Best Practice Template

Admission, Transfer and Discharge Protocol for hospital patients in Scotland.

1. Background

This template provides recommended key points that should be contained in a joint locally agreed Admission, Transfer and Discharge (ATD) protocol for use in NHS facilities in Scotland.

The aim is to offer guidelines on practice to health professionals with the emphasis throughout on multi-disciplinary, inter-agency working and collaboration.

Partnerships must endorse the completed protocol with the Chief Executives of the NHS Board and all relevant Local Authorities signing it off.

2. Introduction

This section should recognise the importance of a jointly agreed protocol for discharge from both acute and longer-term NHS facilities.

- It should direct staff into a consistent co-ordinated approach with multi-disciplinary, multi-agency input while maintaining the individual's interests as central to the discharge planning process.
- It should remind staff that this is a working document and as services and practises develop, it will require to be reviewed to improve or add to ways of working and to accommodate new service developments.
- The ATD protocol should have a date of issue and a review date.
- Good practice indicate that an admission, transfer and discharge steering group should be established to launch, implement, evaluate, monitor, review and audit this working document.
- Completed protocols should be well publicised and promoted to ensure all relevant staff are familiar with the document and encouraged to use it.
- It is vital that each stage of the discharge process has agreed maximum timescales for completion.

3. Policy context

3.1 National guidance

The main national guidance documents regarding discharge protocols are listed below. These and other national guidance could be referenced in the text.

CCD 9/2003 which provided a model framework for the production of joint hospital discharge protocols.
http://www.sehd.scot.nhs.uk/publications/CC2003_09.pdf

Scottish Executive Circular SWSG 10/98 – Community Care Needs of Frail Older People. http://www.scotland.gov.uk/library/swsg/index-f/c216.htm

Scottish Executive Response to the Care 21 Report and HDL 22/2006: Guidance on NHS Carer Information Strategies
http://www.sehd.scot.nhs.uk/publications/DC20060612care21.pdf

CCD 8/2003: Choice of Accommodation – Discharge from hospital
http://www.sehd.scot.nhs.uk/publications/CC2003_08.pdf

CEL 6 (2008): NHS Continuing Health Care
http://www.sehd.scot.nhs.uk/mels/CEL2008_06.pdf

3.2 Local policy

Any particular local issues or policies should be detailed in this section.

It is recommended that locally an ATD flow chart is devised. An example is given in Appendix 1 (to follow).

4. Principles and values

This section would include the principles and values, which are drawn in part from work published in the NHS in Scotland Planned Care Improvement Programme. http://www.scotland.gov.uk/Publications/2006/09/26134950/0

It should explain the aims of the protocols, which might include ensuring:

- Patients receive the right care in the right place at the right time.
- Safe and timely discharge from hospital to a more appropriate setting.
- Effective use is made of public resources.
- Patients do not remain in hospital longer than is clinically necessary.
- Patients and their carers are involved and supported in the discharge process.
- All staff know what to do and where, when and how to do it.

5. Roles and responsibilities

None of the lists in the following sections are exhaustive and should include anything pertinent to local areas.

Relevant web links should be included where appropriate.

The lists are not exclusive to any one part of the process and may be applicable throughout the patient pathway.

This section should clearly identify and describe the roles and responsibilities of all stakeholders involved, for example:

- Patients, family/carers
- Nursing and Medical Staff
- Discharge Managers and Co-ordinators
- Community Health/Care Partnerships
- Acute Sector/Primary Care Services
- Community Hospitals
- Local Authorities
- Allied Health Professionals
- Enabling and Rehabilitation Services
- Pharmacists
- Scottish Ambulance Service
- Clinical Governance
- Registered Providers of Care services
- Housing Authorities and Providers (including homeless services)
- Voluntary Services
- Independent Advocacy Services
- Benefits agency

5.1 Admission

The admission process should be well defined and consistent for each type of admission/specialty. This section should provide evidence that discharge planning has commenced. This should include the following:

