



# **Code of Practice for INTEGRATED DISCHARGE PLANNING**



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive



# Health Service Executive Code of Practice for Integrated Discharge Planning

## Part 1: Background



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

## Reader Information

<b>Directorate:</b>	Health Service Executive (HSE)
<b>Title:</b>	HSE Code of Practice for Integrated Discharge Planning
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<b>Author:</b>	HSE National Integrated Discharge Planning Steering Committee
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<b>Target Audience:</b>	All relevant healthcare providers
<b>Description:</b>	The Code of Practice is a guide to the standards of practice required in the management of integrated discharge planning in the HSE, based on current legal requirements and professional best practice
<b>Superseded Docs:</b>	All previous local and national documents relating to integrated discharge planning
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<b>Contact Details:</b>	<p>Fiona Quinn,  Winter Initiative,  HSE,  31/33 Catherine Street.  Limerick,  Ireland.</p> <p>Email: <a href="mailto:dischargessupport@hse.ie">dischargessupport@hse.ie</a>  Web: <a href="http://www.hse.ie">www.hse.ie</a></p>

## Foreword

### Foreword

The Code of Practice has been produced by the National Integrated Discharge Planning Steering Committee as a guide to the required standards of practice in the management of integrated discharge planning in the HSE and in any facility providing services on behalf of the HSE.

The Code of Practice was drafted by members of the National Integrated Discharge Planning Steering Committee and was prepared by utilising published guidance from expert bodies, and existing best practice guidance and standards. Information has also been drawn from various expert groups and reference sources. A national consultation process on the draft Code was undertaken and feedback, where appropriate, was incorporated into the final version of the Code. Work on the Code also benefited greatly from the input of Liz Lees, Consultant Nurse (Acute Medicine) RGN, Dip N, BSc (hons), Dip HSM, MSc.

The Code provides:

1. A framework for consistent, coherent management of integrated discharge planning in the Health Service Executive.
2. A reference point against which continual improvement and consultation can take place.

The Code applies to healthcare facilities providing services on behalf of the Health Service Executive under S.39 of the Health Act 2004. It is allied to work being undertaken on the Transformation Programme—*Develop integrated services across all stages of the care journey*.

This is an evolving document because standards and practices in relation to integrated discharge planning will change over time, particularly in the context of emerging primary care teams and networks. It will therefore be subject to regular review and updated as necessary.

## Contents

The document has been prepared in five main parts. There is an overall table of contents following the foreword. Each part of the document also has its own contents page, which provides a detailed breakdown of all the sections and subsections in that part of the document.

Part 1	Background	This part provides the foundation for all standards and recommended practices detailed in the remainder of the document.
Part 2	Standards	The standards for integrated discharge planning are described in this section.
Part 3	Recommended Practices	This part identifies the recommended practices that are intended to define correct management of integrated discharge planning.
Part 4	Audit Tool	The audit tool relates to the standards for integrated discharge planning in the Health Service Executive.
Part 5	Additional Resources & Appendices	This part includes a glossary, list of abbreviations and a reference list. Appendices include the membership of the National Integrated Discharge Planning Steering Committee.

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Part 1

*Part 1*  
*Background*

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## Introduction

# 1 Introduction

## 1.1 Integrated discharge planning

Patients being discharged from hospital should receive a seamless transition from one stage of care to the next. A coordinated and patient centred approach to planning for discharge can lead to increased satisfaction with healthcare services, reduced length of stay and prevention of unplanned readmissions.

A patient centred approach to integrated discharge planning occurs when hospitals, general practitioners (GPs) and other Primary, Community and Continuing Care (PCCC) providers coordinate care for the patient from the hospital to the community.

Effective integrated discharge planning supports the continuity of healthcare, between the healthcare setting and the community, based on the individual needs of the patient. It is described as “the critical link between treatment received in hospital by the patient and post-discharge care provided in the community”...NSW Department of Health (2006).

## 1.2 Whole systems approach

Our services cannot work in isolation from each other. Effective multi-agency and multi-disciplinary working is essential to manage the patient’s journey from pre-admission through hospital discharge to the community. To achieve a truly patient centered approach to integrated discharge planning, all stakeholders must accept their inter-dependency and must work together to ensure that there are no gaps in services or duplication of efforts. For example, this approach may involve individuals or teams working innovatively to enable the joined up delivery of services that support individual needs and the transition to an appropriate setting.

Achieving a whole systems approach requires the enhancement and development of relationships, built upon effective communication and cooperation, between primary, community and continuing care (PCCC), hospitals, transport services and the relevant voluntary sectors.

Effective integrated discharge planning relies on knowledge of available healthcare services, partnerships between organisations and a clear understanding of respective roles. The increased emphasis on a whole systems approach challenges us to coordinate services across organisational boundaries in order to deliver seamless and appropriate services for patients.

## Introduction

### 1.3 Common Assessment Process and Common Summary Assessment Record

In December 2006, following a Government decision, the Minister for Health & Children announced plans for a significant change in how long term residential care is provided and paid for. Under the new legislation, the HSE has statutory responsibility to ensure that people with demonstrated need will be able to access state funding for long term residential care. To effectively implement this scheme a number of processes have been implemented by the HSE as follows:

- Common Assessment Process (CAP) and Common Summary Assessment Record (CSAR).
- Integrated Care Pathways—equitable access to Home Care & Long Stay Care (Public & Private).

### 1.4 The principles of integrated discharge planning

- Integrated discharge planning is considered as a *process*, not an event. The process will encompass key elements: written discharge information, provision of a discharge plan and an estimated length of stay.
- Supporting this process, integrated discharge planning systems should include:
  - i. The allocation of responsibilities across healthcare services (which involves defining roles and identifying and reviewing communication channels).
  - ii. Well-defined discharge policies, procedures and activities.
  - iii. Discharge documentation that accompanies the patient throughout the episode of care.
  - iv. Provision for stakeholder feedback and response to that feedback.
  - v. Methods for managing impediments to good discharge practice.
- A *documented discharge plan* should commence at or before admission to hospital. The discharge plan should be subject to ongoing assessment throughout the hospital stay to take account of changes in patient and carer health and social status.
- The assessment and discharge process must be *person centred*. The patients' interests and wishes should be taken into account when considering future care options. This should involve ongoing consultation with the patient and his/her family/carer/advocate.
- Integrated discharge planning is the *responsibility of all healthcare providers* in partnership with the patient/carer/family. A staff member should be identified as being responsible for ensuring that all aspects of integrated discharge planning have been addressed by the time of discharge.

## Introduction

- A ***multi-disciplinary and multi-agency*** approach is the most appropriate one for the development and implementation of discharge plans. To achieve best practice the multi-disciplinary teams should work together collaboratively and in a planned and integrated manner. In addition to hospital and community staff, it is important that integrated discharge planning includes the transport services and voluntary/non-statutory partners.
- Effective integrated discharge planning should be ***consistent*** for all patients receiving care in the healthcare system.
- The ability to discharge effectively is dependent on the ***availability of a range of services*** to meet ongoing or longer-term care needs. Thus the discharge plan should take account of any additional resources required to effect the discharge and work towards a resolution.

## 1.5 Facilitating best practice

Facilitating best practice involves the following steps:

1. ***Patient assessment*** that is thorough and covers pathological, physiological, psychological, social and cultural needs (including the patients' home(s) and social circumstances).
2. ***Planning*** that the patient, carer, nurse, doctor and other appropriate members of the multidisciplinary team conduct together. The documentation of this discharge plan is filed in the patient healthcare record and regularly revised.
3. The plan's ***implementation***, which involves patient and carer education, referrals to hospital-based and PCCC services, and communication with PCCC service providers and general practitioners (GPs).
4. The ***follow-up*** of patients after discharge, to evaluate the effectiveness of the planned interventions and ensure continuity of care.

## 1.6 What is the benefit?

Getting discharge right benefits everyone:

- **Patients** want information about their treatment, how long they are likely to stay in hospital and when they can expect to be discharged. This helps the patient to access services when they need them, have their needs identified and have care delivered in a setting appropriate to their needs.
- **Improved pre-planning** of patient care will result in less stress for staff and a better working environment.
- **Healthcare facilities** will be enabled to employ their valuable resources to maximum effect.

## How healthcare organisations can successfully improve their discharge practice

## 2 How healthcare organisations can successfully improve their discharge practice

### 2.1 Management support

- Management should support the change and review new integrated discharge planning policies and procedures for integration into day to day patient care.
- Management should provide ongoing support of work practice change by involving all relevant healthcare staff and encouraging them to learn from examples of success.

### 2.2 Clinical leadership

- Successful improvement of integrated discharge planning involves the championing and clinical leadership of improved patient care processes.
- The hospital consultant has continuing clinical and professional responsibility for patients under his/her care and each member of the multi-disciplinary team has a key leadership role to play with regard to their area of expertise within the team.

### 2.3 Information sharing

Effective communication between hospitals, GPs, PCCC, voluntary and private service providers is essential to ensure a coordinated patient journey from pre-admission through to discharge. To ensure quality and timely communication, there should be a uniform approach to information management across the public sector in acute and the PCCC sectors. This may involve:

- Conducting multi-disciplinary and multi-agency forums to discuss integrated discharge planning issues.
- Conducting formal education sessions for particular groups or services.
- Educating hospital and PCCC staff about the healthcare services available in the region.
- Working together to develop local service directories. These directories may include contacts, service descriptions and process information. They may also contain referral forms and a description of the eligibility criteria for each service.
- Ensuring local service directories are accessible to staff and up-to-date, and encouraging staff to use them.
- Identifying information needed to help staff communicate with other healthcare providers.

**How healthcare organisations can successfully improve their discharge practice**

- Considering privacy and confidentiality issues when implementing information systems.
- Developing patient information with patients/families/carers to ensure that it is relevant, legible and understandable.

**2.4 Education and training**

- Staff should be informed and educated about any changes in integrated discharge planning practice.
- Staff should be given the knowledge, skills and tools to identify and implement real improvement in integrated discharge planning.
- Training needs analysis should be conducted as part of staff induction programmes and ongoing integrated discharge planning training needs should be identified.

**2.5 Change management and organisational learning**

- All staff involved in the integrated discharge planning process should participate in the improvement effort.
- Patients should also be involved in changing work practices that directly or indirectly improves patient care.
- The organisation should evaluate whether change improves patient care, reduces delays, reduces duplication and increases patient and staff satisfaction.
- The organisation should promote a culture that is comfortable with change and seeks continuous improvement in integrated discharge planning.

## Development of the Integrated Discharge Planning Code of Practice

### 3 Development of Integrated Discharge Planning Code of Practice

#### 3.1 Introduction

The Code of Practice was developed as follows:

- Extensive literature search.
- Consideration of the opinion of experts knowledgeable in the subject.
- Consideration of the available current best practice, both in Ireland and internationally, that may impact on integrated discharge planning.
- Organisation of a series of national workshops to discuss integrated discharge planning with key stakeholder groups.
- Development of draft standards and recommended practices that were distributed for consultation to key stakeholders.
- Incorporation of feedback, where appropriate, into the final version of the Code.

#### 3.2 Definition

The Integrated Discharge Planning Standards present a standardised approach to integrated discharge planning in the Health Service Executive (HSE), from pre-admission to post-discharge. The aim of the Standards is to enhance patient care and safety and improve continuity of care from the hospital to the home and community. The Standards will be used to direct and evaluate integrated discharge planning practices in the HSE.

Standards = Organisational structures and processes needed to identify, assess and manage specified risks in relation to integrated discharge planning and to improve the quality of care.

- Each standard has a **title**, which summarises the area on which that standard focuses.
- This is followed by the standard **statement**, which explains the level of performance to be achieved.
- The **rationale** section provides the reasons why the standard is considered to be important.
- The standard statement is expanded in the section headed **criteria**, where it states what needs to be achieved for the standard to be reached.



## Development of the Integrated Discharge Planning Code of Practice

**Recommended Practices** = recommendations concerning best practice in relation to integrated discharge planning.

The Recommended Practices are intended to define correct management of integrated discharge planning. They are also intended to serve as the basis for policy and procedure development in integrated discharge planning in acute hospitals and local health offices.

- Each recommended practice has an **introduction**, which summarises the area on which the recommended practice focuses.
- This is followed by the recommended practice **scope**, which explains the objective of the recommended practice and why it is considered to be important.
- The contents section outlines the **contents** of the recommended practice.
- This is expanded in the section headed **procedure**, where it states how each recommended practice can be achieved.



