family and carers with the service users consent.

Discharge planning

- The discharge plan is developed with the service user/family/carer in order to explore options for the service user's care post hospitalisation, including family members, voluntary services and other healthcare providers.

- The discharge plan is discussed with the service user/family/carers to ensure that they understand the plan of care, medication management regime and so on.

The nine steps for effective discharge planning and transfer from hospital

- The discharge plan is communicated to primary and community care service providers, as appropriate.

- The discharge plan is documented in the healthcare record, reviewed daily and updated in response to changing needs.

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Communication and information

- Peri-operative services or pre-admission clinics communicate planned admissions to primary and community service providers before admission.

- Changes in the service user's medication or condition between pre-admission and date of planned admission are communicated by primary and community service providers to the acute hospital. This should include information regarding colonisation with a multidrug resistant organisms (e.g., MRSA) or healthcare associated infection (e.g. *C. difficile* infection).

- Once notified of a service user's admission, primary and community care service providers contact the hospital department to discuss existing health condition to ensure continuity of care while the service user is in hospital.

- The hospital notifies appropriate primary and community service providers of unplanned admissions at the time of hospitalisation as appropriate.

- All relevant pre-admission diagnostic or screening tests for planned or elective procedures should be carried out pre-admission where possible to prevent delay in treatment and subsequent discharge.

- Standardised, up-to-date, service user/healthcare records are readily accessible at admission.

- The discharge plan is documented in the service user's healthcare record.

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Step 2:

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Identify whether the service user has simple or complex needs

For most service users, discharge planning is relatively simple (approximately 80 per cent)[5]. The remaining 20 per cent will have more complex needs. Simple on-going care needs do not require detailed planning or delivery, for example, the service user may not require any social care interventions, but may require some community healthcare input. This may include daily wound dressings from the public health nurse for a specified period of time. Complex on-going care requires detailed planning and delivery by a multi-disciplinary team, for example if the service user has high levels of dependency or if the home is environmentally unsafe or the service user's physical and functional status has changed due to a recent hospital admission.
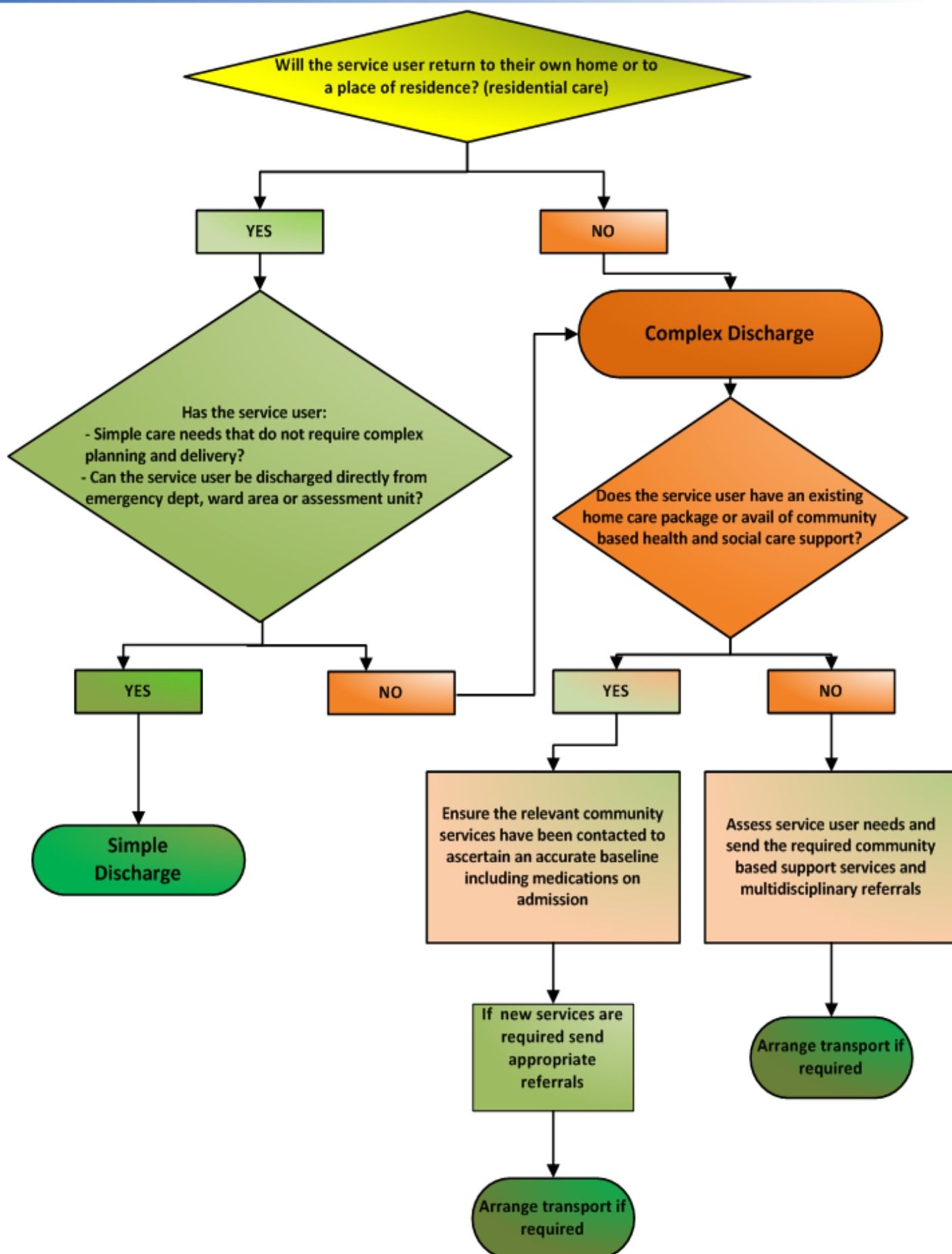
Checklist

- The service users needs are assessed either prior to admission or on first presentation and indicates whether the service user has simple or complex needs (see Figure II).

- The ELOS/PDD is determined by whether the service users needs are simple or complex. The nine key steps should be followed in both simple and complex discharge and transfers from the acute hospital.

- Assessment of needs includes consideration of all relevant primary and community based services e.g. disability services, care of the elderly services, mental health services.

- For further information on transfer and discharge processes to and from approved mental health facilities, please see Mental Health Commission Code of Practice[6].

- The service user is placed on an appropriate clinical care programme pathway of care, where available, relevant to the diagnosis to support seamless management of care e.g. in the event that a terminally ill service users condition changes or deteriorates which requires an acceleration of the transfer or discharge process please refer to the Palliative Care Programme's Guideline on Rapid Discharge Planning[7].

[5.] Department of Health, NHS (2004). *Achieving timely 'simple' discharge from hospital*. DH

[6.] Code of Practice on Admission, Transfer and Discharge to and from an approved centre (Mental Health Commission, 2009)

[7.] Rapid Discharge Planning Guideline, National Palliative Care Programme (2013)

Figure II
Step 2: Has the service user simple or complex discharge/transfer needs?

Will the service user return to their own home or to a place of residence? (residential care)

YES

NO

Has the service user:
- Simple care needs that do not require complex planning and delivery?
- Can the service user be discharged directly from emergency dept, ward area or assessment unit?

Complex Discharge

Does the service user have an existing home care package or avail of community based health and social care support?

YES

NO

YES

NO

Simple Discharge

Ensure the relevant community services have been contacted to ascertain an accurate baseline including medications on admission

Assess service user needs and send the required community based support services and multidisciplinary referrals

If new services are required send appropriate referrals

Arrange transport if required

Arrange transport if required

The nine steps for effective discharge planning and transfer from hospital

Step 3:

Develop a treatment plan within 24 hours of admission

When the admission assessment has been completed, a treatment plan should be developed.

Treatment plans should:

- identify the problem;

- include goals for treatment activities to achieve outcomes;

- include methods for achieving these goals;

- be based on best available evidence and tailored to meet the individual service user's needs and

- identify estimated time to meet the goals.

