RHSC Discharge Planning Process – Consultation paper

1. Introduction
A child’s best interests are served by being in hospital for the briefest possible time necessary for safe and effective treatment. However, the move from hospital to home is a time of increased risk and stress for child and family. ‘Discharge planning’ is the process of identifying the ongoing health and social care needs of the child and family, making plans that ensure the safety and continuity of care, preparing the family, and coordinating the contribution from different professionals and agencies. The phrase ‘discharge planning’ is used as shorthand for a process of assessment, planning and preparation, which begins at admission or, in elective cases, before admission. It is a process rather than a one-off event, aiming to provide a safe, ordered and timely transfer from hospital to community. The detail of a discharge plan will be determined by individual need, but the standard of planning must be consistent across the hospital, regardless of the child’s speciality, hospital ward or home area. “Good quality discharge should not be a matter of chance” (DoH 1994)

2. General Principles of Discharge Planning
• Children & young people and their parents or carers must be fully and actively involved in discharge assessment, planning and decision-making.
• Assessment and planning should consider the whole child and not just healthcare needs.
• Ward staff should identify on admission any child or family with additional needs and any key contact who helps coordinate care at home. This may be a keyworker, community or specialist nurse, or other professional.  The key contact should be informed of the child’s admission by the next working day.
• Children and families should have their homecare needs assessed on or before admission, or as soon as possible after recognition of an ongoing care need. Early identification of complex discharges is vital in avoiding discharge delay.
• Responsibility for initiating and coordinating discharge planning lies at ward level, particularly for the 80% of patients whose discharge is relatively straightforward – the ‘simple discharges’. For those with more complex needs the Ward staff work in partnership with other professionals. The ‘Discharge Type’ helps to identify additional steps and shared responsibilities for ‘Pre-planned’ and ‘Complex’ discharges.
• Each patient will have an identified member of staff responsible for coordinating discharge planning.  This may be a named nurse, keyworker, specialist nurse or other clearly identified individual.
• Discharge planning needs to be an actively managed process with clearly defined responsibilities, goals and timescales. Each member of the discharge planning team is responsible for delivering actions to a timescale that best meets the needs of child and family and minimises discharge delay.
• Discharge information should be gathered and recorded systematically, using the Discharge Checklist for all discharges, supported by an Integrated Care Pathway or Complex Discharge Plan where appropriate.

3. Discharge types
The majority of children and young people are admitted to hospital for routine elective and emergency care and stay less than 48 hours. For very small numbers of children, those with multiple or complex conditions, the hospital stay may extend to months or even years. In these cases the complexity of planning will often delay discharge. Discharge planning needs to be targeted, with a routine process for the many simple discharges, care pathways used for those with common chronic conditions or interventions which take a predictable course (Pre-planned discharges), and a multi-disciplinary planning process for those children and young people with complex conditions needing a individualised package of support (complex discharges). The three discharge types provide a simple tool to help staff identify discharge-planning responsibilities,
the major steps in the planning process, and the collaboration necessary to ensure a seamless transfer from hospital to home.

a. **Simple Discharge**
Discharge after a routine elective or emergency admission where the course of recovery is predictable. There may be a short-term increase in dependency but levels of risk are low. The discharge is managed by ward nursing staff with advice from the Discharge Liaison Nurse if needed. Short-term hospital and community nursing follow-up is arranged, and care discharged back to the GP and universal services. The Discharge Checklist is used to help manage & record the discharge.