# Health Service Executive Code of Practice for Integrated Discharge Planning

## Part 2: Standards



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Health Service Executive

Part 2

# *Part 2*

## *Standards*

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## Communication and consultation

# 1 Communication and consultation

## 1.1 Statement

Appropriate and effective mechanisms shall be in place for communication and consultation on matters relating to integrated discharge planning, with key stakeholders within and outside the organisation.

## 1.2 Rationale

Interactive, timely exchange of information with key stakeholders creates an empowering infrastructure and environment. These are important factors for enabling the integrated discharge planning process and for continually improving and enhancing performance over the continuum of care.

## 1.3 Criteria

1. The organisation shall develop a set of shared values, behavioural guidelines and quality principles in support of the Health Service Executive Code of Practice for Integrated Discharge Planning that are reflected in job descriptions and vision statements.
2. Healthcare workers and patients shall be given an opportunity to provide feedback on these values, guidelines and quality principles.
3. These values, guidelines and quality principles shall be reflected in each departments' business plans.
4. The organisation shall develop and implement a practical methodology for sharing best practice in relation to integrated discharge planning, both internally and with key stakeholders.
5. The organisation shall inform their staff, local healthcare providers and patients about the Health Service Executive Code of Practice for Integrated Discharge Planning.
6. Educational material shall be provided using a variety of different media as required.

## Communication and consultation

7. Healthcare providers and key stakeholders shall be encouraged to use customer feedback mechanisms to help inform service improvement and learning.
8. The organisation shall have in place a formal system for recording and analysing customer feedback in relation to integrated discharge planning.
9. The organisation shall have in place a programme to reduce customer complaints in relation to integrated discharge planning.
10. Relevant information from recording and analysing customer feedback in relation to integrated discharge planning shall be used to continuously improve the service.

**Organisational structure and accountability****2 Organisational structure and accountability****2.1 Standard Statement**

Responsibility for integrated discharge planning shall be clearly defined and there shall be clear lines of accountability throughout the organisation.

**2.2 Rationale**

The CEO/Manager (i.e. hospital CEO/manager or local health office manager) through the senior management team, is responsible for ensuring that there are effective arrangements for integrated discharge planning.

**2.3 Criteria**

1. Individual responsibility for integrated discharge planning shall be defined throughout the organisation and there shall be clear lines of accountability leading up to the most senior manager of the organisation.
2. The scope of responsibility shall include the competence of contractors where the organisation buys in services and professional liability where the organisation buys in or sells services to other organisations.
3. Integrated discharge planning shall be a standard item on the agenda of the appropriate committee in the organisation. The Discharge Co-ordinator (or designated individual) shall submit regular reports on management of integrated discharge planning to the committee.
4. A monthly report on the effectiveness of integrated discharge planning shall be submitted to the appropriate committee for review. This committee, which shall include in its membership the CEO/Manager or CEO/Manager nominee, shall present the report (with suggestions, where appropriate) to the management team.
5. Each organisation shall identify discharge co-ordinators (or a designated manager... see note overleaf). The duties of the designated person shall not be confined to any one aspect of the integrated discharge planning function but shall encompass all integrated discharge planning processes wherever they occur within the organisation.



## Organisational structure and accountability

6. The discharge co-ordinator (or designated individual) shall have responsibility and authority for developing and monitoring policies, continuous quality improvement and/or strategies for integrated discharge planning for approval by the appropriate committee.
7. The discharge co-ordinator (or designated individual) shall attend appropriate meetings and conferences, local and national, relevant to integrated discharge planning, to increase their knowledge and improve their ability to undertake the role.
8. The discharge co-ordinator (or designated individual) shall undertake the dissemination of information relating to integrated discharge planning, where relevant, to all key stakeholders, both within the organisation and externally.
9. The discharge co-ordinator (or designated individual) shall work with clinicians and departmental/line managers to develop and improve the systematic approach to integrated discharge planning.
10. The discharge co-ordinator (or designated individual) shall be responsible for ensuring that the integrated discharge planning audit activity under the responsibility of each head of department has been completed.
11. Each individual delivering care along the care continuum (this includes staff at ward level and staff in PCCC services) shall be made aware of their responsibility in relation to integrated discharge planning.

**Note:** Smaller organisations may decide that the role of the discharge co-ordinator is best performed as part of the duties of a discharge co-ordinator in a larger organisation in the network/PCCC region. What is important is that:

- The CEO/Manager takes active responsibility for integrated discharge planning.
- The reporting pathways are clearly defined.
- The resources devoted to integrated discharge planning are adequate.

## Management and key personnel

### 3 Management and key personnel

#### 3.1 Standard Statement

Appropriately qualified key personnel shall be in place to ensure that integrated discharge planning is provided safely, efficiently and cost-effectively.

#### 3.2 Rationale

To ensure a high quality and safe, integrated discharge planning process.

#### 3.3 Criteria

Key persons and responsibilities shall be as follows:

1. The *CEO/Manager* (i.e. hospital CEO/manager or local health office manager) shall put in place arrangements to ensure effective and efficient management of integrated discharge planning.
2. A *discharge co-ordinator* (or designated individual) shall be identified, shall have formally defined responsibilities in accordance with these Standards and shall be provided with the necessary resources and authority to discharge these responsibilities.
3. The *discharge co-ordinator* (or designated individual) shall have an appropriate combination of experience and qualifications to undertake his/her role.
4. The *discharge co-ordinator* (or designated individual) shall work with designated Nurses (or HSCPs/Others) for integrated discharge planning and shall ensure that these personnel have been trained to the necessary standard of competence.
5. *Healthcare professionals* shall have appropriate training on the principles of integrated discharge planning and shall have a good knowledge of the Health Service Executive Code of Practice for Integrated Discharge Planning.
6. Appropriate *ICT expertise* and support shall be available for integrated discharge planning.

## Education and training

### 4 Education and training

#### 4.1 Standard Statement

Education and Training in relevant aspects of integrated discharge planning shall be provided to all new and existing staff members (both permanent and temporary).

#### 4.2 Rationale

All clinical and administrative staff should have a general knowledge of the principles of integrated discharge planning.

#### 4.3 Criteria

1. **In addition to general induction training there shall be a structured integrated discharge planning foundation training programme for relevant managers and staff commensurate with their work activity/responsibility to include the following:**
  - i. Communication with patients/families/carers in relation to integrated discharge planning.
  - ii. Multidisciplinary team.
  - iii. Nurse (or HSCP/Other) facilitated discharge.
  - iv. Key tasks before admission.
  - v. Key tasks on admission.
  - vi. Key tasks during admission.
  - vii. Key tasks 24 hours before discharge.
  - viii. Key tasks on day of discharge.
  - ix. Follow-up post discharge and evaluation.
  - x. Self-discharge/discharge against medical advice.
  - xi. Information technology training specific to the integrated discharge planning function.
2. Induction training in integrated discharge planning shall be provided to each staff member (where relevant) and shall be documented in the individuals training record.

## Education and training

3. Staff from acute and PCCC services shall participate in joint training sessions. Such sessions shall have a common focus and shall include a focus on person centred care across the continuum of care.
4. Acute and PCCC services shall work in partnership to provide training opportunities which shall increase staff understanding of the role that their services play in the continuum of care, and the skills required.
5. There shall be a continuing programme of training (internal organisation training on HSE Code of Practice for Integrated Discharge Planning) and education (external professional education) for staff on integrated discharge planning. Departmental records of staff attendance at further training in integrated discharge planning shall be kept.
6. Training shall be supported with adequate resources and facilities.
7. Competencies in integrated discharge planning across the organisation shall be assessed and records shall be kept.
8. A formal appraisal system shall be in place to monitor staff performance and to identify individual training needs.
9. The organisation shall undertake an annual training needs analysis for integrated discharge planning and shall develop a training plan to support the needs identified.

**Note:** Integrated discharge planning principles and processes shall be incorporated into undergraduate and postgraduate clinical education for all disciplines.

## Operational policies and procedures

## 5 Operational policies and procedures for integrated discharge planning

### 5.1 Standard Statement

Written policies, procedures and guidelines for the integrated discharge planning process shall be based on the *Health Service Executive Recommended Practices for Integrated Discharge Planning (Part 3)*, shall be available, implemented and shall reflect relevant legislation and published professional guidance.

### 5.2 Rationale

Formal documented control of integrated discharge planning within a quality management system is necessary to monitor each aspect of the patient journey in order to demonstrate compliance with current legislation and guidance. This will reduce risks to patients, staff and the organisation and will ensure person centred care across the patient pathway.

### 5.3 Criteria

1. The organisation shall have documented policies, procedures and guidelines for all of the key elements of the integrated discharge planning process as outlined in the recommended practices sections of the HSE Code of Practice for Integrated Discharge Planning. These policies, procedures and guidelines (where assessed as relevant), shall include:
  - i. Communication with patients/families/carers in relation to integrated discharge planning.
  - ii. Multidisciplinary team working.
  - iii. Nurse (or HSCP/Other) facilitated discharge.
  - iv. Key tasks pre-admission.
  - v. Key tasks on admission.
  - vi. Key tasks during in-patient stay.
  - vii. Key tasks 24 hours before discharge.
  - viii. Key tasks on day of discharge.
  - ix. Follow-up post discharge and evaluation.

## Operational policies and procedures

- x. Self-discharge/discharge against medical advice.
  - xi. Medication management.
  - xii. Procedures for dealing with vulnerable patient groups, e.g. people who are homeless/living in temporary accommodation and people with dementia.
  - xiii. ICT training.
2. All policies and procedures associated with integrated discharge planning shall comply with current legislation, Health Service Executive guidance and published professional guidance.
  3. The appropriate committee shall approve policies, procedures and guidelines for integrated discharge planning in the organisation.
  4. There shall be a system to ensure each department or service has access to a current copy of the approved integrated discharge planning policies, procedures and guidelines pertinent to its activities.
  5. All relevant staff shall be required to read the integrated discharge planning policies and procedures relevant to their area of work and to sign a statement to indicate that they have read, understood and will comply with same.
  6. All policies and procedures associated with integrated discharge planning shall be controlled documents (showing date of issue and revision number) to ensure that current versions are available to all who need to use them.
  7. Master copies shall be kept in a secure location in accordance with good records management practices.
  8. Obsolete documents shall be removed from all points of use and dealt with, in line with good records management practices.
  9. A biennial review of all policies, procedures and documents associated with integrated discharge planning shall be undertaken to check their relevance and issue status.
  10. A document management system for the control and management of integrated discharge planning policies and procedures shall be available within the organisation.
  11. All electronic data shall be stored securely, backed up and audited regularly.
  12. Access to data/records shall be restricted to authorised named persons and specified information shall be maintained in line with relevant legislation.
  13. Staff shall have access to the Intranet as appropriate.

## Integrated discharge planning process

## 6 Integrated discharge planning process

### 6.1 Standard Statement

Integrated discharge planning shall include the patient and as appropriate, the family/ carer in the development and implementation of the patient's discharge plan and shall ensure that steps are taken to address necessary linkages with other healthcare providers in order to ensure a seamless transition from one stage of care to the next.

### 6.2 Rationale

To ensure that every patient discharged from a Health Service Executive (HSE) healthcare facility and from those facilities providing services on behalf of the HSE, is transitioned safely to the community with appropriate arrangements for their continuing care.

### 6.3 Criteria

#### *Assessment*

1. Pre-admission assessments shall be conducted for patients who have planned admissions to hospital.
2. Patient assessment regarding potential for delayed discharge shall begin either prior to admission or at first presentation to the hospital.
3. Patient assessment shall continue throughout the patient's hospital stay.
4. Standardised, up-to-date, patient healthcare records shall be readily accessible at pre-admission and throughout the patient's stay in hospital.
5. The healthcare facility shall have in place defined agreements regarding access (including prioritisation of access) and response times for both internal and external diagnostic services.

*Note: The Common Summary Assessment Record (CSAR) should be utilised, where appropriate.*

#### *Referral*

6. Referral shall be made to the other members of the multi-disciplinary team as appropriate (this includes referral to PCCC services) and this shall be documented in a timely manner.
7. Referral shall be made to the diagnostic services by the appropriate personnel and this shall be documented as appropriate.

**Integrated discharge planning process**

8. Receipt of referrals shall be documented on a integrated discharge planning tracking form in the patient's healthcare record within 24 hours of receiving the referral. Note: this includes referral from hospital to PCCC services.

