Nottinghamshire Hospice
adding life to days

POLICY/PROCEDURE INFORMATION (Policy no CS001)	
Subject	*Discharge/transfer from Hospice Services* *(This policy is non-contractual and is subject to periodic review and will be amended according to service development needs).*
Applicable to	All employees of Nottinghamshire Hospice
Target Audience	Others such as agents, consultants and other representatives of Nottinghamshire Hospice may be required to comply with the policy as a condition of appointment.
Date issued	January 2022
Next review date	January 2025
Lead responsible for Policy	Palliative Care Practice Lead
Policy reviewed by	Director of Care
Notified to (when)	Quality and Safety Board
Authorised by (when)	Board of Governors
CQC Standard if applicable	Safe, Effective, Responsive, Caring
Links to other Hospice Policies	Mental Capacity Act Policy (CS007) Clinical Governance Policy (CS005) Safeguarding of Adults Policy (CS003) Verification of Death Policy (CS012)
Links to external policies	See below
Summary	The documents aims to provide clear guidance for all staff on the discharge or transfer of patients from our services.
This policy replaces	Not applicable

VERSION CONTROL		
Status	**Date**	**Reviewed date**
Original policy written by	Kate Martin	
Policy reviewed by	Rachel McCarty	
Policy notified to	Quality and Safety Boards	
Policy ratified by	Quality and Safety board	March 2022
Updated control sheet and published on website	May 2022	

1. Introduction

A discharge policy is necessary to ensure safe, timely and effective discharge or transfer of care for all patients treated by the Hospice where necessary. It should be a process actively involving patients, family/carers and health and social care parties. The policy is based on current legislation and recommendations taken from the following guidance and policies.

https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

https://www.gov.uk/government/publications/nhs-funded-nursing-care-practice

Quality statement 5: Admission, discharge and transfer | Healthcare-associated infections | Quality standards | NICE

Improving transfer of care (nice.org.uk)

Hospital discharge and preventing unnecessary hospital admissions (COVID-19) (scie.org.uk)

Hospital discharge and community support: policy and operating model - GOV.UK (www.gov.uk)

Designated settings for people discharged to a care home - GOV.UK (www.gov.uk)

2. Principles/Objectives

The principles/objectives on which the policy is based are:

• A safe and timely discharge/transfer to a preferred place of care ie. care home, Specialist Palliative Care Unit or hospital.

• Planning for appropriate discharge/transfer is part of an ongoing process and should start at the earliest opportunity.

• The engagement and active participation of individuals and their family/carers is central to the delivery of care and in the planning of a successful discharge/transfer.

• Staff should work within a framework of integrated multi-disciplinary and multi-agency team working to manage all aspects of the discharge/transfer process.

• The assessment for, and delivery of, continuing health and social care is organised so that individuals understand the continuum of health and social care services and their rights, and receive advice and information to enable them to make informed decisions about their future care. This should include information about their right to appeal against decisions reached.

• Effective and timely discharge/transfer requires the availability of alternative, and appropriate, care options including admission to hospital, palliative care unit or care home to ensure that any rehabilitation, recuperation, re-enablement and continuing health and social care needs are identified and met.

3. Duties and Responsibilities

3.1 Chief Executive

Has overall responsibility for ensuring that this policy is effectively implemented.

3.2 Director of Care

Has overall responsibility for decisions made regarding the transfer or discharge of patients from Hospice services.

3.3 Lead Nurse

Has responsibility for ensuring that appropriate health care professionals are involved and discharge planning is considered, ensuring timely referrals are made and nursing notes are accurate and up to date.

Responsible for ensuring that the patient and carer/family are involved throughout the transfer/discharge process and any information is given in an appropriate and timely manner.

Fully engage and communicate with the receiving healthcare team i.e. hospital/SPCU/care home.

3.5 All Staff

Everyone involved in the patient's journey has a responsibility to actively involve the patient, and family/carer where appropriate.

Responsible for ensuring any documentation is amended and up to date with any involvement of staff through the patient's transfer/discharge process.

4. Transfer of Patients

4.1 To Hospital/Specialist Palliative Care Unit (SPCU)

The transfer of patients from home to hospital or SPCU is rare and is decided and is the responsibility of the GP, District Nursing and/or Palliative Care teams where reversible causes have been identified or when complex symptoms require more effective management. In all circumstances it must agreed by the patient and/or family.

Nottinghamshire Hospice staff can support the patient and family by offering reassurance where necessary.

All documentation should be up to date prior to transfer/discharge.