The Discharge Process as outlined below (4.2) defines the responsibilities of the Ward team for simple discharges. Additional steps are necessary where the discharge is Pre-planned or Complex.

b. **Pre-planned discharge.**
'Pre-planned Discharge' planning is focussed on condition or disease management (eg. Diabetes, cystic fibrosis, oncology), or management of a complex intervention (eg. cleft lip and palate). Care follows a predictable course, often defined in an integrated care pathway (ICP), and is managed by a specialist team. The Pre-planned discharge type also applies to those children with complex needs who have an established community care package and keyworker support. Ward nurses will plan this discharge in partnership with the specialist team or keyworker, using an ICP or existing care plan.

c. **Complex discharge**
The discharge planning needed to develop a bespoke package of care for the child with multiple and complex healthcare needs that have a major impact on health, welfare and development. Multi-disciplinary and multi-agency planning is necessary ensure a safe transition from hospital to home, and maintain effective long-term support for the child and family. The discharge is planned and managed by Ward staff in partnership with the Discharge Liaison Nurse (DLN) and a Core Team that may include the lead consultant, named ward nurse, locality lead professional, discharge liaison nurse and social worker. The Core Team works with the family to agree discharge-planning priorities and progress them in collaboration with a larger multi-disciplinary team. Discharge planning is tracked and recorded on a Complex Discharge Plan.

A very small number of children with exceptional health care needs will require Continuing Care: where one-to-one home care from trained staff is required for all or part of the time, to meet healthcare needs and ensure safety. Early identification is critical in avoiding discharge delay for these children.

4. **The Discharge Planning Process**

4.1 **Pre-admission assessment:** Where possible, for elective admissions, the speciality team should start discharge planning at a pre-admission clinic or home assessment.

4.2 **The Discharge Process**
This Discharge process is common to all discharges and defines the discharge-planning responsibilities of the Ward or unit staff. For the 'simple discharge' the Ward nurse has lead responsibility for planning and implementation as outlined in Figure 1. For the more complex discharge there are additional steps to the process and responsibility is shared with others (see 4.3 and 4.4). Progress is recorded on a Discharge Checklist (Appendix 1) to be used for all admissions.
Figure 1 The Discharge Planning Process

**Discharge Planning Process**

- **On admission**
  - S1 **Start Discharge Checklist.** Refer to Pre-admission assessment if done.
  - S2 **Assess** issues that will affect hospital and home care eg. communication, transport, housing. Identify services and equipment used in community eg. Therapy services. Consider referral or support from Learning Disability Liaison, interpreter, social work.
  - S3 **Inform:** What to expect in hospital and after discharge. Discuss expected discharge date (EDD). Enter EDD on TRAK.
  - S4 **Key Contacts:** Identify Key Contact in hospital and/or community eg. Keyworker, specialist nurse, health visitor. Inform by next working day.

- **During Hospital stay**
  - S5 **Identify Discharge Type and discharge planning partners** eg. Discharge Liaison Nurse, specialist nurse, keyworker. See information on Pre-planned PP1 or Complex C1.
  - S6 **Assess** needs & identify emerging care or social issues that will affect discharge eg. equipment, training, housing, education.
  - S7 **Plan** the discharge and homecare in partnership with child & family, key contacts and multi-disciplinary team.
  - S8 **Educate, train & support** child and family. Signpost to other sources of advice and support. • Record advice & training.
  - S9 **Anticipate** discharge day with timely discharge decision, supplies, pharmacy & transport ordered, community referrals made & discharge letter written in advance.

- **Day of departure**
  - S10 **Inform:** Give follow-up appointments and discharge letter. Advise on aftercare, return to normal activities, who to contact if problems. Reinforce with written information & give an opportunity to ask questions. Ask parent to check & sign Discharge Checklist.
  - S11 **Medicines and supplies:** Advise on administration and source of further supplies. Give medicines & 7 days supply of dressings & consumables.
  - S12 **Home safely**
    • Verify who child is going home with. Confirm discharge address & phone number.
    • Inform Key Contacts of discharge (if any).

- **HOME**
  - S13 **Complete and sign-off Discharge Checklist**
4.3 The Pre-planned discharge
The Pre-planned discharge will apply where planning is condition specific or when the child already has a homecare package. Such children have an established team who will ensure continuity of care from hospital to community. There is no need to establish a new multi-disciplinary team. Following identification of a child, either at admission or diagnosis, additional steps are added to the Discharge Process to ensure that planning is supported by the specialist team and addresses specific issues. The named ward nurse, in partnership with the keyworker or specialist nurse, will manage the discharge, with assistance from the Discharge Liaison Nurse if needed. The Integrated Care Pathway or existing care plan will supplement the Discharge Checklist as a record of discharge planning.