***Nurse (or HSCP/Other) facilitated discharge***

9. The suitability of the patient for Nurse (or HSCP/Other) facilitated discharge shall be agreed with admitting clinician in conjunction with the multi-disciplinary team.
10. Within one hour of patient admission to the ward, an appropriate and competent Nurse (or HSCP/Other) from the ward shall be identified and assigned to actively manage the patient pathway of care.
11. The healthcare record shall indicate that it is a Nurse (or HSCP/Other) facilitated discharge and the name of the Nurse (or HSCP/Other) shall be documented.
12. The Nurse (or HSCP/Other) shall be up to date on all aspects of the patient care pathway, particularly focusing on the current medical and nursing condition and discharge plan.

***Estimated length of stay***

13. Each patient shall have an estimated length of stay.
14. The estimated length of stay shall be identified by the admitting consultant in conjunction with the multi-disciplinary team, during pre-assessment, on the post-take ward round or within 24 hours of admission to hospital and shall be documented in the patient's healthcare record.
15. The estimated length of stay shall be based on the anticipated time needed for tests and interventions to be carried out and for the patient to be clinically stable and fit for discharge. Note: the actual length of stay is dependent on the patient's condition and circumstances.
16. The estimated length of stay shall be discussed and agreed with the patient/family and carers.
17. The estimated length of stay shall be proactively managed against the treatment plan (usually by ward staff) on a daily basis and changes shall be communicated to the patient/carer.
18. Any changes to the estimated length of stay shall be communicated to the PCCC services, as appropriate.



**Integrated discharge planning process*****Treatment plan***

19. Each patient shall have a medical treatment plan.
20. The medical treatment plan shall be discussed and agreed with the patient/family and carers.
21. The medical treatment plan shall be documented in the patient's healthcare record.

***Discharge plan***

22. Integrated discharge planning shall commence at pre-admission or on admission and shall include information about the patients' pre-admission abilities in relation to potential discharge issues.

***Transport arrangements***

23. Transport arrangements shall be confirmed 24 hours before discharge.

***Communication***

24. Peri-operative services or pre-admission clinics shall communicate planned admissions to PCCC service providers before admission.
25. The hospital shall notify PCCC service providers of unplanned admissions at the time of hospitalisation, as appropriate.
26. When aware of a patient's admission, PCCC service providers shall contact the hospital department ( as appropriate) to discuss premorbid health status to ensure continuity of care while the patient is in hospital.
27. The hospital shall advise PCCC service providers, as appropriate, of the planned discharge date as soon as possible, and at least two days prior to patient discharge (for patients who are in-patients for five days or longer) to enable them to plan the necessary post-hospital service commencement.
28. Two-way communication between the hospital and the GP and other PCCC service providers, as appropriate, shall be arranged to ensure such services are available and in place for the patient to use when needed post discharge.
29. The discharge check list shall be completed twenty four hours before discharge to ensure all of the above activities have been carried out.
30. The family/carers, GP and other PCCC service providers shall be contacted at least the day before discharge to confirm that the patient is being discharged and to ensure that services are activated or re-activated, as appropriate.

### Integrated discharge planning process

31. At the time of leaving the hospital, each patient shall be provided with an information pack containing relevant information such as patient/carer plan, a medication record, and information.
32. Information and education shall be provided to the patient and the family/carer in the appropriate language, verbally and in written form relating to:
  - i. The anticipated course of treatment and estimated length of stay.
  - ii. Ongoing health management.
  - iii. An appropriate post-discharge contact to answer queries and address concerns.
  - iv. Medications.
  - v. The use of aids and equipment.
  - vi. Follow-up appointments.
  - vii. PCCC based service appointments.
  - viii. Possible complications and warning signs.
  - ix. When normal activities can be resumed.

## Integrated discharge planning process

*Transfer and discharge communication*

33. The transfer or discharge communication shall include information under the following headings:
- Organisation Name.
  - Patient identification information.
  - Responsible clinician name and contact details.
  - Ward or department or specialty issuing the discharge document (including contact details).
  - Patient's registered GP details/referring clinician if different.
  - Patient's PHN details.
  - Diagnoses on discharge (including problem list).
  - Patient alerts/allergies.
  - Infection status (as appropriate).
  - Presenting problem/complaint (include current diagnoses).
  - Procedures and investigations.
  - Results of investigations.
  - Relevant findings on systems review, examination findings and summary of management care plan.
  - Functional state (self-care/baseline mobility/walking aids and appliances) on discharge.
  - Medications and diets including nutritional supplements and relevant information on administration of medicines.
  - The name, signature, grade and contact details of the member of staff who has completed the transfer/discharge communication.
  - Discharge plan.
  - The name, signature, grade and contact details of the member of staff who has completed the discharge plan.
  - The name and title of the receiving clinician in the case of a transfer.
34. Transfer/discharge communications shall be multi-disciplinary where multi-disciplinary care is to be continued.

### Integrated discharge planning process

35. A copy of the transfer/discharge communication which is completed before discharge shall be sent to the patient, the patients GP, PHN and other healthcare providers (e.g. Nursing Home) and a further copy shall be retained in the healthcare record.
36. Transfer/discharge communication shall be authorised by the relevant responsible healthcare professionals (including contact details).
37. A copy of the Common Summary Assessment Record (CSAR) shall be included, where appropriate.
38. Where a decision to recommend the patient for long-term residential care has been made, it shall be documented in the healthcare record that the patient was informed within fifteen days of that decision being made.

#### *Time of discharge*

39. Each patient discharge shall be effected (i.e. hospital bed becomes available for patient use) by 12 noon 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 patients, carers and other healthcare providers (where relevant).

#### *Follow-up of discharge plan*

40. Contact shall be made with all referred patients within three days post discharge (either via telephone and/or contact with the GP and other PCCC service providers) to find out if the problems identified as requiring intervention post-discharge were adequately addressed and to deal with any new problems.

**Audit and monitoring****7 Audit and monitoring****7.1 Standard Statement**

Audits shall be carried out to ensure that the local policies and procedures for integrated discharge planning conform to the required Standards and that the processes undertaken conform to the policies and procedures. The audit results shall be used to identify opportunities for improvement.

**7.2 Rationale**

Audit is necessary to provide evidence that the system of integrated discharge planning in place is effective.

**7.3 Criteria**

1. Audit of integrated discharge planning shall include:
  - i. Accountability arrangements.
  - ii. Staff knowledge, expertise and resources.
  - iii. Processes, including risk management arrangements.
  - iv. Policies, procedures and guidelines.
2. Each relevant head of department shall be responsible for preparing a written agreed programme which shall ensure that all aspects of integrated discharge planning within their department are audited at least once a year.
3. Each relevant head of department shall be responsible for ensuring that the audit is conducted in accordance with this programme.
4. Each relevant head of department is responsible for ensuring that any deficiencies identified during audit are reported and discussed with line management and the discharge co-ordinator (or designated individual) and for verifying the efficacy of remedial actions undertaken.
5. The discharge co-ordinator (or designated individual) shall be responsible for ensuring that the audit activity, under the responsibility of each relevant head of department has been completed.
6. The appropriate committee shall be responsible for the implementation and monitoring of a integrated discharge planning audit and monitoring programme in each organisation.

## **Audit and monitoring**

7. Audit results shall be fed back to the discharge co-ordinator (or designated individual), the appropriate committee, relevant staff and the organisation management team.
8. Audit results shall be included in the appropriate annual report.
9. Audit results shall be used to help inform and improve integrated discharge planning practices.
10. The audits shall be carried out by appropriate personnel trained in the audit tool.
11. The senior management team shall submit an annual assurance statement on audit findings for consideration and approval by the Network Manager/Assistant National Director Primary Community and Continuing Care (PCCC).
12. The Network Manager/Assistant National Director PCCC shall submit annual assurance statements on audit findings to the Director of the National Hospitals Office/Director of Primary, Community and Continuing Care.
13. External national audits of integrated discharge planning shall be carried out as appropriate under the direction of the Assistant National Directors of Quality, Risk and Customer Care.
14. The audit should form part of a cycle of continuous improvement and re-auditing going forward.

## Key performance indicators

## 8 Key performance indicators

## 8.1 Standard Statement

Key performance indicators that are capable of showing improvements in the efficacy of integrated discharge planning in the organisation shall be used.

## 8.2 Rationale

Key performance indicators are designed to demonstrate improvement in the performance of integrated discharge planning services over time.

## 8.3 Criteria

*Assessment*

1. Patient assessment shall begin either **prior to admission** or at **first presentation to the hospital**.

*Referral*

2. Receipt of referrals shall be documented on an integrated discharge planning tracking form in the patient's healthcare record **within 24 hours of receiving the referral**. Note: this includes referral from hospital to PCCC services.

*Nurses (or HSCPs/Others)*

3. Within **one hour of patient admission to the ward**, appropriate and competent Nurses (or HSCPs/Others) shall be identified and assigned to actively manage the patient pathway of care.
4. These Nurses (or HSCPs/Others) shall be up to date on all aspects of the patient care pathway, particularly focusing on the current medical and nursing condition and discharge plan.

*Estimated length of stay*

5. **Each patient** shall have a documented length of stay.
6. The patient's estimated length of stay shall be identified **during pre-assessment, on the post-take ward round or within 24 hours of admission to hospital** and shall be documented in the healthcare record.

**Key performance indicators**

7. The estimated length of stay shall be **discussed and agreed with the patient/family and carers.**

***Treatment plan***

8. **Each patient** shall have a medical treatment plan.

***Transport arrangements***

9. Transport arrangements shall be confirmed **24 hours before discharge.**

***Communication***

10. The hospital shall advise PCCC service providers, as appropriate, of the planned discharge date as soon as possible, **and at least two days prior to patient discharge (for patients who are in-patients for five days or longer)** to enable them to plan the necessary post-hospital service commencement.

***Transfer/Discharge communication***

11. A copy of the transfer/discharge communication which is completed before discharge shall be given to the patient and sent to the patient's GP, PHN and other healthcare providers (e.g. Nursing Home) and a further copy shall be retained in the healthcare record.

***Time of discharge***

12. Each patient discharge shall be effected (i.e. hospital bed becomes available for patient use) no later than **12 noon** 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 patients, carers and other healthcare providers (where relevant).







# Health Service Executive Code of Practice for Integrated Discharge Planning

## **Part 3: Recommended Practices**



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

Part 3

*Part 3*

*Recommended Practices*

*for integrated discharge planning*

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## Communication with patients/families/carers

## 1 Communication with patients/carers/families

## 1.1 Introduction

Patient, families and carers who are fully engaged in all stages of the patient journey from pre admission to post discharge can better understand what is happening, the expected outcomes and their role in the process. For patients 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.

## 1.2 Scope

The objective of this procedure is to provide guidelines in relation to integrated discharge planning and communication with patients, families and carers.

## 1.3 Contents

Section One: Estimated length of stay

Section Two: Discharge plan

Section Three: Information pack

Section Four: Individualising information

Section Five: Medication management

Section Six: Feedback

## 1.4 Procedure

Section One: Estimated length of stay

- The estimated length of stay should be identified as soon as possible (at pre-admission or on admission) and discussed with patients, families and carers.

## Communication with patients/families/carers

## Section Two: Discharge plan

- The discharge plan should be developed with the patient/family/carer in order to explore options for the patient's care post hospitalisation, including family members, voluntary services and other healthcare providers.
- The discharge plan should be discussed with the patient/family/carers to ensure that they understand the plan, medication management regime, etc.
- The Common Assessment Process (CAP) and Common Summary Assessment Record (CSAR) shall be explained to the patient/family, where appropriate.

## Section Three: Information pack

- An information pack should be developed in which to keep all information brochures and sheets for the patient/family/carer.
- Patient information should be developed with patients/families/carers, to ensure that it is relevant, legible and understandable.
- Patients and carers should be involved in determining what information should be provided.
- The **information pack** may include the following:
  - i. The names and telephone numbers of hospital/PCCC contacts in the event that the patient has questions following discharge.
  - ii. Details about the patient's medical condition.
  - iii. Details about the patient's health management, including activity and diet advice.
  - iv. Details about ongoing investigations, including any special instructions.
  - v. The date, time and location of the appointments for any investigations, where possible.
  - vi. Medication management information, including instructions on administration, the management of side-effects, and storage.
  - vii. Details about follow-up appointments, including the name and address of the healthcare provider, the date and time of the appointment and the reason for the appointment.