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| **Step 3** |
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It is essential that treatment plans are developed and agreed with the service user and their carer, if they are able to participate. It is important to clarify service user expectations as soon as possible as they may be very different from those of the practitioners.

Checklist

- All service users have a treatment plan, approved by a senior decision maker, documented in their healthcare record within 24 hours of admission, that is discussed and agreed with the service user/family and carers.

- The treatment plan includes a review of pre-admission against admission medication list, with a view to reconciling identified differences to ensure medication regimen is accurate and clear (see 5.1, steps 2-4 Medication Safety).

- Co-ordinating and implementing discharge activities start as soon as the treatment plan is developed.

- The treatment plan is proactively monitored on a daily basis and any changes are communicated to the service user.

The nine steps for effective discharge planning and transfer from hospital

- Changes to the treatment plan which are relevant to primary and community service providers are communicated as appropriate.

- The discharge plan is proactively managed against the treatment plan (usually by ward staff) on a daily basis and changes are communicated to the service user.

- Changes to the discharge plan are documented in the healthcare record.

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Step 4:

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Work together to provide comprehensive service user assessment and treatment

Effective co-ordination can have a significant impact on the speed and quality of the service user journey. Many service users will require healthcare services from a number of different disciplines including medicine, nursing and health and social care professionals. Effective integrated discharge planning will thus need to reflect a full understanding of the service user's medical condition and the resources that the service user can access on discharge from the hospital. Best practice indicates that assigning responsibility to a named individual for coordinating progress through the system results in improved and timely integrated discharge planning. This whole systems approach will require clear definition of roles and responsibilities.

Checklist

Multi-disciplinary team

Membership

- Regular multi-disciplinary forums across the hospital, primary and community care settings are established to ensure admission; discharge and transfer of care are planned appropriately.

- The multi-disciplinary team consists of any number of people who are involved in service user care, including hospital, primary and community services.

Roles and responsibilities

- The responsibilities of the multi-disciplinary team in taking a more pro-active approach to discharges are clarified.

The nine steps for effective discharge planning and transfer from hospital

- Responsibilities are agreed around the following:

    ◊ Who can identify and document the ELOS/PDD?

    ◊ Who can review the service user?

    ◊ How multi-disciplinary decisions are made about when the service user is clinically stable and fit for discharge or safe to transfer?

- Staff in the acute hospital services are informed and educated about primary and community services and vice versa.

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- The service user's healthcare record is kept up to date and legibly dated, timed and signed by each member of the multi-disciplinary team involved in the service user's discharge.

- Progress is documented as treatment commences.

Team meetings

- The multi-disciplinary team meets to further plan service user care, set goals and adjust timeframes for discharge, where necessary.

- Multi-disciplinary review team meetings are planned, where appropriate, to ensure continuity of service user care.

Case conferences

- Where there are complex needs or significant input of services required from the multi-disciplinary team/primary and community services, a case conference may well be appropriate and is considered.

The nine steps for effective discharge planning and transfer from hospital

- Family members and carers are encouraged to attend case conferences where appropriate. Otherwise they are kept informed of-up-to date integrated discharge planning arrangements. **This information is documented in the healthcare record.**

- Typically, this involves all/any key personnel from each service to establish the needs of the service user and how best they may be delivered.

- The case conference also includes service users, families and carers as appropriate.

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Nurse or Health and Social Care Professional (HSCP)/Others taking responsibility for discharge or transfer

Nurse (or HSCP/Other) facilitated discharge or transfer

- The suitability of the service user for Nurse (or HSCP/Other) facilitated discharge is agreed with the admitting clinician in conjunction with the multi-disciplinary team.

- Within one hour of service user admission to the ward, an appropriate and competent Nurse (or HSCP/Other) from the ward is identified and assigned to actively manage the service users pathway of care.

- The Nurse (or HSCP/Other) is up to date on all aspects of the service user care pathway, particularly focusing on the current medical and nursing condition and discharge plan. and documents progress in the healthcare record.

- The healthcare record indicates that it is a Nurse (or HSCP/Other) facilitated discharge and the name of the Nurse (or HSCP/Other) is documented.

The nine steps for effective discharge planning and transfer from hospital

- If the service user is transferred to another ward or healthcare facility, the Nurse (or HSCP/Other) who is facilitating discharge provides a formal transfer of responsibility to the Nurse (or HSCP/Other) who is facilitating discharge in that ward or healthcare facility.

- If the Nurse (or HSCP/Other) who is facilitating discharge is off duty, a second named team member provides cover to ensure continuity of care planning.

- The Nurse (or HSCP/Other) who is facilitating discharge sources and co-ordinates client information and links with families, carers, primary care teams and voluntary agencies where appropriate.

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- This two-way process of information sharing is standardised and formalised.

- The format of this communication is agreed locally (e.g. e-mail or fax) and these details are readily available.

Criteria for Nurse (or HSCP/Other) to undertake discharge (see Appendix III)

Discharge framework

- Nurse (or HSCP/Other) who have successfully completed the specific training in relation to integrated discharge planning and demonstrated competency will become a Nurse (or HSCP/Other) with responsibility for service user discharge, authorised by their line manager.

- Nurse (or HSCP/Other) only discharge service users in the ward or clinic setting in which they are working or in their area of clinical responsibility.

- Nurse (or HSCP/Other) only discharge service users where it has been documented that no further medical review prior to discharge is required.

The nine steps for effective discharge planning and transfer from hospital

- Before discharging, the Nurse (or HSCP/Other) carry out a holistic assessment of the service user, which includes ensuring all relevant test results have been obtained and appropriate action taken where necessary.

- The decision to discharge takes cognisance of service user choice and involvement, and all treatment and care is considered. Nurse (or HSCP/Other) authorised to discharge recognise those situations where it is inappropriate for them to authorise discharge.

- It is the responsibility of each Nurse (or HSCP/Other) to ensure that all the discharge details are complete and written clearly and legibly.

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Step 5:

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Set an Estimated Length of Stay /Predicted Date of Discharge, (ELOS/PDD) transfer within 24-48 hours of admission

Effective integrated discharge planning includes preparing a plan for discharge. Some important elements of a discharge plan include the ELOS/PDD and the destination of the service user on discharge. The ELOS/PDD is based on the expected time required to complete tests and treatments and the time it is likely for the service user to be fit for discharge or transfer.

The ELOS/PDD can be determined in two ways:

- Performance in the ward or unit.

- Benchmarking information.

<u>Checklist</u>

Estimated Length of Stay/Predicted Date of Discharge

- Each service user has an ELOS/PDDD.

- The ELOS/PDD is identified by the admitting consultant in conjunction with the multi-disciplinary team, during pre-assessment, on the post-admission ward round or within 24 hours of admission to hospital (for simple discharges) or 48 hours (for complex discharges) and documented in the health care record.

- The ELOS/PDD is agreed and proactively managed against the treatment plan by a named accountable person (SDU, 2013).

- The ELOS/PDD is displayed in a prominent position.

- The ELOS/PDD is based on the anticipated time needed for tests and interventions to be carried out and for the service user to be clinically stable and fit for discharge.

Note: The actual length of stay is dependent on the service user's condition and circumstances.

The nine steps for effective discharge planning and transfer from hospital

- The ELOS/PDD is discussed and agreed with the service user/family and carers and communicated to the primary and community service providers, as appropriate.

Step 1	
Step 2	
Step 3	
Step 4	
Step 5	
Step 6	
Step 7	
Step 8	
Step 9	

- The ELOS/PDD is proactively tracked and managed against the treatment plan (usually by ward staff) on a daily basis and changes are communicated to the service user (SDU,2013).

- The hospital advises primary and community service providers of the planned discharge date as soon as possible and at least two days prior to service user discharge (for service users who are in-service users for five days or longer) to enable them to plan the necessary post-hospital service commencement.

- Two-way communication between the hospital, the GP, the community pharmacist and other primary and community service providers is arranged to ensure such services are available and in place for the service user to use when needed post discharge.