PP1 Child has a condition for which a specialist team and care pathway exist. See Ward Resource Folder. Go to PP2
OR Child has additional healthcare needs and an existing community care package. Go to PP3

PP2 If condition specific:
• Inform Specialist team of admission
• Initiate the relevant integrated care pathway, or if there is no ICP use the complex discharge record.
• Agree discharge plan with Family & Specialist Team
Day of departure checks are signed off by the Ward nurse to compete the Discharge. See S10

PP3 If existing care package:
• Ensure that the keyworker is aware of admission and check that the current care package is suspended while child in hospital.
• Assess discharge needs with family and Keyworker and review the current homecare plan. Have the child’s care needs changed significantly?

NO – needs have not changed:
• Agree discharge plan with Family & Keyworker
• Give Keyworker 48hours notice to restart the care package.
Day of departure checks are signed off by the Ward nurse to complete the Discharge. See S10.

YES – needs have changed significantly: Follow complex path from C1 to review the multi-disciplinary plan. Inform the Discharge Liaison Nurse.

4.4 The Complex Discharge
The Complex Discharge starts when it is identified that a child or young person is likely to have multiple and complex care needs that will have a major effect on health, welfare or development and will require an individualised multi-disciplinary and multi-agency support package. Planning may start at a number of points:
• A child is newly diagnosed with a condition that will entail a high level of community support.
• A child is critically ill but likely to survive to require a high level of support.
• A child with a known progressive condition has reached crisis point and needs more support.
• A child receiving palliative care has reached the end-of-life phase, and the family need intensive support to allow him/her to die at home.

The complex discharge is a collaborative effort, planned across agencies and specialities, with those involved understanding the decisions that need to be made and the implications for child & family. The twelve additional steps for the Complex Discharge are outlined below. The Discharge Liaison Nurse and a ‘Core Team’ work with the Ward Nurse to plan the discharge, and this is recorded on a Complex Discharge Record.
For families who need Continuing Care there will be parallel process initiated in the child’s home locality. The system for arranging packages varies with Health Board. In Lothian the Lothian Exceptional Needs Support Group (LENS Group) agrees multi-agency packages. Funding, recruiting and training the homecare staff will normally take nine months or more, so it is vital that Continuing Care planning starts as early as possible in the admission. The Discharge Liaison Nurse will help initiate negotiations with the local board. Key steps are mapped in Figure 2 and outlined below.

Figure 2: The Complex Discharge Process
The Complex Discharge

C1 Confirm lead consultant and lead nurse to take a holistic view of the needs of child and family and ensure they are at the centre of the discharge planning process. Children with complex needs often receive care from multiple specialities. It is important that one consultant assumes a coordinating role. The lead nurse may change as the child moves Ward within the Hospital.

C2 Discuss homecare needs with family: Lead consultant and nurse discuss the implications of homecare and potential sources of practical and emotional support. They obtain consent to share information with the wider team and progress discharge planning. The detail of the care package (eg. hours of homecare support) is not discussed at this point.

C3 Identify Core Group – a small group (no more than 6) to drive the discharge plan. The Discharge Liaison Nurse supports the Lead Consultant and nurse in convening the group. A lead local professional, social worker and key contacts are identified. Early notification is given to the local health board and council if the child needs continuing care or re-housing.

C4 Core Group action planning. The Core Group plans the comprehensive assessment of child and family health, development & social needs. Group and family agree a target discharge date and discharge planning priorities. The Discharge Liaison Nurse chairs the meetings and action plans are produced.

C5 Family information and support needs. Members of the Core Group advise and refer the child and family to additional sources of information, support and advocacy.

C6 Multi-disciplinary assessment and planning: The Core Group engages with the wider health and social care team and with Primary Care. May require multiple meetings targeted at specific issues, at a frequency demanded by the action plan. Meetings are organised and chaired by the Discharge Liaison Nurse with Core Group support.