## Communication with patients/families/carers

### Section Four: Individualising information

- The Nurse (or HSCP/Other) who is facilitating discharge should find out what is important to the patient/carer and what are their concerns.
- Medical terms should be clearly explained.
- Information, either written or verbal, should be timely, repeated and checked out to ensure patients and carers understand that information.
- The Nurse (or HSCP/Other) who is facilitating discharge should check that the patient/carer understands the diagnosis, the reason for particular treatments and how to perform or use treatments.
- The Nurse (or HSCP/Other) who is facilitating discharge should check whether the patient/carer understands what follow-up is required and why this is required.
- The Nurse (or HSCP/Other) who is facilitating discharge should confirm that the healthcare facility and the patient/carer have a shared understanding of the problem and the plan of action.
- The Nurse (or HSCP/Other) who is facilitating discharge should confirm that the patient/carer agrees with the plan of action.
- Members of the multidisciplinary team should give the patient/carer and family members an opportunity to ask questions.
- The needs of patients with poor vision, cognitive deficits, cultural and language barriers should be considered.
- The method of education which is best suited for a specific patient population or individual should be assessed.

### Section Five: Medication management

- A complete medication management history, including over-the-counter and complementary medicines should be taken.
- Contraindications, allergic reactions and interactions between medications should be checked.
- The pre-admission medication management list should be reconciled with the list of medication prescribed on the hospital drug chart and any anomalies resolved.
- Dosing should be simplified where possible.

### Communication with patients/families/carers

- Patients (families/carers) should be provided with verbal and written information including:
  - i. Medicine contents.
  - ii. How to take the medicine.
  - iii. Actions of the medicine.
  - iv. Potential benefits, adverse effects and side effects of the medicine.
- The medication management details listed on the discharge summary/communication, the discharge prescription and the patient information should be cross checked for accuracy.
- Patients (families/carers) should be taught to monitor their medication use.
- Patients (families/carers) should be taught self-monitoring skills (for example peak flow measurement, blood glucose readings, blood pressure).
- Patients (families/carers) should be taught how to obtain their test results (for example, drug levels, blood glucose tests, clotting times).
- Patients (families/carers) should be provided with medication management charts.
- Counselling and family/carer therapy should be provided for complex medication management regimes (for example, insulin, antidepressants, biologicals).
- Education regarding self-management should be documented in the patient's healthcare record.

### Section Six: Feedback

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

**Multidisciplinary team****2 Multidisciplinary Team****2.1 Introduction**

Multidisciplinary teams are groups of professionals from different disciplines, who work together to provide comprehensive patient assessment and treatment. The benefits of effective multidisciplinary team working include timely and effective patient discharge, increased patient confidence, continuity of quality care, enhanced communication and partnership regarding resource management. The patient, their carer and family must be viewed as essential members of this multidisciplinary team.

**2.2 Scope**

The objective of this procedure is to provide guidelines in relation to the multidisciplinary team and integrated discharge planning.

**2.3 Contents**

Section One: Membership

Section Two: Roles and responsibilities

Section Three: Documentation and the healthcare record

Section Four: Team meetings

Section Five: Case conferences

**2.4 Procedure****Section One: Membership**

- Regular multi-disciplinary forums across the hospital and local health office should be established to ensure admission, discharge and transfer of care are planned appropriately.
- The multidisciplinary team should consist of any number of people who are involved in patient care, including hospital and PCCC services staff.

**Multidisciplinary team****Section Two: Roles and responsibilities**

- The responsibilities of the multi-disciplinary team in taking a more pro-active approach to discharges should be clarified.
- Responsibilities should be agreed around the following:
  - i. Who can identify and document the estimated length of stay?
  - ii. Who can review the patient?
  - iii. How multi-disciplinary decisions are made about when the patient is clinically stable and fit for discharge or safe to transfer?
- Staff in the acute hospital services should be informed and educated about PCCC services and vice versa.

**Section Three: Documentation and the healthcare record**

- The estimated length of stay should be documented in the patient's healthcare record.
- The treatment plan should be documented in the healthcare record, reviewed daily and updated in response to changing needs.
- The discharge plan should be documented in the healthcare record, reviewed daily and updated in response to changing needs.
- Relevant internal referrals (diagnostics, health & social care professionals, specialist nursing services, liaison services, etc) should be made to the various members of the multidisciplinary team and this should be documented as appropriate.
- The Common Summary Assessment Record (CSAR) should be completed, where appropriate.
- Receipts of referrals should be documented on an integrated discharge planning tracking form in the patient's healthcare record within 24 hours of receiving the referral.
- The patient's healthcare record should be kept up to date and legibly signed by each member of the multi-disciplinary team involved in the patient's discharge.
- Progress should be documented as intervention commences.

## Multidisciplinary team

### Section Four: Team meetings

- The multidisciplinary team should meet to further plan patient care, set goals and adjust timeframes for discharge, where necessary.
- Family members and carers should be encouraged to attend multi-disciplinary team meetings where appropriate. Otherwise they should be kept informed of up-to date integrated discharge planning arrangements. This information should be documented.
- Multi-disciplinary review team meetings should be planned, where appropriate, to ensure continuity of patient care.

### Section Five: Case conferences

- Where there are complex needs or significant input of services required by the multi-disciplinary team/PCCC services, a case conference may well be appropriate and should be considered.
- Typically, this should involve all/any key personnel from each service to establish the needs of the client and how best they may be delivered.
- The case conference should also include patients, families and carers as appropriate.

*Note: The Common Assessment Process (CAP) and Common Summary Assessment Record (CSAR) should be undertaken for those patients who will require access to long term residential care.*

**Nurse (or HSCP/Other) facilitated discharge****3 Nurse (or HSCP/Other) facilitated discharge****3.1 Introduction**

Many patients 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 patient's medical condition and the resources that the patient can access on discharge from the hospital. Research indicates that assigning responsibility to a named individual for coordinating progress through the system results in improved and timely integrated discharge planning.

**3.2 Scope**

The objective of this procedure is to provide guidance in relation to Nurse (or HSCP/Other) facilitated discharge.

**3.3 Contents**

Section One: General principles

Section Two: Criteria for the Nurse (or HSCP/Other) to undertake discharge

Section Three: Education and training

Section Four: Discharge framework

Section Five: Informing patients

Section Six: Legal liability

**3.4 Procedure****Section One: General principles**

- The suitability of the patient for Nurse (or HSCP/Other) facilitated discharge should be agreed by the admitting consultant in conjunction with the multi-disciplinary team.
- Within one hour of patient admission to the ward, an appropriate and competent Nurse (or HSCP/Other) from the ward should be identified and assigned to actively manage the patient pathway of care.

**Nurse (or HSCP/Other) facilitated discharge**

- Nurses (or HSCP/Other) should be up to date on all aspects of the patient care pathway, particularly focusing on the current medical and nursing condition and discharge plan.
- The healthcare record should indicate that it is a Nurse (or HSCP/Other) facilitated discharge and the name of the Nurse (or HSCP/Other) should be documented.
- If the patient is transferred to another ward or healthcare facility, the Nurses (or HSCPs/Others) who are facilitating the transfer or discharge should provide a formal transfer of responsibility to the Nurses (or HSCPs/Others) who are facilitating discharge in that ward or healthcare facility.
- If the Nurses (or HSCPs/Others) who are facilitating discharge are off duty, a second named team member should provide cover to ensure continuity of care planning.
- The Nurses (or HSCPs/Others) who are facilitating discharge should source and co-ordinate client information and links with families, carers, PCCC Services and voluntary agencies where appropriate.
- This two-way process of information sharing should be standardised and formalised.
- The format of this communication should be agreed locally (e.g. e-mail or fax) and these details should be readily available.

**Section Two: Criteria for Nurse (or HSCP/Other) to undertake discharge**

- The ability to advocate on behalf of the patient and family/carer.
- The ability to educate patients, family/carer and other staff.
- Advanced clinical knowledge in the speciality area.
- Well-developed communication and negotiation skills.
- The ability to work as a member of the multidisciplinary 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:
  - i. Their post is one in which they will have the need and opportunity to initiate and authorise discharge.
  - ii. Local protocols and patient criteria have been developed, agreed and are in operation
  - iii. They will have access to, and the support of, the multi-disciplinary clinical team.

**Nurse (or HSCP/Other) facilitated discharge****Section Three: Education and training**

- Nurses (or HSCPs/Others) preparing for a role within discharge planning should undertake specific education and training.
- The training programme should provide the Nurse (or HSCP/Other) with supervision, support and opportunities to develop competence in authorised discharge practice.
- Competency in integrated discharge planning should be successfully completed and authorised by their line manager through appraisal.
- The Nurse (or HSCP/Other) should inform 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) should not continue with discharge activities in this case until their needs have been addressed and competence is restored.

**Section Four: Discharge framework**

- Nurses (or HSCPs/Others) 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 patient discharge, authorised by their line manager.
- Nurses (or HSCPs/Others) should only discharge patients in the ward or clinic setting in which they are working or in their area of clinical responsibility.
- Nurses (or HSCPs/Others) should only discharge patients where it has been documented that no further medical review prior to discharge is required.
- Before discharging, the Nurses (or HSCPs/Others) should have carried out a holistic assessment of the patient, which should include ensuring all relevant test results have been obtained.
- The decision to discharge should take cognisance of patient choice and involvement, and all treatment and care should be considered. Nurses (or HSCPs/Others) authorised to discharge should also 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.
- The Common Assessment Process (CAP) and Common Summary Assessment Record (CSAR) should be undertaken for those patients who will require access to long term residential care.



**Nurse (or HSCP/Other) facilitated discharge****Section Five: Informing patients**

- Nurses (or HSCPs/Others) authorised to discharge should ensure that patients are aware of the duties of employment and scope of Nurse (or HSCP/Other) facilitated discharge.

**Section Six: Legal liability**

- The healthcare organisation, as the employer, will invariably be fixed in law with vicarious liability for the tortious acts or omissions of Nurses (or HSCPs/Others) authorised to discharge, provided that they are acting lawfully and within the normal parameters and scope of their duties of employment and professional practice.
- In order to protect the organisation from exposure to liability, it is important that:
  - i. Their duties and responsibilities are clearly defined.
  - ii. They have undergone the appropriate training and the preparation.
  - iii. They are deemed competent and qualified to undertake the role and are subject to appraisal by line management.
  - iv. The framework for authorised discharge has been followed and the member of staff has been designated with the necessary authority by the healthcare organization to undertake the role.
  - v. The provision of this recommended practice has been followed by the member of staff at all times.

**Key tasks pre-admission****4 Key tasks pre-admission****4.1 Introduction**

Pre-admission assessments are conducted for patients who have planned admissions to hospital. Such assessments are usually required for patients requiring elective procedures. The pre-admission assessment determines the patient's fitness for procedures and ensures that adequate arrangements are made in preparation for hospitalisation and for planning the discharge process.

**4.2 Scope**

The objective of this procedure is to outline the principles of best practice for pre-admission assessment.

**4.3 Contents**

Section One: Assessment

Section Two: Estimated length of stay

Section Three: Integrated discharge planning

Section Four: Referral

Section Five: Medication management

Section Six: Communication

**4.4 Procedure****Section One: Assessment**

- Pre-admission assessments should be conducted for patients who have planned admissions to hospital. Such assessments are usually required for patients requiring elective procedures.
- Patient assessment should begin either prior to admission or at first presentation to the hospital.
- An anaesthetic assessment should be performed where relevant (this may be performed in an anaesthetic clinic).

**Key tasks pre-admission**

- The procedure, risks and expected outcomes should be explained to the patient and carer.
- Options and preferences for hospital care and treatment and convalescence, as well as patient concerns should be discussed.
- An assessment should be carried out concerning:
  - i. The presence of a carer, the home environment for convalescence and/or the requirements for home modifications
  - ii. Social issues which may impact on the patient's stay.
  - iii. Rehabilitation.
  - iv. The delivery of PCCC services if required (including eligibility for access to services).
- Where other healthcare professionals across the continuum of care provide care relating to the condition for which hospital admission is occurring, those practitioners should be involved in the pre-admission process.
- Standardised, up-to-date, client/healthcare records should be readily accessible at pre-admission.