- Any changes to the ELOS/PDD are communicated to the primary and community service providers as appropriate.

- The appropriate assessment tool is used to undertake an assessment for those service users who will require access to long term residential care.

The nine steps for effective discharge planning and transfer from hospital

Step 6:

Involve service users and carers so they make informed decisions and choices

Service users are encouraged to take accountability for their own health and well-being. To achieve this, they need good information about the local service options available and support to access those options. Involving service users to make informed decisions and choices will empower them to maintain their health and well-being in the longer term. This involves managing expectations, individualising information and having sufficient information of the local service options available.

Step 1
Step 2
Step 3
Step 4
Step 5
Step 6
Step 7
Step 8
Step 9

<u>Checklist</u>

Managing expectations

- With the service user's permission, their carers and family members may be consulted on admission and at the beginning of the assessment process.

- The treatment plan is shared with the service user and they are encouraged to ask questions about the plan.

- It is made clear to the service user that the aim of the plan is to assist them in achieving their optimal level of functioning.

Individualising information

- The Nurse (or HSCP/Other) who is facilitating discharge finds out what is important to the service user/carer/family and what their concerns are.

- Medical terms are clearly explained.

- Develop an information pack for service user/carer/family with pertinent information including medication list, care of any indwelling devices such as intravascular lines or urinary catheters, wound care and instructions for the service user to share with their GP, community pharmacist and other relevant healthcare provider.

The nine steps for effective discharge planning and transfer from hospital

- Counsel and educate the service user and ensure they are provided with appropriate information leaflets (e.g. in relation to medication see 5.1: Step 5 - 6 Medication Safety, infection control precautions for the care of wounds and of indwelling devices such as intravascular lines or urinary catheters).

| Step 1 |
| Step 2 |
| Step 3 |
| Step 4 |
| Step 5 |
| Step 6 |
| Step 7 |
| Step 8 |
| Step 9 |

- The Nurse (or HSCP/Other) who is facilitating discharge, checks that the service user/carer/family understands the diagnosis, the reason for particular treatments, how to perform or use treatments and what follow-up is required and why this is required post discharge.

- The Nurse (or HSCP/Other) who is facilitating discharge confirms that the service user/carer/family agrees with the plan of action.

- Members of the multi-disciplinary team give the service user, carers and family an opportunity to ask questions.

- The needs of service users with poor vision, hearing difficulties, cognitive deficits, cultural, language and literacy barriers are considered.

Information pack

- A literacy friendly information pack is developed in which to keep all information brochures and sheets for the service user/carer/family

- Service user information is developed in plain English with service users/carers/families, to ensure that it is relevant, legible and understandable.

- Service users and carers are involved in determining what information is provided.

- The information pack may include the following:

    ◊   The names (if possible) and telephone numbers of hospital/primary and community services contacts in the event that the service user has questions following discharge.

The nine steps for effective discharge planning and transfer from hospital

◊   Details about the service user's medical condition.

◊   Details about the service user's health management, including lifestyle and dietary advice.

◊   Details about on-going investigations, including any special instructions.

◊   The date, time and location of the appointments for any investigations, where possible.

◊   Available details about follow-up appointments, including the name (if possible) and address of the healthcare provider, the date and time of the appointment and the reason for the appointment.

◊   Details of the appropriate infection control precautions for the care of wounds and of indwelling devices such as intravascular lines or urinary catheters, specifics of how to take prescribed medications including completion of antibiotic courses etc.

| Step 1 |
| Step 2 |
| Step 3 |
| Step 4 |
| Step 5 |
| **Step 6** |
| Step 7 |
| Step 8 |
| Step 9 |

The nine steps for effective discharge planning and transfer from hospital

Step 7:

Review the treatment plan on a daily basis with the service user

It is important to review the treatment plan each day to review the service user's condition and their response to treatment. This will allow staff to identify any problems in the care pathway and to prevent these problems arising, where possible and consider their impact on the ELOS/PDD.

| Step 1 |
| Step 2 |
| Step 3 |
| Step 4 |
| Step 5 |
| Step 6 |
| Step 7 |
| Step 8 |
| Step 9 |

Checklist

- Practitioners talk to the service user daily about progress.

- The treatment plan is monitored, evaluated and updated (where necessary).

- Changes to the treatment plan and ELOS/PDD are documented in the healthcare record (SDU, 2013).

- Any problems or actions required are identified and are escalated or resolved as necessary.

The nine steps for effective discharge planning and transfer from hospital

Step 8:

Use a discharge checklist 24-48 hours before discharge

Step 1
Step 2
Step 3
Step 4
Step 5
Step 6
Step 7
Step 8
Step 9

Towards the end of the hospital stay, all discharge plans should have been put in place. Services should be organised and implemented as appropriate, to ensure that there are no delays on the day of discharge or in the provision of services for the service user following discharge from hospital.

Discharge checklists can enhance effective communication between the service user, members of the multi-disciplinary team, hospital, primary and community service providers. They communicate what actions have been taken and what actions remain outstanding.

<u>Checklist</u>

Discharge arrangements

- The carers/family, primary care team/GP, PHN and other primary and community service providers are contacted at least 48 hours before discharge to confirm that the service user is being discharged and to ensure that services are activated or re-activated.

- Discharge arrangements are confirmed 24 hours before discharge (SDU, 2013).

- Clinical teams conduct discharging ward rounds at weekends (SDU, 2013).

- There are processes in place for delegated discharging to occur between clinical teams or to other disciplines, within agreed parameters (SDU, 2013).

Transport arrangements

- Transport arrangements are confirmed 24 hours before discharge.

- The clinical and/or mobility needs of the service user are specified, where appropriate.

The nine steps for effective discharge planning and transfer from hospital

Communication

Step 1
Step 2
Step 3
Step 4
Step 5
Step 6
Step 7
Step 8
Step 9

- Discharge information (transfer or discharge communication) is prepared. This may include a description of the unresolved, on-going problems listed on the hospital care plan, key test results, emergency contact person, contact number and availability.

- Identify discharge medication list, review discharge against pre admission medication list, identify and reconcile all changes (see 5.1 medication safety step 7-8).

- Transfer/discharge communications is multi-disciplinary where multi-disciplinary care is to be continued.

- A copy of the transfer/discharge communication which is completed before discharge is sent to the service user, the service users GP, PHN and other healthcare providers (e.g. nursing home) and a further copy is retained in the healthcare record.

- Transfer/discharge communication is authorised by the relevant responsible healthcare professionals, contact details are included.

Medical certificate

- The medical (sick) certificate is written if required.

  Note: Social welfare certificates are issued by a General Practitioner (GP).

Service user education and information

- The service user and carer/family have received and been educated in the use of any aids/appliances as appropriate.

The nine steps for effective discharge planning and transfer from hospital

Step 9:

| Step 1 |
| Step 2 |
| Step 3 |
| Step 4 |
| Step 5 |
| Step 6 |
| Step 7 |
| Step 8 |
| **Step 9** |

Make decisions to discharge/transfer service users each day

On the day of discharge or transfer, confirmation is needed that the service user is ready for discharge or transfer. Traditionally these decisions have been made by the consultant responsible for the service user's care. The consultant, however, can delegate this responsibility to an appropriately qualified health and social care professional.

<u>**Checklist**</u>

Time of discharge

- Each service user discharge is effected (i.e. hospital bed becomes available for service user use) no later than 11 am on the day of discharge. This includes completion of all necessary discharge procedures, documentation of the time of discharge in the healthcare record and communication with service users, carers and other healthcare providers, where relevant , (SDU, 2013).

Communication

- No service user leaves the hospital until the details of admission, medication management changes (including additions/deletions) and arrangements for follow up have been communicated to the healthcare provider(s) nominated by the service user as being responsible for his or her on-going care.

- Primary care services and homelessness services should be notified when a service user who is homeless or living in temporary or insecure accommodation is due for discharge to ensure appropriate accommodation and support is sought. This must involve the hospital convening a case management meeting and the provision of appropriate information to ensure the receiving services are adequately informed and have sufficient time to plan for accommodation needs.