Nottinghamshire Hospice staff will explain that the patient will be discharged from our services but can be re-referred at any time. This information will be handed over to the Care Coordinators who will discharge the patient from the Hospice on SystmOne.

4.2 Out of Hours

If there is a clinical urgency for a patient to be transferred to an alternative health setting, this should be arranged at the earliest opportunity by the community on call medical/surgical specialties regardless of the time of day if this is in the interest of the patient's wellbeing.

All documentation should be up to date.

For transfers to a SPCU or hospital a verbal handover will provided by Nottinghamshire Hospice at the earliest opportunity.

5. Discharge of Patients from Hospice Outreach and Discharge Service (HODS)

Hospice Outreach and Discharge service provides care for up to 30 days. Regular case conference reviews ensure that fast-track continuing care are notified prior to the end of the 30 day period.

It is the responsibility of the fast-track team to liaise with the family to find alternative

provision. This may be through the use of another care agency or admission to a care home.

For patients being discharged to a care home or a care agency, a verbal handover is generally sufficient as the care home/agency will undertake their own assessment of the patient's needs.

6. Discharge of Patients from the GRACE Unit

Patients are not discharged from the GRACE Unit because they will always be made a follow up offer to 'Keep in Touch' groups or transferred to Hospice in Your Home as necessary. However, some patients will discharge themselves and in these instances the following will apply

- All communication regarding their decision and any conversations around it will be documented on SystmOne.
- Their decision will be communicated clearly to their family or main carer.
- A discharge letter will be sent to the patient and their GP or referring health professional explaining the reason for their discharge and that re-entry into the service will be possible on receipt of another referral (see Appendix 3).

7. Discharge of Patients following death

If a member of staff is present at the time of death and they are qualified and competent to do so, they can verify the death. The GP/District Nurses will be notified to verify the death if necessary.

The death of a patient will trigger a discharge from Hospice services which is documented on SystmOne by the Care Coordinators.

Documentation around the details of the death will be provided by a Registered Nurse or Healthcare Assistant if present at the time of death.

A bereavement card will be sent to the family by Support Services.

CQC will be notified of the death.

8. Discharge from Support Services

8.1 Counselling Service

Counselling at the hospice is offered weekly for a 12 week period or less if the client feels that would be sufficient. This is detailed in a welcome letter sent out at the start of the sessions and a reminder given at week 11.

The last session at week 12 is called "the ending session" and is used to review the goals set at the start to ensure progress has been made. This is also the time when information on other bereavement services and how to access them is provided e.g. the bereavement group or emotional support.

A discharge letter is sent to the client following the final session reiterating the above information (see Appendix 1) and included is a feedback form for the client to complete.

8.2 Emotional Support

Emotional support is also provided for up to 12 sessions, but this may be over a longer time period e.g. monthly for one year or fortnightly for 6 months.

A discharge letter is also sent to the client explaining how to re-access bereavement services should that be necessary (see Appendix 2) and a feedback form is also included for the client to complete.

8.3 Bereavement group

The bereavement group is an open group and as such does not require a discharge process. People can continue to access support from this group for as long as they feel it is necessary.

9. Mental Capacity

It is recognised that patients have the right to discharge themselves from the hospice services. If the patient expresses this wish it is important to establish that the patient has the capacity to make the decision. If the patient does not have capacity for this decision, after careful assessment and it is felt to be in their best interests not to allow self-discharge, then staff can make a safe-guarding referral and will continue to provide care until a suitable alternative has been arranged.

9.1 The Mental Capacity Act 2005

Listed below are the key points of the Mental Capacity Act (2005) that influence discharge/transfer planning.

The Mental Capacity Act 2005 provides a statutory framework for acting and making decisions on behalf of individuals who lack the mental capacity to do so for themselves. The Act specifies the principles that must be applied by everyone who is working with or caring for adults who lack capacity. It also provides options for those who may choose to plan and make provision for a future time when they may lack capacity.

The Five Key Principles

1. A person is assumed to have capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done or decision made on behalf of a person who lacks capacity must be done or made in their best interests.
5. Before any such act or decision is made the person making or taking it must consider whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights or freedom of action.

Independent Mental Capacity Advocates (IMCAs)

The Secretary of State is to make such arrangements as to enable IMCAs available to

represent and support persons who do not have capacity and have no other appropriate representative to consent concerning what would be in their best interest. ii.

The appointment of IMCAs only relates to the provision of one of the following:

- Serious medical treatment by the NHS
- Change of accommodation in hospital or care home for the person by the NHS.
- Change of residential accommodation by the local authority.