**Section Two: Estimated length of stay**

- Each patient should have an estimated length of stay.
- The estimated length of stay should be identified during pre-assessment, on the post-take ward round or within 24 hours of admission to hospital.
- The estimated length of stay should be based on the anticipated time needed for tests and interventions to be carried out and for the patient to be clinically stable and fit for discharge.
- The estimated length of stay should be discussed and agreed with the patient/family and carers.
- The estimated length of stay should be communicated to the PCCC service providers, as appropriate.
- The estimated length of stay should be documented in the patient's healthcare record.

## **Key tasks pre-admission**

### **Section Three: Integrated discharge planning**

- Integrated discharge planning should be commenced by gathering information about the patients' pre-admission abilities in relation to potential discharge issues.
- The discharge plan should be discussed and agreed with the patient/family and carers.
- The discharge plan should be communicated with PCCC service providers, as appropriate.
- The discharge plan should be documented in the patient's healthcare record.

### **Section Four: Referral**

- Referral should be made to the other members of the multi-disciplinary team by the appropriate personnel and this should be documented as appropriate.
- Referral should be made to the diagnostic services by the appropriate personnel and this should be documented as appropriate.
- Referral should be made to the PCCC services by the appropriate personnel and this should be documented as appropriate.
- Receipts of referrals should be documented on an integrated discharge planning tracking form in the patient's healthcare record within 24 hours of receiving the referral.

### **Section Five: Medication management**

- A medication management discharge plan should be developed and co-ordinated for each patient.
- Staff should obtain an accurate pre-admission list, including prescription and over the counter medicines, nutritional support and other therapies such as herbal products, at the time of admission.

**Key tasks pre-admission**

- Patient's admission medication should be reviewed in consultation with the patient's GP, community pharmacist or other relevant clinicians, with a view to:
  - i. Identifying the appropriateness and effectiveness of current medication management, and rationalising current medication management if appropriate.
  - ii. Paying particular attention to any problems associated with current drug therapy, including any possible relationship with the current medical condition.
  - iii. Documenting allergies and any previous adverse drug reactions.
- Any necessary pre-admission medication management or treatment should be commenced.

**Section Six: Communication**

- Peri-operative services or pre-admission clinics should communicate planned admissions to PCCC service providers before admission.
- Changes in the patient's medication or condition between pre-admission and date of planned admission should be communicated by PCCC to the acute hospital.
- Information and education should be provided to the patient and the family/ carer in the appropriate language, verbally and in written form relating to:
  - i. The anticipated course of treatment and estimated length of stay.
  - ii. Likely requirements post-discharge.

**Key tasks on admission****5 Key tasks on admission****5.1 Introduction**

Management of inpatient admissions and discharges is essential to enhance the quality of patient care. After the patient has been admitted to hospital, the acute hospital service should work with PCCC service providers to provide an integrated service delivery system.

**5.2 Scope**

The objective of this procedure is to outline the principles of best practice for integrated discharge planning on patient admission.

**5.3 Contents**

Section One: Assessment

Section Three: Estimated length of stay

Section Three: Treatment plan

Section Four: Discharge plan

Section Five: Referral

Section Six: Medication management

Section Seven: Communication

**5.4 Procedure****Section One: Assessment**

- Patient assessment should begin either prior to admission or at first presentation to the hospital.
- Patient assessment should continue throughout the patient's hospital stay whenever the patient's condition changes.
- The procedure, risks and expected outcomes should be explained to the patient and carer.

**Key tasks on admission**

- Options and preferences for hospital care and treatment, as well as patient concerns should be discussed.
- An assessment should be carried out concerning:
  - i. Rehabilitation, the presence of a carer, the home environment for convalescence and/or the requirements for home modifications.
  - ii. Social issues which need to be attended to (such as financial arrangements, sickness benefits, compensation requirement).
  - iii. The delivery of PCCC services if required.
- Where other healthcare professionals across the continuum of care, provide care, relating to the condition for which hospital admission is occurring, those practitioners should be involved in the admission process.
- Standardised, up-to-date, client/healthcare records should be readily accessible at admission.

**Section Two: Estimated length of stay**

- Each patient should have an estimated length of stay.
- The estimated length of stay should be identified during pre-assessment, on the post-take ward round or within 24 hours of admission to hospital.
- The estimated length of stay should be based on the anticipated time needed for tests and interventions to be carried out and for the patient to be clinically stable and fit for discharge.
- The estimated length of stay should be discussed and agreed with the patient/family and carers.
- The estimated length of stay should be communicated to the PCCC service providers, as appropriate.
- The estimated length of stay should be documented in the patient's healthcare record.

## Key tasks on admission

### Section Three: Treatment plan

- All patients should have a treatment plan.

### Section Four: Discharge plan

- Co-ordinating and implementing discharge activities should start as soon as the treatment plan is developed.
- Integrated discharge planning should be commenced **as soon as possible** and certainly within two days of admission by gathering information about the patient's pre-admission abilities in relation to potential discharge issues.
- The discharge plan should be discussed and agreed with patient/family and carers.
- The discharge plan should be communicated with PCCC service providers, as appropriate.
- The discharge plan should be documented in the patient's healthcare record.
- The Common Assessment Process (CAP) and Common Summary Assessment Record (CSAR) should be undertaken for those patients who will require access to long term residential care.

### Section Five: Referral

- Referral should be made to the other members of the multi-disciplinary team by the appropriate personnel and this should be documented as appropriate.
- Referral should be made to the diagnostic services by the appropriate personnel and this should be documented as appropriate.
- Referral should be made to the PCCC service providers by the appropriate personnel and this should be documented as appropriate.
- Receipts of referrals should be documented on a integrated discharge planning tracking form in the patient's healthcare record within 24 hours of receiving the referral.

### Section Six: Medication management

- A medication management discharge plan should be developed and coordinated for each patient.
- Staff should obtain an accurate medication management history, including prescription and over the counter medicines, nutritional support and other therapies such as herbal products, at the time of admission.



**Key tasks on admission**

- An accurate pre-admission medication management list should be established. Where necessary, this should be done in consultation with the patient's GP, community pharmacist or other relevant clinicians, with a view to:
  - i. Identifying the appropriateness and effectiveness of current medication management, and rationalising current medication management if appropriate.
  - ii. Paying particular attention to any problems associated with current drug therapy, including any possible relationship with the current medical condition.
  - iii. Documenting allergies and any previous adverse drug reactions.
- If it is not possible to take a complete or accurate medication management list on admission, a request should be made to take one as soon as is practical after admission.

**Section Seven: Communication**

- The hospital should notify appropriate PCCC service providers of unplanned admissions at the time of hospitalisation.
- Once notified of a patient's admission, PCCC service providers should contact the hospital department to discuss premorbid health status to ensure continuity of care while the patient is in hospital.

**Key tasks during in-patient stay****6 Key tasks during in-patient stay****6.1 Introduction**

Effective integrated discharge planning includes preparing a plan for discharge. Some important elements of a discharge plan include the estimated length of stay and the destination of the patient on discharge. The discharge plan should be subject to ongoing assessment throughout the hospital stay to take account of changes in patient and carer health and social status.

**6.2 Scope**

The objective of this procedure is to outline the principles of best practice for integrated discharge planning during admission.

**6.3 Contents**

Section One: Assessment

Section Two: Treatment plan

Section Three: Estimated length of stay

Section Four: Discharge plan

Section Five: Nurse (or HSCP/Other) facilitated discharge

Section Six: Communication

**6.4 Procedure****Section One: Assessment**

- Patient assessment should continue throughout the patient's hospital stay.

**Key tasks during in-patient stay****Section Two: Treatment plan**

- The treatment plan should be monitored on a daily basis and changes should be communicated to the patient.
- Any changes to the treatment plan should be communicated to the PCCC service providers as appropriate.
- Any changes to the treatment plan should be documented in the healthcare record.

**Section Three: Estimated length of stay**

- The estimated length of stay should be proactively managed against the treatment plan (usually by ward staff) on a daily basis and changes should be communicated to the patient.
- Any changes to the estimated length of stay should be communicated to the PCCC service providers as appropriate.
- Any changes to the estimated length of stay should be documented in the healthcare record.
- The Common Assessment Process (CAP) and Common Summary Assessment Record (CSAR) should be undertaken for those patients who will require access to long term residential care.

**Section Four: Discharge plan**

- The discharge plan should be proactively managed against the treatment plan (usually by ward staff) on a daily basis and changes should be communicated to the patient.
- Any changes to the discharge plan should be communicated to the PCCC service providers as appropriate.
- Any changes to the discharge plan should be documented in the healthcare record.

## Key tasks during in-patient stay

### Section Five: Nurse (or HSCP/Other) facilitated discharge

- The suitability of the patient for Nurse (or HSCP/Other) facilitated discharge should be agreed with the multi-disciplinary team.
- Within one hour of patient admission to the ward, an appropriate and competent Nurse (or HSCP/Other) from the ward should be identified and assigned to actively manage the patient pathway of care.
- This Nurse (or HSCP/Other) should be up to date on all aspects of the patient care pathway, particularly focusing on the current medical and nursing condition and discharge plan.
- The healthcare record should indicate that it is a Nurse (or HSCP/Other) facilitated discharge and the name of the Nurse (or HSCP/Other) should be documented.

### Section Six: Communication

- The hospital should advise PCCC service providers of the planned discharge date **as soon as possible and at least two days prior to patient discharge** (for patients who are in-patients 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 PCCC service providers should be arranged to ensure such services are available and in place for the patient to use when needed post discharge.

**Key tasks twenty-four hours before discharge****7 Key tasks twenty-four hours before discharge****7.1 Introduction**

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 patient following discharge from hospital.

**7.2 Scope**

The objective of this procedure is to outline the principles of best practice for integrated discharge planning twenty-four hours before discharge.

**7.3 Contents**

Section One: Discharge arrangements

Section Two: Transport arrangements

Section Three: Medication management

Section Four: Communication

Section Five Medical certificate

Section Six: Patient education

**7.4 Procedure****Section One: Discharge arrangements**

- Discharge arrangements should be confirmed with the patient, their family/carers and the PCCC service providers.

**Section Two: Transport arrangements**

- Transport arrangements should be confirmed **24 hours before discharge**.
- The clinical and/or mobility needs of the patient should be specified, where

**Key tasks twenty-four hours before discharge****Section Three: Medication management**

- Medication management review should take place in a planned and timely fashion before the patient leaves the hospital.
- Where appropriate, the patient's own medication management should be reviewed to remove any expired or discontinued medication before return to the patient.
- Arrangements should be put in place to facilitate continuity of the patient's medication management supply.
- Dispensing of adequate medication, where required, to ensure continuity of supply, should be facilitated through the Pharmacy Department. Where this does not apply, the Community Pharmacy will provide one week's emergency supply to medical card holders.
- Communication should be made with the patient's community pharmacy concerning the following:
  - i. Special arrangements for administration of medication (e.g. via enteral feeding tube, provision of compliance aids).
  - ii. Special arrangements for ordering, supply or facilitation of funding of medication (e.g. unlicensed or difficult to source medication, extemporaneous preparation, High-Tech medication, use of the Hardship scheme).

**Section Four: Communication**

- Discharge information (transfer or discharge communication) should be prepared. This may include a description of the unresolved, ongoing problems listed on the hospital care plan, key test results, medication regimen, emergency contact person, contact number and availability.
- The discharge check list should be completed to ensure all of the above activities have been carried out.
- The family/carers, GP, PHN and other PCCC service providers should be contacted at least the day before discharge to confirm that the patient is being discharged and to ensure that services are activated or re-activated.

**Section Five: Medical certificate**

- Medical (sick) certificates should be written if required for employees to give to their Employers. Certificates for persons who wish to apply for Disability Benefit must go to their own GP as these certificates are only available to GPs and are supplied by the Department of Social and Family Affairs.

**Section Six: Patient education**

- The patient should have received and been educated in the use of any aids/equipment as appropriate.

**Key tasks on day of discharge****8 Key tasks on day of discharge****8.1 Introduction**

On the day of discharge, the patient should be ready to leave the hospital at the agreed time and the patient/carer/receiving healthcare facility should have sufficient information to guarantee continuity of care. Good integrated discharge planning practices suggest that on the day of discharge all arrangements for PCCC services should have been put in place and very little new information should be imparted to the patient or carer.

**8.2 Scope**

The objective of this procedure is to outline the principles of best practice for integrated discharge planning on the day of discharge.

**8.3 Contents**

Section One: Patient

Section Two: Time of discharge

Section Three: Communication

**8.4 Procedure****Section One: Patient**

- The patient should be confirmed as clinically fit and safe for discharge.
- Patient should be discharged from the ward to their place of residence/transfer healthcare facility or the discharge lounge.