The nine steps for effective discharge planning and transfer from hospital

- At the time of leaving the hospital, each service user is provided with an information pack containing relevant information such as service user/carer/family plan, a medication management record, details of the appropriate infection control precautions for the care of indwelling devices such as intravascular lines or urinary catheters, management of multidrug resistant organism colonisation/infection as appropriate and information on the availability and future supply of medication.

| Step 1 |
| Step 2 |
| Step 3 |
| Step 4 |
| Step 5 |
| Step 6 |
| Step 7 |
| Step 8 |
| **Step 9** |

- Communicate discharge medication list and all changes (see 5.1 step 9, medication safety).

- Hospitals confirm with primary and community service providers that the service user has left the hospital and that service provision needs to commence.

- Information and education is provided to the service user and the carer/family in the appropriate language, verbally and in written form relating to:

  ◊ On-going health management and health promotion, including appropriate infection control precautions for the care of indwelling devices such as intravascular lines or urinary catheters.

  ◊ Multidrug resistant organism colonisation/infection or healthcare associated infection (e.g. *C. difficile* infection).

  ◊ An appropriate post discharge contact to answer queries and address concerns.

  ◊ GP letter.

  ◊ Medication management.

  ◊ The use of aids and appliances.

  ◊ Follow-up appointments.

  ◊ Primary and community based service appointments.

  ◊ Possible complications and warning signs.

  ◊ When normal activities can be resumed.

The nine steps for effective discharge planning and transfer from hospital

The transfer/discharge communication and discharge prescription contains a complete and comprehensive list of all medication the service user is to continue taking on discharge from hospital. Where possible, any pre-admission medication which was discontinued during the hospital stay is listed, outlining a brief reason for discontinuation. There is no ambiguity as to whether a medication which is absent from the list was discontinued or omitted unintentionally.

Step 1
Step 2
Step 3
Step 4
Step 5
Step 6
Step 7
Step 8
Step 9

- At the time of leaving the hospital, each service user is provided with an information pack containing relevant information such as service user/carer/family plan, a medication record and information.

- Information and education is provided to the service user and the carer/family in the appropriate language, verbally and in written form relating to:.

   ◊ On-going health management, including appropriate infection control precautions for the care of indwelling devices such as intravascular lines or urinary catheters.

   ◊ Multidrug resistant organism colonisation/infection or healthcare associated infection (e.g. *C. difficile* infection).

   ◊ An appropriate post-discharge contact to answer queries and address concerns.

   ◊ Medications.

   ◊ The use of aids and appliances.

   ◊ Follow-up appointments.

   ◊ Primary and community based service appointments.

   ◊ Possible complications and warning signs.

   ◊ When normal activities can be resumed.

The nine key steps are intended to be viewed alongside the underpinning principles of the Health Care Charter (2010) outlined in Chapter 4

4.   Principles of the Healthcare Charter

'You and Your Health Service' (2010), a health service charter, sets out eight principles that are considered fundamental to both health service employees and to people who use the services. The principles are designed to promote care that is compassionate, more predictable, personal to service users, preventative and participatory.

This practical guide to integrated care is underpinned by these eight core principles:

1. Access:	Our services are organised to ensure equity of access to public health and social care services.
2. Accountability:	We welcome your complaints and feedback about care and services; investigate your complaints and work to address your concerns.
3. Dignity and respect:	We treat people with dignity, respect and compassion. We respect diversity of culture, beliefs and values in line with clinical decision making.
4. Safe and effective services:	We provide services in a safe environment, delivered by competent, skilled and trusted professionals.
5. Communication and information:	We listen carefully and provide clear, comprehensive and understandable health information and advice.
6. Participation:	We involve people and their families and carers in shared decision making about their healthcare.
7. Privacy:	We ensure adequate personal space to ensure privacy in providing care and personal social services. We maintain strict confidentiality of personal information.
8. Improving health:	Our services promote health, prevent disease and support and empower those with chronic illness to self-care.

Principles of the Health Care Charter

Access:

Service users should receive care that is appropriate, timely and based on need, not the ability to pay and have reasonable access to the most appropriate public health services regardless of physical, sensory or intellectual ability.

Accountability:

Accountability is about making discharges and transfers of care everybody's business, including the service user. All involved must commit to the process and joint accountability to ensure that the service user remains at the centre.

Healthcare services can learn about the effectiveness of their integrated discharge planning by obtaining service user/family/carer feedback on the quality of discharge processes in the acute hospital and primary and community care settings. This information should be used to give feedback to staff (particularly positive reinforcement of activities that meet service user and carer needs) and to identify how to improve integrated discharge planning practices.

Dignity and respect:

Service providers should adopt a person centred care approach and recognise the rights, needs and expectations of each service user. Service users can only make informed choices when provided with a good knowledge of the service options available locally and how to access them. Discharge planning should take account of the individual needs of the service user including those with specific needs relating to a physical or sensory disability, mental health needs or cognitive impairment. Other vulnerable people include those who are homeless, living in temporary or insecure accommodation or seeking asylum.

Safe and effective services:

Integrated care requires groups of professionals from different disciplines, working together to provide comprehensive service user assessment and treatment using appropriate infection prevention and control precautions to prevent the acquisition of multidrug resistant organisms/ healthcare associated infection. This requires trust, respect, joint ownership and early planning.

Principles of the Health Care Charter

Shared systems and protocols, as well as multi professional training, will help break down professional barriers and develop a culture of collaboration.

The benefits of collaborative working include timely and effective service user discharge, increased service user confidence, and continuity of quality care, enhanced communication and partnership regarding resource management. The service user, their carer and family must be viewed as essential members of this multi-disciplinary team.

Best practice indicates that assigning responsibility to a named individual for coordinating progress through the system results in improved and timely integrated discharge planning. This whole systems approach will require clear definition of roles and responsibilities.

Communication and information:

Good communication will help the service user and their carer understand the discharge and transfer process and know what to expect, thereby allaying any fears and confusion at this time. This requires effective sharing of up to date information between service users, carers and providers.

Service users must have sufficient information and understand that information to be able to participate in decisions regarding their discharge or transfer. Provide information in a way that takes into consideration the person's ability to understand and literacy level. Regularly check this understanding. Use language and terminology that is familiar to the service user and is culturally sensitive.

Participation:

Service users and their carers are often experts in the management of their condition and their level of understanding should be acknowledged. For example, if you are talking to a person with a long-term condition and several previous admissions to hospital, it is likely that they will have a good understanding of their circumstances and the journey ahead.

Principles of the Health Care Charter

Service users, families and carers who are fully engaged at all stages of the admission to, length of stay in and discharge from hospital can better understand what is happening and what outcomes are expected. For service users who are discharged home, education about self-management can reduce re-presentations and readmissions to hospital. Part of this education should deal with medication management, since re-presentation to hospital is often associated with medication mismanagement[8,9].

Privacy:

Service users are entitled to inspect and obtain a copy of their health information; to know the source(s) of that information, why the hospital is holding it and with whom it will be shared.

Improving health:

Rehabilitation and service user empowerment should always be considered as the first options during discharge or transfer. Prior to discharge service users should be assessed to ensure they have returned to baseline ability. If the service user has not reached their full potential, then rehabilitation and/or service user enablement using community services should be considered under the guidance of the multi disciplinary team and with service user and family/carer input.

Should these options be deemed unsuitable for their care needs the decision for long term placement can be considered.

The multi disciplinary team should carry out a robust assessment and with the service user and family/carer the decision is made for long term care.

Service users who have complex discharge or transfer of care needs will need a creative and flexible person centred care approach from all service providers. Staff will need support and information about the range of available resources in order to develop person centred, appropriate solutions to discharges and transfers of care.

[8.] Hamilton et al, (2011). Potentially inappropriate medications defined by STOPP criteria and the risk of adverse drug events in older hospitalised patients. Archives of Internal Medicine

[9.] Scullin et al, (2007). An innovative approach to integrated medicines management.