The function of the IMCA is to:

- Provide support to the person to ensure they participate as fully as possible in any relevant decision.
- Obtain and evaluate any relevant information in health records.
- Ascertain what the person's wishes were likely to be
- Ascertain if alternative courses of action are available to the person.
- Obtain alternative medical opinion where treatment is proposed and the advocate thinks one is required.

10. Lasting Power of Attorney

The person who has LPOA will be able to make decisions about the person's health and welfare should the person become incapacitated, if such power is conferred.

11. Advanced Decisions to Refuse Treatment

These have also been known as 'advanced directives' or 'living wills':

- Advanced decisions can be withdrawn or altered at any time when the maker has the capacity to do so.

- Where it is clear that an Advanced Decision exists in writing, this should be attached to the patient's file.

- Advanced decisions need not be in writing to be valid, withdrawal or partial withdrawal need not be in writing.

- Alteration of Advanced decisions need not be in writing unless it refers to life sustaining treatments.

- The Advanced Decision has to be valid in that it must address current circumstances and current treatment.

12. Monitoring Compliance and Effectiveness

In order to ensure that this discharge policy is fit for purpose there will be at least an annual monitoring and audit of this policy either in full or in part. Any omissions or actions required will be monitored and the policy updated in line with this.

13. Equality, Diversity and Inclusion

		YES/NO	COMMENT
1.	**Does the policy affect one group less or more favourably than another on the basis of:**	No	
	Age	No	
	Disability – learning disabilities, physical disability, sensory impairment and mental health problems	No	
	Gender Reassignment	No	
	Marriage/Civil Partnership	No	
	Pregnancy/Maternity	No	
	Race	No	
	Religion or Belief	No	
	Sex	No	
	Sexual Orientation	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy without the impact?**	N/A	
7.	**How can the impact be reduced by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the sponsoring director; together with any suggestions as to the action required to avoid/reduce this impact.

Appendix 1

Name
Address:
Address
Address
Postcode Date:

Dear XXXXXXXX

Re: End of Counselling Service

I am aware that your counselling sessions with XXXXXXXX have now come to an end. As a valued service user we would appreciate it if you would give us feedback regarding the counselling you received. As a charitable organisation, feedback is essential to us in order to gain funding applications in the future, and ensure that we can continue to provide a free service.

I enclose a questionnaire that is designed to help us to evaluate the Hospice Counselling Service and to enable us to obtain your thoughts on how we can develop and improve the support we offer. Any feedback you give to us is of great value. A pre-paid envelope as been provided for you to return the form.

If you have any concerns about this form or any other matter relating to the Counselling Service, or should you feel you would like to access our support again in the future, please do not hesitate to contact us on **0115 9621222**.

Yours sincerely

Debbie Hastings
Bereavement Services Manager

Appendix 2

Name
Address:
Address
Address
Postcode Date:

Dear XXXXXXXX

Re: End of Emotional Support Service

I am aware that your support sessions with xxxxxxxxxx have now been completed. As a valued service user we would appreciate if you would give us feedback regarding the support you received. As a charitable organisation, feedback is essential to us in order to gain funding applications in the future, and ensure that we can continue to provide a free service.

I enclose a questionnaire that is designed to help us to evaluate the Hospice Support Service and to enable us to obtain your thoughts on how we can develop and improve the support we offer. Any feedback you give to us is of great value. A pre-paid addressed envelope has been provided for you to return the form.

If you have any concerns about this form or any other matter relating to the Support Service, or should you feel you would like to access our support again in the future, please do not hesitate to contact us on **0115 962 1222**.

Yours sincerely

Debbie Hastings
Bereavement Services Manager

Appendix 3

Name:
Address:
Address
Address
Postcode

Date:

Dear Health Professional,

Re: Discharge from GRACE Unit

Thank you for your referral of XXXXXXX into the GRACE Unit.

Unfortunately they have decided not to attend as we have been unable to meet their needs at this time.

We will not contact them again but would be happy discuss how we can best support them moving forward.

Our telephone number is **0115 9621222** should you have any queries.

Yours sincerely

Clair Russell
GRACE Unit Manager

Appendix 4

Name:
Address:
Address
Address
Postcode

Date:

Dear XXXXXXXX,

Thank you for your interest in coming to the GRACE Unit here at Nottinghamshire Hospice.

Further to our telephone call explaining the Therapy and Wellbeing sessions and your needs at present I am enclosing some information about other ways in which we may be able to support you and your family.

Please contact us if you have any questions or would like any other advice or information.

Our telephone number is **0115 962 1222**.

Yours sincerely

Clair Russell
GRACE Unit Manager