## Key tasks on day of discharge

### Section Two: Time of discharge

- Each patient discharge should be effected (i.e. hospital bed becomes available for patient use) no later than 12 noon 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 patients, carers and other healthcare providers (where relevant).

### Section Three: Communication

- No patient should leave the hospital until the details of admission, medication management changes (including addition/deletions) and arrangements for follow up have been communicated to the healthcare provider(s) nominated by the patient as being responsible for his or her ongoing care.
- At the time of leaving the hospital, each patient should be provided with an information pack containing relevant information such as patient/carer plan, a medication management record, and information on the availability and future supply of medication.
- Hospitals should confirm with PCCC service providers that the patient has left the hospital and that service provision needs to commence.
- Information and education should be provided to the patient and the family/carer in the appropriate language, verbally and in written form relating to:
  - i. Ongoing health management.
  - ii. An appropriate post discharge contact to answer queries and address concerns.
  - iii. GP letter.
  - iv. Medication management.
  - v. The use of aids and equipment.
  - vi. Follow-up appointments.
  - vii. PCCC based service appointments.
  - viii. Possible complications and warning signs.
  - ix. When normal activities can be resumed.
- The transfer/discharge communication and discharge prescription should contain a complete and comprehensive list of all medication the patient is to continue taking on discharge from hospital. Where possible, any pre-admission medication which was discontinued during the hospital stay should be listed, outlining a brief reason for discontinuation. There should be no ambiguity as to whether a medication which is absent from the list was discontinued or omitted unintentionally.



**Follow up post discharge and evaluation****9 Follow up post discharge and evaluation****9.1 Introduction**

The purpose of following up a patient after they have been discharged from hospital is two-fold:

- i. To evaluate the impact of the planned interventions on the patient's recuperation and possibly identify recurrent and new care needs.
- ii. To assess the effectiveness and efficiency of the discharge process.

This part of the discharge process is key to ensuring continuity of care for the patient.

**9.2 Scope**

The objective of this procedure is to provide guidelines in relation to follow up post discharge and evaluation.

**9.3 Contents**

Section One: General principles

**9.4 Procedure**

Section One: General principles

- All planned interventions should be monitored for their impact on the patient (as identified in the care plan). This may involve follow-up of patients post discharge to find out if the problems identified as requiring intervention post discharge were adequately addressed and to deal with any new problems.
- Teaching initiated in the hospital should also be reinforced and assurance provided to the patient and their home carers.
- The expected outcomes identified on the care plan should inform the areas to be evaluated.

**Self discharge/discharge against medical advice****10 Self-discharge/discharge against medical advice****10.1 Introduction**

Healthcare professionals should provide patients with sufficient information during their hospital stay to enable them to understand their medical treatment. In cases where a patient decides to self-discharge or takes discharge against medical advice they should be informed of the risk they are taking and possible consequences of their actions.

**10.2 Scope**

The objective of this procedure is to provide guidelines in relation to self discharge/discharge against medical advice.

**10.3 Contents**

Section One: General principles

**10.4 Procedure****Section One: General principles**

- Every effort should be made to persuade the patient to avail of treatment.
- If available, the registrar on duty should see the patient prior to their self-discharge and reinforce the need to stay for treatment.
- The senior nurse on duty should witness the explanation and discussion regarding discharge between doctor and patient.
- There should be clear documentation in the healthcare record regarding the events.
- With the patient's permission, the person nominated by the patient should be informed of the patient's decision to self-discharge.
- The patient and family/carer should sign a document to indicate that the patient made a decision to self-discharge which was contrary to medical advice. This document should be signed by the doctor/nurse if the patient refuses to sign.
- Local incident reporting policy should be complied with.

**People who are homeless or living in temporary or insecure accommodation****11 People who are homeless or living in temporary or insecure accommodation****11.1 Introduction**

Better integrated health and social care can help prevent the inappropriate use of specialist or acute healthcare and can help prevent or reduce homelessness. People who are homeless or living in temporary or insecure accommodation are more likely to suffer from poor physical, mental and emotional health than the rest of the population, and hospitalisation presents an opportunity to deal with underlying medical, social and mental health problems and to address their accommodation needs.

**11.2 Scope**

The objective of this procedure is to provide guidelines in relation to discharge of people who are homeless or living in temporary or insecure accommodation.

**11.3 Contents**

Section One: General principles

**11.4 Procedure****Section One: General principles**

- A hospital admission and discharge policy should be developed in partnership by the hospital, PCCC service providers, the voluntary sector and the local authority.
- Homeless people should be identified on admission and PCCC services and homelessness services should be notified.
- PCCC services and homelessness services should be notified when homeless people are due for discharge.

## Planning discharge from hospital for people with dementia

## 12 Planning discharge from hospital for people with dementia

### 12.1 Introduction

People with dementia can have complex needs and may find acute hospitals stressful and this can have a detrimental effect on their dementia. They should therefore only be admitted when their physical care needs demand the sort of specialist interventions that are only available in general hospitals. It is recognised that dementia can sometimes lead to complex discharge needs but not necessarily so. The authors are aware that there are sensitivities around categorising patients into such groups.

### 12.2 Scope

The objective of this procedure is to provide guidelines in relation to discharge from hospital for people with dementia.

### 12.3 Contents

Section One: General principles

### 12.4 Procedure

Section One: General principles

- People with dementia with complex discharge needs should be identified and referred to the discharge co-ordinator as soon as possible.
- There should be an agreed care pathway in place for people with dementia.
- Information should be available regarding local and national services for people with dementia and their carers.





# Health Service Executive Code of Practice for Integrated Discharge Planning

## **Part 4: Audit Tool**



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

Part 4

*Part 4*  
*Audit Tool*

Contents

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## Introduction

# 1 Introduction

## 1.1 Standards for integrated discharge planning in the Health Service Executive

During 2008, standards for integrated discharge planning in the Health Service Executive were developed using a consistent methodology. A literature review was undertaken which included a search for all relevant guidance and evidence. Expert opinion was also sought for the standards. A national consultation process was undertaken and feedback where appropriate was incorporated into Version 1.0 of the standards. An audit tool (based on the 'Safety and Health Audit Tool for the Healthcare Sector') was then developed to assist in the monitoring of the standards.

## 1.2 Audit

Audit is a function of all developing and progressive organisations. The outcome from an audit can facilitate an organisation to be knowledgeable about its areas of non-conformance and to identify and implement corrective action where necessary.

## 1.3 Audit tool

This audit tool relates to the principles of integrated discharge planning and includes: organisational structure and accountability, audit and monitoring and communication and consultation. The audit tool can be used to provide objective data on conformance with the standards within the Health Service Executive. Year-on-year data can assist in monitoring the effectiveness of integrated discharge planning programmes and assist in strategic planning to meet long term integrated discharge planning objectives.

## 1.4 Levels of audit

There are two levels of audit against the HSE standards for integrated discharge planning: self-assessment and external review.

**Self assessment** is a process whereby the organisation measures its conformance against national standards. Each service area will be asked to undertake a self-assessment exercise for its service against the standards. This will be completed annually, signed by the CEO/manager and sent to the Network Manager/Assistant National Director for Primary, Community and Continuing Care as appropriate.

**External review** uses the same national standards to independently measure the service area through an on-site audit. The findings from the audit will be summarised in a written report and service areas will be supported in the development of quality improvement action plans.

## **Guidelines for using the audit tool**

## **2 Guidelines for using the audit tool**

### **2.1 Integrated discharge planning audit tool**

The audit tool is intended for use by the discharge co-ordinator, staff with a demonstrated interest in integrated discharge planning and trained audit personnel.

### **2.2 Planning the audit programme**

It is envisaged that the appropriate committee will plan and prioritise the use of the audit tool based on a review of specific policies or in response to specific clinical incidents.

### **2.3 Time required**

The time required to complete a specific audit will vary according to the tool, the size of the organisation, the type of procedures audited and the experience of the auditor.

### **2.4 Conformance**

A conformance categorisation has been incorporated into the scoring system to provide a clear indication of conformance. The allocation of conformance levels is based on the scores obtained. For the purpose of these audits the categories will be allocated as follows: minimal conformance 75% or less, partial conformance 76-84% and conforming 85% or above.

### **2.5 Feedback of information and report findings**

It is advised that the auditor should verbally report any areas of concern and of good practice to the head of department in charge of the area being audited prior to leaving. A written report should also be developed by the auditor and should be given to the relevant head of department for action. The report should clearly identify areas requiring action. The head of department is responsible for developing an action plan to address the issues identified within a given timescale.

The audit team may decide to re-audit the ward/department if there are concerns or a minimal conformance rating is observed. A system of feedback to the appropriate committee on the action taken by wards/departments should be in place. This may involve feedback meetings or the return of completed action plans to the discharge co-ordinator.

## Guidelines for using the audit tool

### 2.6 Scoring

Eight standards for audit of integrated discharge planning are described in the audit tool worksheets. Each standard is stated and followed by questions based on the standard criteria. Below is an explanation of the abbreviation used under each criterion.

I = Interview  
O = Observation  
D = Documentation

Y = Yes  
P = Partial  
N = No

#### Instructions on the completion of a standard worksheet

In order to effectively audit integrated discharge planning it is necessary that all standards are audited as part of the audit process. The auditor can repeat a full audit of all standards at regular intervals in order to measure the level of improvement in the effectiveness of integrated discharge planning.

There are eight standards in the audit tool and for each standard there is a worksheet, which details a list of questions to be answered. There is specific information to be completed in each worksheet and this is explained below:

#### Step 1:

For each question the auditor can use an “X” to indicate the appropriate answer, which is “Yes”, “Partial” or “No”. In this example we will assume the answer is “No”

	I		Y	P	N								
I	<input type="checkbox"/>	<b>Each individual delivering care along the care continuum (this includes staff at ward level and staff in PCCC services) shall be made aware of their responsibility in relation to integrated discharge planning?</b>			X								
O	<input type="checkbox"/>												
D	<input type="checkbox"/>												
		<table border="1"> <tr> <td>Yes</td> <td>Partial</td> <td>No</td> <td>Total score</td> </tr> <tr> <td>Score 10</td> <td>Score 5</td> <td>Score 0</td> <td></td> </tr> </table>	Yes	Partial	No	Total score	Score 10	Score 5	Score 0				
Yes	Partial	No	Total score										
Score 10	Score 5	Score 0											
		Supporting Evidence/Comments											

## Guidelines for using the audit tool

## Step 2

For each question the auditor can use an “X” to indicate the method of verification used in trying to get an answer to the question. The auditor may have interviewed ( **I** ) an employee, observed ( **O** ) a particular work practice or reviewed a particular document ( **D** ). The auditor may have used all three methods. For this example the auditor interviewed an employee and used an “X” to indicate this on the worksheet.

	<b>I</b>		<b>Y</b>	<b>P</b>	<b>N</b>								
<b>I</b>	<input checked="" type="checkbox"/>	<b>Each individual delivering care along the care continuum (this includes staff at ward level and staff in PCCC services) shall be made aware of their responsibility in relation to integrated discharge planning?</b>			<b>X</b>								
<b>O</b>	<input type="checkbox"/>												
<b>D</b>	<input type="checkbox"/>												
		<table border="1"> <tr> <td>Yes</td> <td>Partial</td> <td>No</td> <td>Total score</td> </tr> <tr> <td>Score 10</td> <td>Score 5</td> <td>Score 0</td> <td></td> </tr> </table>	Yes	Partial	No	Total score	Score 10	Score 5	Score 0				
Yes	Partial	No	Total score										
Score 10	Score 5	Score 0											
		Supporting Evidence/Comments											

## Step 3

The auditor can then detail some supporting evidence or comments to explain the reason for the relevant answer. In this example the answer to the question was “No” because staff were not aware of their responsibilities in relation to integrated discharge planning.

## Step 7

	<b>I</b>		<b>Y</b>	<b>P</b>	<b>N</b>							
<b>I</b>	<input checked="" type="checkbox"/>	<b>Each individual delivering care along the care continuum (this includes staff at ward level and staff in PCCC services) shall be made aware of their responsibility in relation to integrated discharge planning?</b>			<b>X</b>							
<b>O</b>	<input type="checkbox"/>											
<b>D</b>	<input type="checkbox"/>											
		<table border="1"> <tr> <td>Yes</td> <td>Partial</td> <td>No</td> <td>Total score</td> </tr> <tr> <td>Score 10</td> <td>Score 5</td> <td>Score 0</td> <td></td> </tr> </table>	Yes	Partial	No	Total score	Score 10	Score 5	Score 0			
Yes	Partial	No	Total score									
Score 10	Score 5	Score 0										
		Supporting Evidence/Comments										
		No evidence of staff being made aware of their responsibilities.										