5.   Medication management

See 5.1 for key steps and guidance to support undertaking the Medication Reconciliation process.

Pre-admission or on admission

- Obtain an accurate pre-admission medication list to reflect the therapies a service user actually used before admission to hospital. This should include: prescription and over-the-counter medicines, nutritional support and other therapies such as herbal products. This should ideally be undertaken by referring to two sources of information, one of which should be the service user. The medication details and any compliance issues may be discussed in consultation with their GP, community pharmacist or other relevant clinicians.

- Reconcile the pre-admission medication list with the admission medication list prescribed on the hospital medication prescription and administration record (MPAR) and resolve any anomalies (see 5.1).

- Where relevant, record details of the service user's nominated community pharmacy in the healthcare record.

- Where appropriate, obtain formal written consent from the service user for disposal of any of their own brought-in medication that will not be continuing.

- Where appropriate, undertake a cognitive assessment to determine the service user's suitability for self-medication and document this in the healthcare record.

- Review the service user's pre-admission medication list where appropriate, in order to:

   ◊ Identify any problems associated with current drug therapy, including any possible relationship with the current medical condition. Bear in mind that problems with medication are a main cause or contributory factor to one in four non-elective medical admissions.

Medication management

◊ All necessary pre-admission medication or treatment should be prescribed for administration during the admission.

- Document the service user's allergy status, including no known allergies and the type and details of known allergies and any previous adverse drug reactions.

During the hospital stay

- Continue medication review.

- Simplify dose regimens, where possible.

- If a Patients Own Drugs Scheme is operating, as part of this, check the medications brought in and use only those items which are suitable under local policy.

- If it is intended to use the service user's own medication during hospital stay, and consent has not been received prior to admission, obtain written consent for this and for the disposal of any of the service user's own medications brought in but not being continued.

- When necessary, provide the service user (family or carers) with verbal and written information regarding their medication regime and any changes made to it.

- As required, provide information and education regarding the use and monitoring of medication.

- Document all education regarding self-management in the service user's healthcare record of medication.
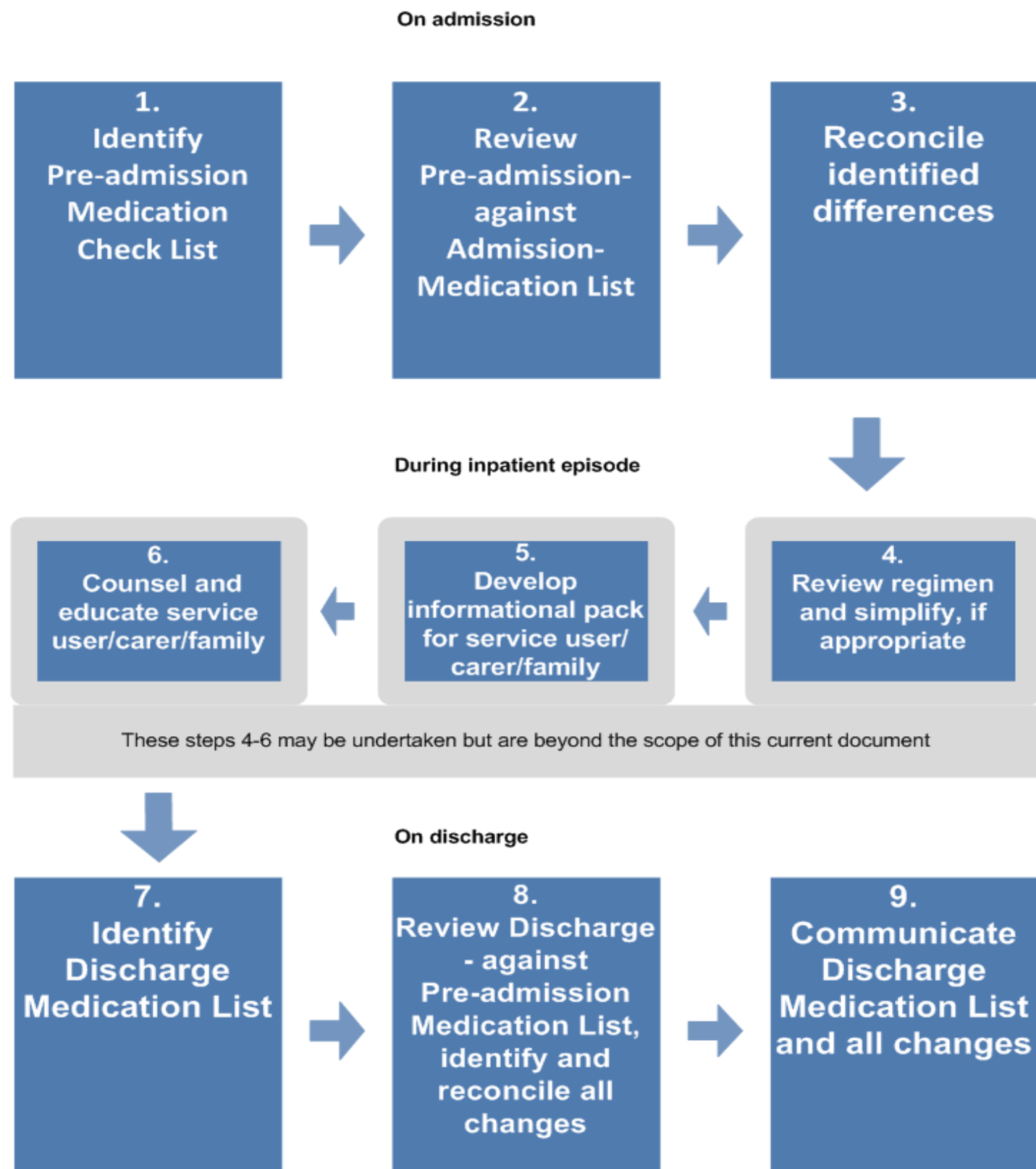
On discharge

- Develop a Discharge Medication Communication (DMC) inclusive of the ongoing Discharge Medication List (DML) and a description of any changes made to the pre-admission medications, including all medications stopped or changed during the hospitalisation episode and the reasons for these (See 5.1).

- Include any special arrangements for administration of medication in the discharge medication communication (e.g. via enteral feeding tube, provision of compliance aids).

- Discharge medication reconciliation and development of the discharge medication communication takes place in a planned and timely fashion, preferably on the day before the service user leaves the hospital.

- Where appropriate, review the service user's own medication supply to remove any expired or discontinued medication before return to the service user.

- Put in place any specific arrangements required to facilitate continuity of the service user's medication supply. In exceptional cases, this may include dispensing take-home medication from the hospital pharmacy department.

- A copy of the discharge medication communication should be provided to the service user, their nominated community pharmacy, GP and filed in the healthcare record.

Medication management

5.1 Medication Reconciliation in Acute Hospital Care in Ireland

On admission

1. Identify Pre-admission Medication Check List	→	2. Review Pre-admission-against Admission-Medication List	→	3. Reconcile identified differences

During inpatient episode

6. Counsel and educate service user/carer/family	←	5. Develop informational pack for service user/carer/family	←	4. Review regimen and simplify, if appropriate

These steps 4–6 may be undertaken but are beyond the scope of this current document

On discharge

7. Identify Discharge Medication List	→	8. Review Discharge - against Pre-admission Medication List, identify and reconcile all changes	→	9. Communicate Discharge Medication List and all changes

The service user's best possible pre-admission medication list should ideally be identified before medication is prescribed for administration in the hospital. This is a proactive Medication Reconciliation process.

Proactive Medication Reconciliation Process		
Step 1 →	Step 2 →	Step 3
Best possible pre-admission medication list is used to decide and list the admission medication orders.	Admission medication orders.	Verify every medication has been assessed by prescriber and pharmacist.

A retroactive process occurs when a best possible preadmission medication list cannot be ascertained on admission. It is created and reconciled after admission medication orders are written. Although it is desirable to follow the proactive process, the retroactive process may be necessary on evenings and weekends, or where service users need immediate treatment (e.g. trauma).