C7 Family education and training. The Lead nurse ensures that family & associate carers are trained in routine and emergency care by competent ward or specialist staff, using agreed training programmes. The Family gradually increase their practical involvement in care. All Education and training is formally signed-off and recorded.

C8 Keeping on track: The Core Group identifies issues that are likely to delay hospital discharge and considers ways to ‘work around’ the problems. Concerns and delays are escalated to senior health and social care management if needed. Finalise agreement on the care package with the local providers.

C9 Identify local keyworker and team. Agree and introduce the local support team, and plan a handover that will ensure continuity of care.

C10 Confirm readiness that the family are ready and competent to meet child’s needs, and have the necessary equipment, resources and support for safe and effective home care. Confirm that the local Care team is also ready to meet the child’s needs.

C11 Trial homecare: Phase discharge so as to build child, family and carer confidence and troubleshoot care arrangements. Consider step-down arrangement with local hospital or respite units.

C12 Handover to local team.

Day of departure organised, checked and signed-off by Ward nurse as per Discharge Process S10.

5. Conclusion
The discharge process as outlined above, provides a framework to help clarify roles and responsibilities, promote systematic planning and make best use of resources. As part of a hospital policy, accompanied by staff education and training and the development of planning tools, it is hoped that the Process can help reduce delay, increase safety and make a real difference to the experience of children and families.
Appendix 1: The Discharge Checklist (Draft)

<table>
<thead>
<tr>
<th>On admission</th>
<th>Admission date:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Label</td>
<td>Admitted by:</td>
<td>Signed</td>
</tr>
<tr>
<td></td>
<td>Expected Date of Discharge (EDD)</td>
<td>EDD on Trak</td>
</tr>
<tr>
<td></td>
<td>Existing key contacts:</td>
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</tr>
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</table>

<table>
<thead>
<tr>
<th>Discharge Type:</th>
<th>Simple</th>
<th>Pre-planned</th>
<th>Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care pathway to be used if pre-planned:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral or contacts made</th>
<th>Date</th>
<th>No need</th>
<th>Date</th>
<th>No need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key contact informed</td>
<td></td>
<td>Social Work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health visitor</td>
<td></td>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td></td>
<td>Date Ambulance booked</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Children’s Nurse</td>
<td></td>
<td>Date of Ambulance transport</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge prescription done</td>
<td></td>
<td>Discharge medication on ward</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other referrals &amp; date made:</td>
<td></td>
<td>Follow-up appointments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Advice and information given:

**Family discharge checklist.** *Use this checklist to help make sure that your child’s discharge plan is complete. Do you…*

<table>
<thead>
<tr>
<th>Yes</th>
<th>No need</th>
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</thead>
<tbody>
<tr>
<td>Understand his/her condition and treatment, and any care needed at home</td>
<td></td>
</tr>
<tr>
<td>Know when s/he can return to normal activities and to school</td>
<td></td>
</tr>
<tr>
<td>Know how to seek advice if you have concerns after discharge</td>
<td></td>
</tr>
<tr>
<td>Have the Discharge letter.</td>
<td></td>
</tr>
<tr>
<td>Have the medicines your child will need.</td>
<td></td>
</tr>
<tr>
<td>Understand how to give the medicines and where to get further supplies.</td>
<td></td>
</tr>
<tr>
<td>Know about any follow-up appointments.</td>
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<table>
<thead>
<tr>
<th>Discharge telephone no:</th>
<th>Discharge address as label?</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td></td>
<td>Discharge address if different:</td>
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<td></td>
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<table>
<thead>
<tr>
<th>Parent/carer name:</th>
<th>Signed:</th>
<th>Relationship:</th>
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<tbody>
<tr>
<td>Discharged by</td>
<td>Position</td>
<td></td>
</tr>
<tr>
<td>Date &amp; time</td>
<td>Signed</td>
<td></td>
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</tbody>
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