**Guidelines for using the audit tool****Step 4**

The auditor can use an “X” to indicate the appropriate answer for each question, which will be “Yes”, “Partial” or “No”.

**The different scoring options are as set out below:**

If the auditor selects “Yes” as his/her answer to the question, then the auditor uses an “X” to select “Yes” in the score table and enters a total score of “10” in the score table. An answer of “Yes” means there is full evidence of conformance and this is allocated a score of 10.

YES X
Score 10

If the auditor selects “No” as his/her answer to the question, then the auditor uses an “X” to select “No” in the score table and enters a total score of “0” in the score table. An answer of “No” means there is no evidence of conformance and this will be allocated a score of “0”.

NO X
Score 0

If the auditor selects “Partial” as his/her answer to the question, then the auditor uses an “X” to select “Partial” in the score table and enters a total score of “5” in the score table. An answer of “Partial” means there is evidence of a reasonable level of conformance and this will be allocated a score of “5”.

PARTIAL X
Score 5

**Guidelines for using the audit tool****Step 5**

The auditor should check that he/she has entered the appropriate total score in the score table for each question.

Yes	No	Partial	Total score
Score 10	Score 0	Score 5	0

**Step 6**

The criterion score is then calculated as a percentage. This is explained by a worked example below:

Number of Questions in Standard:	13
Maximum Standard Score ( MS )	
(Total Number of Questions x Maximum Score (10)):	130 (13 x 10)
Actual Standard Score ( AS ) (Sum of the total scores for each question)	100

**Note:** In this example the actual score used is 100, however the actual score will vary depending on the scores allocated to each question.

Standard Score as a percentage =  $AS/MS \times 100/1$

In this example Standard Score as a percentage =  $100/130 \times 100/1 = 76.92\%$

Note: Where a question in a standard is not applicable, it will not be given a score.

*Example:*

*In the above case; if there were only 12 questions applicable then the maximum criterion score (MS) would be 120 (12 x 10).*

### Guidelines for using the audit tool

The auditor repeats Step 1-6 for each question in the standard worksheet.

#### Step 8

When a standard has been fully audited, the auditor can detail a summary of the results in the standard report form. This information can be taken from the worksheet or the auditor may use his/her own notes taken during the audit. This report form should be completed for each standard. An example of what information can be included in this report form is detailed below.

#### Step 9

<b>Standard 2: Organisational structure and accountability</b>
Responsibility for integrated discharge planning shall be clearly defined and there shall be clear lines of accountability throughout the organization.
<b>Summary of documentation audited and referenced</b>
<b>Summary of main findings of the audit</b>
<b>Conformance in the area</b> <i>Managers are aware of responsibilities</i>
<b>Non-conformance in the area</b>
<b>Standard Score: 100/130 76.92%</b>

### Guidelines for using the audit tool

The areas of non-conformance in each standard report form should be transferred to a quality improvement action plan. An example of a blank quality improvement action plan is detailed in section 5 of this document. Below is an example of the type of information that would be documented in this quality improvement action plan by the auditor.

Standard	Area of Non Conformance	Corrective Action	Responsible Person	Time-frame	Review
1	Staff not aware of their responsibilities in relation to integrated discharge planning	Discuss with each relevant Head of department	Discharge co-ordinator	Dec 2008	Feb 2009

The auditor may have a number of areas of non-conformance for each standard. The quality improvement action plan will need to be agreed in consultation with the senior management committee (or appropriate committee). The action plan is used to summarise the main findings of the audit and it is used as a tool for continuous improvement.

**Note:** The auditor may use the auditors note section in section 7 of this document to compile further relevant information.



## Guidelines for using the audit tool

## STANDARD SCORING SUMMARY SHEET

## Step 10:

The scoring for each Standard is detailed in a Standard Scoring Summary Sheet. A completed Standard Scoring Summary sheet is set out below and a blank Standard Scoring Summary sheet is detailed in section 6 of this document.

Standard	Actual Standard Score (AS)	Maximum Standard Score (MS) Total Number of Question x Maximum Score (10)	Standard Score as a percentage (AS/MS x 100/1)
1	70	100	70
2	90	110	81.81
3	40	60	66.66
4	50	90	55.55
5	125	130	96.15
6	350	490	71.42
7	100	130	76.92
8	110	140	78.57
Overall Audit Score	965	1,250	77.2

### Guidelines for using the audit tool

#### Step 11:

Using the example above the overall audit score is calculated as follows.

#### Overall

**audit score** = Sum of all actual standard scores (AS)/Sum of all maximum standard  
Scores (MS) x 100/1

**Overall audit score** =  $965/1250 \times 100/1 = 77.2\%$

This overall audit score can be used to benchmark performance from year to year and the individual standard score allows the auditor to identify areas where most attention is needed.

A summary sheet with Standard and overall audit score could be attached to the quality improvement action plan as a full audit report.

## Risk level categories

### 3 Risk level categories

A response is categorised as non-conforming if it does not meet the criteria identified in the Health Service Executive Standards for Integrated Discharge Planning. An indication of the seriousness of the non-conformance is given by a risk category that is attached to each non-conformance statement. The categorisation of risk should provide some assistance in prioritising remedial actions.

On the right hand side of each statement is a risk level categorisation. These are organised as shown in Table 1.

**Table 1: Definition of risk levels used in non-conformance statements**

Level	Category	Description
1	Observation	This category includes reported facts which, although not necessarily non-conformances, should be considered when any remedial action is planned.
2	Low Risk	The reported fact(s) indicate a minor hazard with a low likelihood of the hazard occurring.
3	Medium Risk	The reported fact(s) indicate either a minor hazard with a significant likelihood of the hazard occurring or a significant hazard with a low likelihood of the hazard occurring.
4	High Risk	The reported fact(s) indicate a significant hazard with a significant likelihood of the hazard occurring.

## Standards for integrated discharge planning

### 4 Standards for integrated discharge planning

#### Standard 1: Communication and consultation

Appropriate and effective mechanisms shall be in place for communication and consultation on matters relating to integrated discharge planning, with key stakeholders within and outside the organisation.

#### Standard 2: Organisational structure and accountability

Responsibility for integrated discharge planning shall be clearly defined and there shall be clear lines of accountability throughout the organization.

#### Standard 3: Management and key personnel

Appropriately qualified key personnel shall be in place to ensure that the integrated discharge planning service is provided safely, efficiently and cost-effectively.

#### Standard 4: Education and training

Education and Training in relevant aspects of integrated discharge planning shall be provided to all new and existing staff members (both permanent and temporary).

#### Standard 5: Operational policies and procedures

Written policies, procedures and guidelines for the integrated discharge planning process shall be based on the *Health Service Executive Recommended Practices for Integrated Discharge Planning (Part 3)*, shall be available, implemented and shall reflect relevant legislation and published professional guidance.

#### Standard 6: Integrated discharge planning process

Integrated discharge planning shall include the patient and as appropriate, the family/carer in the development and implementation of the patient's discharge plan and shall ensure that steps are taken to address necessary linkages with other healthcare providers in order to ensure a seamless transition from one stage of care to the next.

#### Standard 7: Audit and monitoring

Audits shall be carried out to ensure that the procedures for integrated discharge planning conform to the required Standards and that the processes undertaken conform to the procedures. The audit results shall be used to identify opportunities for improvement.

## **Standards for integrated discharge planning**

### **Standard 8: Key performance indicators**

Key performance indicators that are capable of showing improvements in the efficacy of integrated discharge planning in the organisation shall be used.

## Quality improvement action plan

## 5. QUALITY IMPROVEMENT ACTION PLAN

[illegible]

## Standard scoring summary sheet

## 5. STANDARD SCORING SUMMARY SHEET

Standard	Actual Standard Score (AS)	Maximum Standard Score (MS) Total Number of Question x Maximum Score (10)	Standard Score as a percentage (AS/MS x 100/1)
1			
2			
3			
4			
5			
6			
7			
8			
Overall Audit Score			

**Auditors notes**

5. AUDITORS NOTES




Auditors notes

AUDITORS NOTES




# Health Service Executive Code of Practice for Integrated Discharge Planning

## **Part 5: Additional Resources and Appendices**



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

Part 5

*Part 5*  
*Additional Resources*  
*and Appendices*

## Contents

# Contents

1. Discharge Checklist
2. Key Tasks
3. Patient Information Brochure
4. References
5. Abbreviations

Appendix 1: Membership of National Integrated Discharge Planning Steering Committee

Appendix 2: List of key stakeholder groups

# Discharge Checklist (please note that this is not an exhaustive list)

General *	Yes (Y)/No (N)/ Not Applicable (NA)
<input type="checkbox"/> Patient understands findings and treatment plan	
<input type="checkbox"/> Observations within normal limits	
<input type="checkbox"/> Pain control satisfactory	
<input type="checkbox"/> Adequate nutrition and fluid intake	
<input type="checkbox"/> Passed urine	
<input type="checkbox"/> All dressings checked	
<input type="checkbox"/> IV cannula removed	

\*A medical review of the patient prior to discharge is required if the answer to any of the above questions is 'No'

Personal items returned to patient	Yes (Y)/No (N)/ Not Applicable (NA)
<input type="checkbox"/> Own medications (once reviewed)	
<input type="checkbox"/> Own equipment	
<input type="checkbox"/> Own X-Rays	
<input type="checkbox"/> Valuables	

PCCC Services Referred to/Arranged	Yes (Y)/No (N)/ Not Applicable (NA)
<input type="checkbox"/> Contact made with Public Health Nurse (PHN)	
<input type="checkbox"/> Home Help	
<input type="checkbox"/> Meals on Wheels	
<input type="checkbox"/> Occupational Therapist	
<input type="checkbox"/> Physiotherapist	
<input type="checkbox"/> Speech & Language Therapist	
<input type="checkbox"/> Community Pharmacist	
<input type="checkbox"/> Carer identified	
<input type="checkbox"/> Other (please specify)	

Items arranged for/provided to patient	Yes (Y)/No (N)/ Not Applicable (NA)
<input type="checkbox"/> Transfer/Discharge communication	
<input type="checkbox"/> Medications and medication list—explained to patient/carer, as appropriate	
<input type="checkbox"/> Follow-up appointment	
<input type="checkbox"/> Information pack	
<input type="checkbox"/> Aids and appliances	
<input type="checkbox"/> Wound care information	
<input type="checkbox"/> Common Summary Assessment Record (CSAR) completed	
<input type="checkbox"/> Home oxygen	

Transport	Time Booked (24 hour)
<input type="checkbox"/> Relative/friend	
<input type="checkbox"/> Taxi	
<input type="checkbox"/> Ambulance	
<input type="checkbox"/> Community transport provider	
<input type="checkbox"/> Other (please specify)	

Follow up appointments	Yes (Y)/No (N)/ Not Applicable (NA)
<input type="checkbox"/> General Practitioner (GP)	
<input type="checkbox"/> OPD (please specify)	
<input type="checkbox"/> Medical specialist/other hospital (please specify)	
<input type="checkbox"/> Other (please specify)	

Signature/Printed Name

Date

Time (24 hour)