Retroactive Medication Reconciliation Process			
Step 1 →	Step 2 →	Step 3 →	Step 4
Primary medication history is used to decide and list the admission medication orders.	Admission medication orders.	Best possible pre-admission medication list is determined as early as possible during the hospital stay.	Compare best possible list with admission medication orders and resolve any differences.

Medication management

Organisational support for Medication Reconciliation

- Develop clear policies and procedures for each step in the reconciling process.

- Provide access to drug information and pharmacist advice at each step in the reconciling process.

- Improve access to complete medication lists at admission.

- Develop a protocol for discharge medication reconciliation.

- Provide orientation and ongoing education on procedures for reconciling medications to all healthcare providers.

- Provide feedback and ongoing monitoring (within context of non-punitive learning from mistakes/near misses).

- Utilise one medication reconciliation form for all disciplines (e.g., nursing, pharmacy, doctors, radiology) and in all care areas.

- Have senior leadership make medication reconciliation an organisational wide goal.

Undertaking Medication Reconciliation – Key steps and guidance notes.

1. **Identify pre-admission medication list**

   Collect a complete list of current medications (including dose and frequency) for each service user on admission**.**

   - Validate the pre-admission medication list with the service user (whenever possible).

   - If necessary contact service user's pharmacy to verify home medications.

   - If necessary contact primary care physician to verify home medications.

   - Assign primary responsibility for collecting the pre-admission list to someone with sufficient expertise, within a context of shared accountability (the prescriber, nurse, and pharmacist must work together to achieve accuracy).

   - Place the list in a consistent, highly visible location within the service user chart (easily accessible by clinicians writing orders at any point during the service user's stay may be paper or electronic).

2. **Review pre-admission- against admission- medication list**

   Use the pre-admission medication list when writing orders for administration in hospital**.**

3. **Reconcile identified differences**

   Assign responsibility for identifying and reconciling variances between the pre-admission medication list and new orders to someone with sufficient expertise. Reconcile service user medications within specified time frames.

4. **Review regimen and simplify, if appropriate**

5. **Develop informational pack for service user/carer/family**

   Create a discharge folder with pertinent service user information (e.g., medication list, wound care) and instructions for service user to share with their GP, community pharmacist and other relevant healthcare providers; provide multiple copies.

Medication management

6. **Counsel and educate service user/carer/family**

    Initiate service user medication education upon admission and continue throughout the hospital stay**.**

7. **Identify discharge medication list**

    Assign responsibility for identifying the discharge medication list, having regard to medication administered during the hospital stay and those on the pre-admission medication list.

8. **Review discharge- against pre-admission- medication list, identify and reconcile all changes**

    Assign responsibility for identifying and reconciling variances between the pre-admission medication list and the discharge medication list to someone with sufficient expertise, within a context of shared accountability:

    *   Resolve any identified variances, determine whether they are intentional or not.

    *   Develop a list of any intentional changes made to the service user's pre-admission medication.

    *   Develop a list of the new medication commenced and to be continued after discharge.

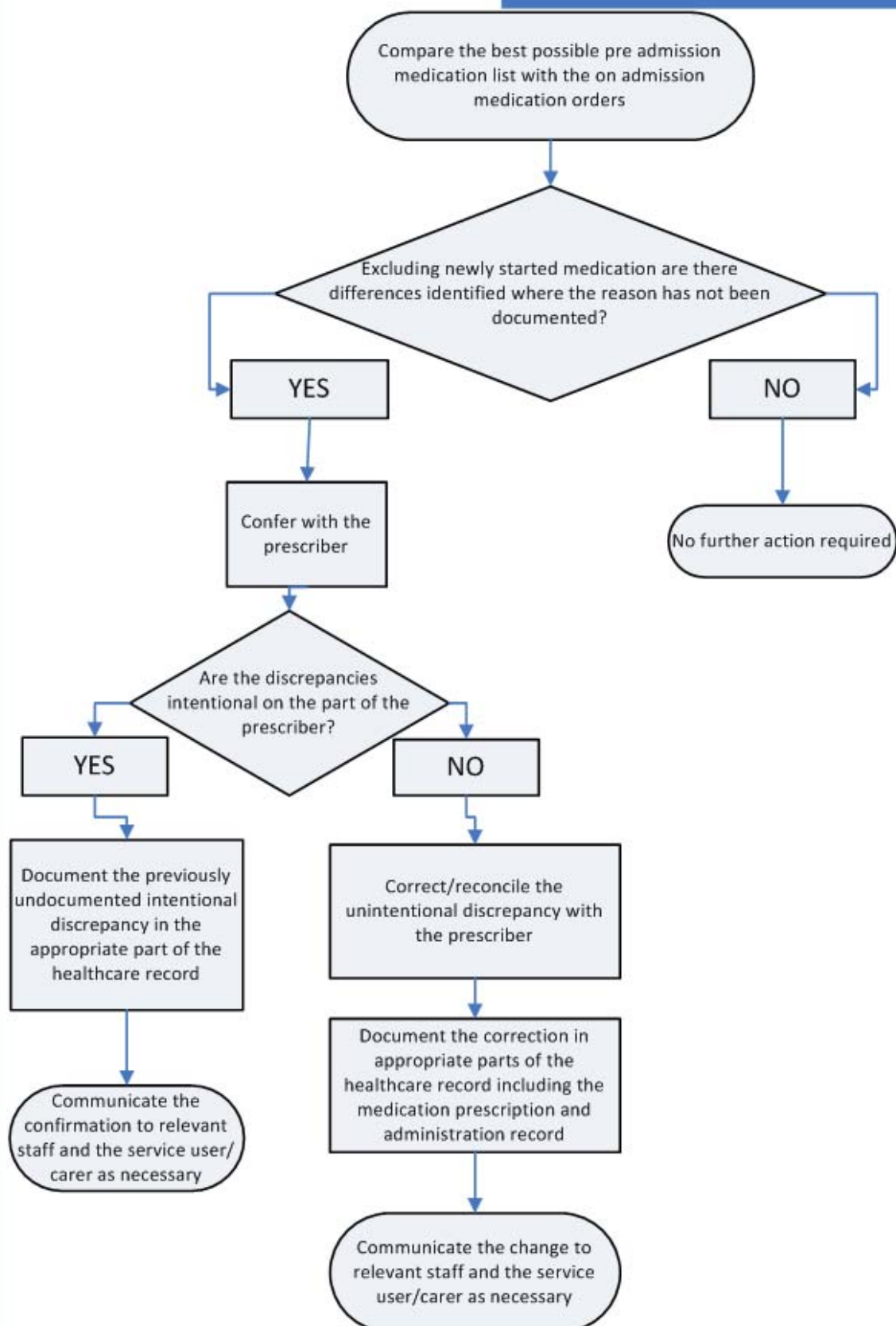   *   Follow up and identify the correct intended action for any unintentional variances.