- Recorded consent to information sharing between organisations and systems.
- Communication plan.
- Planned admission criteria.
- Unplanned admission criteria.
- Planned assessment/initial assessment of need - this should be inclusive of functional cognitive screening.
- Early identification of adults in need of support or protection.
- Early identification of adults with incapacity
- Early identification of issues relating to homelessness
- Estimated/Planned Date of Discharge should be agreed, recorded and reviewed as required ensuring that patient and carers are consulted at all times.
- Documentation should be agreed locally and take into account the principles of single shared assessment.
- Consent/information sharing should be in alignment with local and professional standards.
- Evidence of clear communication strategy for each patient that takes into account of their needs, abilities and appropriate means of communication.
- Communication with other agencies/multi professional to ensure effective patient admission and discharge pathways.
- Mental health – Advanced Statement .

5.2 Post assessment

Following the outcomes from assessment the information identified could be used to inform the discharge plan below:

- Post hospital care services
- Post acute care – communication with Primary Care
- Choice of accommodation
- Care Home information including access to Care Commission reports
- Care at home information including 4 weeks free personal care and Council charging policies
- Choice issues including interim care settings
- Carers' assessment
- Adults with Incapacity issues
- NHS Continuing Health Care criteria

- NHS Appeals Process as detailed in CEL 6 (2008) – appealing against decision to discharge and eligibility for NHS Continuing Health Care
- End of life care
- Equipment and adaptations
- Telecare
- Housing
- Benefits and funding
- Advocacy services

5.3 Transfer

The transfer process should be well defined and consistent for each type of transfer. The processes, procedures and authorisation required should all be outlined in this section:

- Transfer of assessment information and other details
- Transport issues to be addressed.
- Examine options for intermediate care
- Ward to ward transfer within NHS facility
- Inter hospital transfer within Health Board
- Out of area transfer
- Unplanned/emergency transfer
- Capacity issues due to increased demands on other parts of the service
- NHS Continuing Health Care
- Consideration of legal aspects for vulnerable adults/adults with incapacity

5.4 Discharge

Effective planning facilitates a safe, appropriate and timely discharge into the community. This section should include

- Definition of “Estimated Date of Discharge” and “Clinically Ready for Discharge Date”.
- Current/ongoing risk assessment and management plans that should facilitate an effective move to the community setting.
- Cares Strategy
- A completed discharge checklist that is signed and dated.
- A written discharge plan should be agreed and given to the patient/carer**.**
- All follow up arrangements should detail follow up plans with dates, frequency, contact names, telephone numbers and web links.
- Protocol must describe the frequency of review of the Estimated Date of Discharge and how the patient carers are updated should the Estimated Date of Discharge need to be revised**.**
- Nurse led discharge.

- Use of discharge lounge.
- Integrated Care Pathway

If at this point discharge does not take place then there must be a clear process outlined within this section of how this information is captured as per the delayed discharge definition and data recording manual.
http://www.isdscotland.org/isd/5966.html

6. Monitoring, Review and Audit

The completed Admission, Transfer and Discharge Protocol must have an agreed monitoring and review procedure and an audit tool in place to evaluate its effectiveness.

The following are some examples of how this may achieved:

- Failed or poorly executed admissions, transfers and discharges.
- Delayed Discharges outlining the reason/s for delays.
- Measuring actual journeys against agreed times scales as set out in the Protocol.
- A review of procedures where systems have failed.
- Management of both formal and informal complaints procedure..
- Effective and relevant Audit tool
- Post discharge questionnaire.
- Reports and statistics.
- Date for review and update of the Protocol.

7. Training and Development

This section should evidence the importance of induction and ongoing training and development for all Partners involved in the Admission, Transfer and Discharge process. Consideration must be given to the following:

- Students/Learners/Trainees.
- Multidisciplinary Team.
- Sessional/Bank staff.
- Leadership.
- Understanding other professionals, organisations and other services.
- Documentation, Record Keeping.
- National Policy.
- Local Policy.
- Professional Development Plans.
- Knowledge and Skills Framework.
- Annual Development Reviews.
- Self assessed training needs.