9. **Communicate discharge medication list and all changes**

    Assign responsibility for communication of reconciled discharge medication list and list of intentional changes made to the service user's GP, community pharmacist and other necessary healthcare providers, as appropriate**.**

Medication Reconciliation Process Flow Charts for Admission to and Discharge from Acute Care
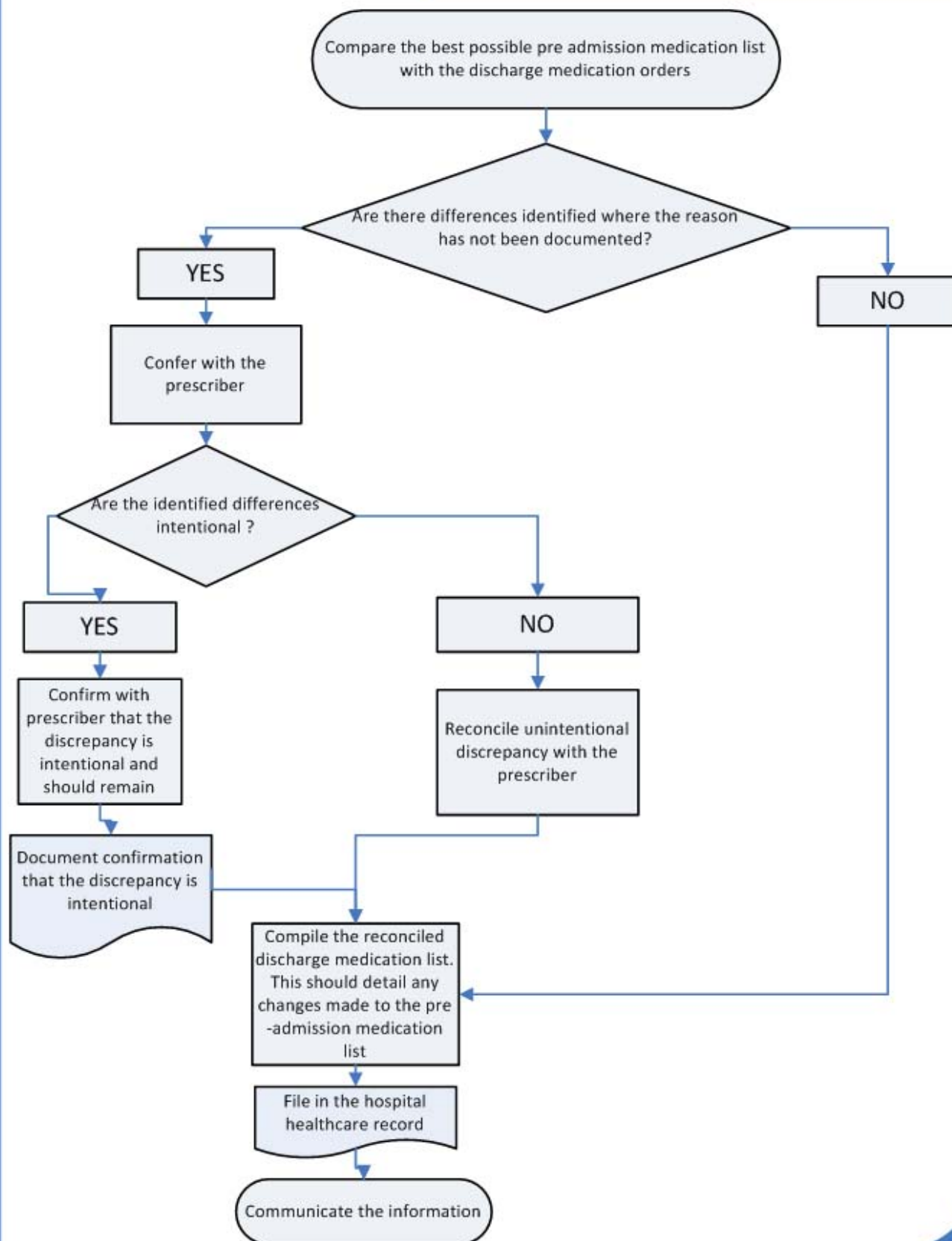
Medication Reconciliation Process Flow Chart

Admission to Acute Care

Compare the best possible pre admission medication list with the on admission medication orders

Excluding newly started medication are there differences identified where the reason has not been documented?

YES

NO

No further action required

Confer with the prescriber

Are the discrepancies intentional on the part of the prescriber?

YES

NO

Document the previously undocumented intentional discrepancy in the appropriate part of the healthcare record

Correct/reconcile the unintentional discrepancy with the prescriber

Communicate the confirmation to relevant staff and the service user/carer as necessary

Document the correction in appropriate parts of the healthcare record including the medication prescription and administration record

Communicate the change to relevant staff and the service user/carer as necessary

Medication Reconciliation Process Flow Chart

Discharge from Acute Care

Compare the best possible pre admission medication list with the discharge medication orders

↓

Are there differences identified where the reason has not been documented?

YES → Confer with the prescriber

NO

Are the identified differences intentional ?

YES

NO

Confirm with prescriber that the discrepancy is intentional and should remain

Reconcile unintentional discrepancy with the prescriber

Document confirmation that the discrepancy is intentional

Compile the reconciled discharge medication list. This should detail any changes made to the pre-admission medication list

File in the hospital healthcare record

Communicate the information

Figure III: the nine key steps in effective discharge and transfer of care from hospital to community

	Yes	No

Step 1, Page 15
Begin planning for discharge or transfer before or on admission

	Yes	No
• Pre-admission assessments conducted for planned admissions to hospital e.g. elective procedures, or alternatively at first presentation to the hospital for unplanned admissions.		
• Most accurate pre-admission medication list should be identified prior to administration of medication in the hospital.		
• Prior history of colonisation with a multidrug resistant organism (e.g. MRSA) or healthcare associated infection should be recorded in health-care record and healthcare staff informed as per local hospital policy.		
• Timely referrals are made to multidisciplinary team and receipt of referrals recorded on integrated discharge planning tracking form within 24 hours of receiving referral. *NOTE: this includes referrals from hospital to primary care services (homelessness services where relevant).*		
• Each service user should have an Estimated Length of Stay/ Predicted Date of Discharge (ELOS/PDD) identified within 24 hours of admission and documented in the healthcare record related to the estimated length of stay required (SDU, 2013).		

Step 2, Page 19
Identify whether the service user has simple or complex needs

	Yes	No
• The service users needs are assessed either prior to admission or on first presentation and indicates whether the service user has simple or complex needs.		
• The ELOS/PDD is determined by whether the service needs are simple or complex.		
• The service user is placed on an appropriate clinical care programme care pathway relevant to the service users diagnosis to support seamless care and management.		

Step 3, Page 21
Develop a treatment plan within 24 hours of admission

	Yes	No
• All service users have a treatment plan documented in their healthcare record within 24 hours of admission, which is discussed and agreed with the service user/carers and family.		
• The treatment plan includes a review of pre-admission against admission medication list with a view to reconciliation.		
• Changes to the treatment plan are communicated to the service user and relevant primary care services as appropriate and documented in the healthcare record.		

Step 4, Page 23
Work together to provide comprehensive service user assessment and treatment

	Yes	No
• The multidisciplinary team comprises of the appropriate healthcare professionals to proactively plan service user care, set goals and adjust timeframes for discharge where necessary.		
• Regular multidisciplinary team meetings or case conferences for complex care cases, are held where appropriate.		
• Roles and responsibilities for proactive management of discharge are clarified.		

Appendix I: Nine step checklist

	Yes	No

Step 5, Page 28
Set an ELOS/PDD/transfer within 24-48 hours of admission

- The ELOS/PDD is identified by the admitting consultant in conjunction with the multi-disciplinary team, during pre-assessment, on post admission ward round or within 24 hours of admission to hospital (for simple discharges) and 48 hours (for complex discharges) and documented in the healthcare record.
- The ELOS /PDD is agreed by specialty and proactively managed against a treatment plan by a named accountable person (SDU, 2013).
- The ELOS/PDD is displayed in a prominent position.
- Changes to the treatment plan and ELOS/PDD are documented in the healthcare record (SDU, 2013).

Step 6, Page 30
Involve service users and carers so they make informed decisions and choices

- The treatment plan is shared with the service users and they are encouraged to ask questions about the plan.
- Develop information pack for service user/carer/family e.g. medications list, care of any indwelling devices such as intravascular lines or urinary catheters, wound care and instructions for the service user to share with their GP, community pharmacist and other relevant healthcare provider.
- Counsel and educate the service user, considering the needs of service users with poor vision, hearing difficulties, cognitive deficits, cultural and language barriers.

Step 7, Page 33
Review the treatment plan on a daily basis with the service user

- Practitioners talk to the service user daily about progress.
- The treatment plan is monitored, evaluated and updated (where necessary) and changes to the treatment plan and ELOS/PDD are documented in the healthcare record (SDU, 2013).
- Any problems or actions required are identified and are escalated or resolved as necessary.

Step 8, Page 34
Use a discharge checklist 24-48 hours before discharge

- The carers/family, Primary Care Team /GP, PHN and other primary and community service providers are contacted at least 48 hours before discharge to confirm that the service user is being discharged and to ensure that services are activated or re-activated.
- Discharge arrangements are confirmed 24 hours before discharge (SDU, 2013).
- Clinical teams conduct discharging ward rounds at weekends (SDU, 2013).
- Process in place for delegated discharging to occur between clinical teams or to other disciplines, within agreed parameters (SDU, 2013).

Step 9, Page 36
Make decisions to discharge/transfer service users each day

- Each service user discharge is effected no later than 11am on the day of discharge (SDU, 2013).
- Discharge medication reconciliation and development of the discharge medication communication takes place in a planned and timely fashion, preferably on the day before the service user leaves the hospital.
- Primary Care services and homelessness services should be notified when a service user who is homeless or living in temporary or insecure accommodation is due for discharge.

Appendix II: Service user discharge tracking form

Appendix II: Service user discharge tracking form

Service user discharge tracking form

Name: _____   **Hospital no:_____**

This form can be used to assist the implementation of discharge and transfer from hospital and track the patient's ELOS/PDD against the s treatment plan. Please date time and sign when.......

Action	Date & time	Signature (Print name & job title)
Service user assessment complete		
Discharge/transfer plan complete		
ELOS/PDD identified		
Referrals made	See referrals section	
Discharge/transfer arrangements discussed with service user/carer/ family/other		
Transport arranged for discharge/ transfer		
Documentation: 1. Discharge/transfer checklist 2. Discharge/transfer summary		
Medication reconciliation on discharge		
Service user education provided		
Medical (sick) certificate provided		
Information pack provided		
Confirm date/arrangements with primary care services as relevant regarding discharge/transfer		
Follow-up appointments/ongoing tests/investigations		

Appendix II: Service user discharge tracking form

Referrals section

Internal referrals made

Referral made	Date made & signature/name of who made referral	Received by … signature & date

External primary care services referrals made

Referral made	Date & mode of referral	Signature

Appendix III: *Criteria for Nurse (or HSCP/Other) to undertake discharge*

- The ability to advocate on behalf of the service user and carer/family

- The ability to educate service users, carer/family and other staff.

- Advanced clinical knowledge in the specialty area i.e. the service user's condition or primary diagnosis.

- Well-developed communication and negotiation skills.

- The ability to work as a member of the multi-disciplinary team.

- Detailed knowledge of what services are available and to whom.

- The ability to assess and make critical decisions regarding discharge.

- The support of their manager/director of nursing/lead clinician to confirm that:

  ◊ Their post is one in which they will have the need and opportunity to initiate and authorise discharge.

  ◊ Local protocols and service user criteria have been developed, agreed and are in operation.

  ◊ They will have access to, and the support of, the multi-disciplinary clinical team.

Appendix III: *Criteria for Nurse (or HSCP/Other) to undertake discharge*

Education and training

- Nurse (or HSCP/ Other) preparing for a role within discharge planning undertake specific education and training.

- The training programme provides the Nurse (or HSCP/Other) with supervision, support and opportunities to develop competence in authorised discharge practice.

- Competency in integrated discharge planning is successfully completed and authorised by their line manager through appraisal.

- The Nurse (or HSCP/Other) informs their manager if they feel that their competence or confidence in their discharging abilities is no longer at an acceptable or safe level.

- The Nurse (or HSCP/Other) does not continue with discharge activities in this case until their needs have been addressed and competence is restored.

Appendix IV: Rapid Discharge Planning Guideline summary
Palliative Care Clinical Care Programme

Rapid Discharge Planning (RDP) is a form of integrated discharge planning that begins when a seriously ill patient expresses the wish to die in their home environment. The national rapid discharge guidance for patients who wish to die at home aims to facilitate a safe, smooth and seamless transition of care from hospital to community for patients with terminal illness who choose to be cared for in their own home for their last days of life. For further information refer to: http://www.hse.ie/eng/about/Who/clinical/natclinprog/palliativecareprogramme/ *National rapid discharge guidance for patients who wish to die at home.*

Glossary

Assessment

A process whereby the needs of an individual are identified and their impact on daily living and quality of life evaluated.

Best possible pre-admission medication list

Is the list of medication a patient was actually using before admission to hospital, created following a comprehensive medication history taking involving the patient/family/carer and corroborated by at least one external source, e.g. the patient's general practitioner or community pharmacist.

Care pathway

A multi-disciplinary care plan that outlines the clinical and social care interventions undertaken by different healthcare professionals in the care of service users with a specific condition or set of symptoms.

Care planning

A process based on an assessment of an individual's care needs that involve determining the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved.

Carer

A person, maybe a relative, friend, or paid support worker who provides care.

Complex discharge

Relates to service users:

- who will be discharged home or to a carer's home, or to intermediate care, or to a nursing or residential care home, and

- who have complex ongoing health and social care needs which require detailed assessment, planning, and delivery by the multi-professional team and multi-agency working, and whose length of stay in hospital is more difficult to predict.

Glossary

Discharge medication communication

A structured communication that includes the discharge prescription plus information about any medication changes that were made to the patient's treatment (new medications, stopped medications, dose changes, or formulation changes).

ELOS

Estimated length of stay.

Family

May include the immediate biological family and/or other relatives, spouses, partners (including civil, same sex and de facto partners).

Healthcare

Services received by individuals or communities to promote, maintain, monitor or restore health.

Healthcare professional

A person who exercises skill or judgement in diagnosing, treating or caring for service users, preserving or improving the health of service users.

HSE

Health Service Executive.

Integrated care

Healthcare services working together, both internally and externally, to ensure service users receive continuous and co-ordinated care.

Integrated discharge planning

The activities that facilitate a service user's movement from one health care setting to another, or to home. It is a multi-disciplinary process involving physicians, nurses, social workers, and other health and social care professionals; its goal is to enhance continuity of care. It begins before or on admission.

Intentional medication discrepancy

A medication discrepancy that was intended.

Medication discrepancy

Any difference between medication listed before transfer and those listed after the transfer.

Medication reconciliation

The process of creating the most accurate list possible of all medications a service user is taking — including drug name, dosage, frequency, and route — and comparing that list against the clinician's admission, transfer, and/or discharge orders, with the goal of providing correct medication to the patient at all transition points within the hospital.

MPAR

The national standard acute hospitals' Medication Prescription & Administration Record as approved by the HSE Management Team in 2013, and any subsequent approved modifications thereof.

Multi-disciplinary assessment:

An assessment of an individual's needs that has actively involved professionals from different disciplines in collecting and evaluating this information.

Multi-disciplinary team

An approach to the planning of treatment and the delivery of care for a service user by a team of professionals who work together to provide integrated care.

Patients Own Drugs Scheme

A scheme that encourages patients to bring their usual medicines (in their original container) into hospital with them from home, and are particularly beneficial for patients admitted in an emergency when there may not be the opportunity to get information quickly from a GP.

PDD

Predicted Date of Discharge.

SDU

The Special Delivery Unit (SDU) is a unit within the Department of Health established to unblock access to acute services by improving the flow of patients through the system, working with the HSE and the National Treatment Purchase Fund.

Glossary

Service user:

The term 'service user' includes:

- People who use health and social care services as patients.

- Carers, parents and guardians.

- Organisations and communities that represent the interests of people who use health and social care services.

- Members of the public and communities who are potential users of health services and social care interventions.

The term service user also takes account of the rich diversity of people in our society whether defined by age, colour, race, ethnicity or nationality, religion, disability, gender or sexual orientation, and may have different needs and concerns.

Simple discharge

Relates to 80% of service users discharged from hospital to their own home that have simple ongoing healthcare needs which can be met without complex planning and service delivery.

Stakeholder

Those people and organisations who may affect, be affected by or perceive themselves to be affected by a decision or activity in terms of services provided.

Unintentional medication discrepancy

A medication discrepancy that was not intended.

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