# KEY TASKS FOR STANDARD ADMISSION AND DISCHARGE PROCESS

## Pre admission

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | <ul style="list-style-type: none"> <li>● Patient assessment</li> <li>● Explain procedure, risks, expected outcomes</li> <li>● Discuss options and preferences for hospital care and treatment</li> <li>● Discuss patient concerns</li> <li>● Assessment concerning—social issues/rehabilitation/delivery of PCCC services/availability of carer</li> <li>● Standardised, up-to-date, healthcare records available</li> <li>● Common Assessment Process (CAP) and Common Summary Assessment Record (CSAR) should be undertaken, where appropriate</li> </ul> |
| <input type="checkbox"/> | <ul style="list-style-type: none"> <li>● Identify estimated length of stay (ELOS)</li> <li>● Discuss ELOS with patient/family/carers</li> <li>● Record ELOS in the patient's healthcare record</li> <li>● Communicate ELOS to PCCC service providers</li> </ul>   |
| <input type="checkbox"/> | <ul style="list-style-type: none"> <li>● Gather information regarding pre-admission abilities (potential discharge issues)</li> <li>● Discuss discharge plan with patient/family/carers</li> <li>● Communicate discharge plan with PCCC service providers</li> <li>● Discharge plan recorded in the patient's healthcare record</li> </ul>  |
| <input type="checkbox"/> | <ul style="list-style-type: none"> <li>● Referral to other members of the multi-disciplinary team</li> <li>● Referral to PCCC services</li> <li>● Referral to diagnostic services</li> <li>● Document receipt of referrals on discharge planning tracking form</li> </ul>   |
| <input type="checkbox"/> | <ul style="list-style-type: none"> <li>● Establish pre-admission medication list, if necessary in consultation with the patient's GP and community pharmacist</li> <li>● Commence pre-admission medication/treatment as appropriate</li> </ul>  |
| <input type="checkbox"/> | <ul style="list-style-type: none"> <li>● Communicate planned admissions to PCCC service providers</li> <li>● Provide information and education to the patient/family/carers in the appropriate language, verbally and in written form</li> </ul>  |

## On admission

- 
- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | <ul style="list-style-type: none"> <li>● Patient assessment</li> <li>● Explain procedure, risks, expected outcomes</li> <li>● Discuss options and preferences for hospital care and treatment</li> <li>● Discuss patient concerns</li> <li>● Assessment concerning—social issues/rehabilitation/delivery of PCCC services/availability of carer</li> <li>● Standardised, up-to-date, healthcare records available</li> <li>● Common Assessment Process (CAP) and Common Summary Assessment Record (CSAR) should be undertaken, where appropriate</li> </ul> |
|--------------------------|---|
- 
- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | <ul style="list-style-type: none"> <li>● Identify estimated length of stay (ELOS)</li> <li>● Discuss ELOS with patient/family/carers</li> <li>● Record ELOS in the patient's healthcare record</li> <li>● Communicate ELOS to PCCC service providers</li> </ul> |
|--------------------------|---|
- 
- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> <li>● Patient treatment plan available</li> </ul> |
|--------------------------|--|
- 
- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | <ul style="list-style-type: none"> <li>● Co-ordinate and implement discharge plan</li> <li>● Discuss discharge plan with patient/family/carers.</li> <li>● Communicate discharge plan with PCCC service providers</li> <li>● Document discharge plan in the patient's healthcare record</li> </ul> |
|--------------------------|--|
- 
- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | <ul style="list-style-type: none"> <li>● Referral to other members of the multi-disciplinary team</li> <li>● Referral to PCCC services</li> <li>● Referral to diagnostic services</li> <li>● Document receipt of referrals on discharge planning tracking form</li> </ul> |
|--------------------------|---|
- 
- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | <ul style="list-style-type: none"> <li>● Obtain an accurate medication history</li> <li>● Review admission medication in consultation with patient's GP, the community pharmacist and other relevant clinicians</li> <li>● Develop and co-ordinate a medication discharge plan</li> </ul> |
|--------------------------|---|
- 
- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | <ul style="list-style-type: none"> <li>● Notify PCCC service providers of unplanned admissions</li> <li>● PCCC service providers contact hospital to discuss premorbid health status</li> </ul> |
|--------------------------|---|
-

## During in patient stay

<input type="checkbox"/>	<ul style="list-style-type: none"> <li>● Patient assessment</li> </ul>
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>● Monitor treatment plan on a daily basis</li> <li>● Communicate changes to the patient</li> <li>● Communicate changes to PCCC service providers</li> <li>● Document changes to treatment plan in the healthcare record</li> </ul>
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>● Manage ELOS against treatment plan</li> <li>● Communicate changes to the patient/carer</li> <li>● Communicate changes to PCCC service providers</li> <li>● Document changes to the ELOS in the healthcare record</li> </ul>
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>● Manage discharge plan against treatment plan</li> <li>● Communicate changes to the patient/carer</li> <li>● Communicate changes to PCCC service providers</li> <li>● Document changes to the discharge plan in the healthcare record</li> </ul>
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>● MTD agree suitability of patient for nurse (or HSCP/Other) facilitated discharge</li> <li>● Identify nurse (or HSCP/Other) to facilitate discharge within one hour of admission</li> <li>● Document the name of the nurse (or HSCP/Other) to facilitate discharge in the healthcare record</li> </ul>
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>● Advise PCCC service providers/carer of planned discharge (at least 2 days prior to discharge)</li> </ul>
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>● Arrange 2 way communication between the hospital, the GP, the community pharmacist and other PCCC service providers</li> </ul>



## 24 hours before discharge

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | ● Confirm discharge arrangements with the patient/family/carers and PCCC service providers                            |
| <input type="checkbox"/> | ● Confirm transport arrangements 24 hours before discharge  |
| <input type="checkbox"/> | ● Undertake medication review<br>● Put arrangements in place to facilitate ongoing supply of the patient's medication |
| <input type="checkbox"/> | ● Prepare transfer/discharge communication  |
| <input type="checkbox"/> | ● Complete discharge checklist  |
| <input type="checkbox"/> | ● Contact family/carers and PCCC service providers to confirm that the patient is being discharged                    |
| <input type="checkbox"/> | ● Write medical (sick) certificate  |
| <input type="checkbox"/> | ● Check that the patient/carer has received and been educated in the use of any aids/equipment                        |

## On day of discharge

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | ● Confirm that patient is clinically fit and safe for discharge  |
| <input type="checkbox"/> | ● Discharge patient to place of residence/transfer healthcare facility or discharge lounge   |
| <input type="checkbox"/> | ● Discharge to be effected by 12 noon  |
| <input type="checkbox"/> | ● Ensure transfer/discharge communication has been communicated to the healthcare provider(s) nominated by patient   |
| <input type="checkbox"/> | ● Confirm with PCCC service providers that patient has left the hospital and that service provision needs to commence  |
| <input type="checkbox"/> | ● Provide patient with information pack<br>● Provide information and education to the patient/family/carer in the appropriate language, verbally and in written form   |
| <input type="checkbox"/> | ● Determine if the patient needs follow-up<br><i>If follow-up is required...</i> <ol style="list-style-type: none"> <li>1. Determine who should telephone the patient post hospitalisation</li> <li>2. Obtain the patient's/carer's consent for the follow-up call</li> <li>3. Ask them to nominate a call time</li> <li>4. Check that telephone details are correct</li> <li>5. Check language skills and record any special needs for the telephone follow-up</li> </ol> |

## Post discharge

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☐

- Reinforce teaching initiated in the hospital
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- Provide assurance to the patient and their home carers

# Health Service Executive Code of Practice for Integrated Discharge Planning



## Patient Information Brochure



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# PLANNING YOUR TRANSITION FROM HOSPITAL TO HOME

## INTRODUCTION

- Many people require no special services after they have been discharged home.
- If you require some extra assistance then hospital staff, your GP and primary, community and continuing care (PCCC) staff will help you to plan ahead so that the appropriate arrangements can be made before you are discharged.
- This brochure is to prompt you (the patient) and your carer, family and friends to consider a range of practical aspects about your return home from hospital.



## YOUR DISCHARGE PLAN

- From the day you are admitted to hospital, a number of different staff involved in your care (the multidisciplinary team) will work with you, your relatives and carers to plan your discharge.
- Your length of stay will depend on your condition. The date of your discharge will be agreed and discussed with you by the consultant and the multidisciplinary team.
- Please advise your nurse, as early as possible during your stay, if you think you will have any problems with going home.
- On the day of your discharge please make arrangements to be collected no later than **12 midday**. This is necessary to make way for other patients who are being admitted to hospital.

## QUESTIONS YOU NEED TO ASK ABOUT YOUR CARE

- How long will I be in hospital?
- What can I expect to happen to me during my time in hospital?
- How soon should I feel better after leaving the hospital?
- When can I expect to return to work?
- Are there any special instructions for my daily activities?
- Will I need any special equipment at home? Who will help me to arrange this? Is this equipment covered by my insurance or medical card?
- Do I need to have follow-up tests? Who should I follow-up with to get the test results?
- If I need help and care at home after I leave hospital, who will help me to arrange it?
- Will I need to have other treatment following my time in hospital?, (e.g. physiotherapy). Are there any exercises that I need to do? (If so, ask for written instructions).
- When I leave hospital, will I be able to go directly home?
- Will there be any follow-up appointments?
- Do I need to schedule any follow-up visits with my doctor?
- Will I be able to walk, climb stairs, go to the bathroom, prepare meals, drive, etc.
- Who can I call if I have any problems after leaving the hospital?

## QUESTIONS YOU NEED TO ASK ABOUT YOUR MEDICINES

- What medicines will I need to take at home? *Get a complete list of all your medicines at discharge, including any changes made while you were in hospital. Take this list with you when you leave the hospital.*
- Can I get written instructions about my medicines? *Ask any questions before you leave the hospital.*
- Are there any food or drinks that I should avoid while taking my medicines?
- Are there any drugs (including non-prescription drugs) or vitamins that I should not take with my medicines?

## AFTER YOU LEAVE THE HOSPITAL

- The hospital staff will let your GP/Public Health Nurse (PHN) know when you are leaving hospital.
- When you leave the hospital, hospital staff will prepare a discharge communication (a summary of medical information about your treatment in hospital and ongoing services that have been arranged for you). This communication will be given to you and a copy will be sent to your GP.
- You may wish to make an appointment to see your GP following discharge.
- If you feel that you are not well and/or are not managing at home, contact your GP and/or PHN.

## THINGS TO DO BEFORE YOU GO HOME

- **Speak to at least one hospital member** about how long it might be before you will be feeling better and can expect to resume usual activities.
- If your physical abilities have changed as a result of your illness, **make sure you understand** about what you can and can't do when you go home.
- **Ask staff questions** about what has happened to you, and what changes you can expect in your health and daily activities when you return home.
- If you have any questions after you leave hospital, you may wish to contact **your GP or Public Health Nurse (PHN)**.

## MULTIDISCIPLINARY TEAM

The staff involved in your care are known as the multidisciplinary team and may include the following:

- Medical Staff (Consultant, Registrar)
- Nursing Team
- Discharge Co-ordinator
- Community Services Discharge Liaison Officer
- Dietician
- Physiotherapist
- Occupational Therapist
- Speech & Language Therapist
- Pharmacist
- Social Worker
- Public Health Liaison Nurse
- Chaplain / Spiritual Advisor



**Hospital/Local Health Office (LHO) Name Here**

**Phone: 555-555-5555**

**Fax: 555-555-5555**

**E-mail: someone@example.ie**

## 1. References

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14. HSE Transformation Programme 2007-2010, Health Service Executive
15. Review of Discharge Planning Sligo General Hospital/Sligo/Leitrim Community Services 2005



## Appendix 1: Membership of National Integrated Discharge Planning Steering Committee

Name	Title
John O'Brien	National Director Winter Initiative - Chairperson
Claire Broderick	Discharge Co-Ordinator, AMNCH
Dr. Garry Courtney	Consultant Physician, St. Luke's Hospital, Kilkenny
Jennifer Feighan	Project Manager, National Hospitals Office
Ken Fitzgibbon	Divisional Nurse Manager, Medical Division, Beaumont Hospital
Cate Hartigan	Assistant National Director PCCC
Anne Keating	Head of Bed Management, Cork University Hospital
Helena Maguire	Senior Projects Officer, Sligo General Hospital
Frank McClintock	Assistant National Director, Ambulance Service
Winifred Ryan	Joint Chairperson, NHO Healthcare Records Steering Committee
Carmel Taheny	General Manager, PCCC, Sligo/Leitrim
Dr. David Weakliam	Consultant in Public Health Medicine, Population Health
William Reddy	Transformation Programme 1 Manager
Mary Boyd	Director of Nursing, Cork University Hospital
Dr. Ronan Collins	Consultant Geriatrician, AMNCH
Dr. Joe Devlin (co-opted)	Consultant Rheumatologist, WRH and Joint Chairperson of NHO Healthcare Records Group
Eddie Byrne (co-opted)	Director of Nursing, Cavan/Monaghan General Hospital, member of NHO Healthcare Records Steering Committee
Brendan Murphy (co-opted)	General Manager, Organisational Design & Development and member of NHO Healthcare Records Steering Committee
Tamasine Grimes	Research Pharmacist, AMNCH
Virginia Pye	Director of Public Health Nursing, Longford/Westmeath
Dr. Siobhan O'Halloran	Director of Nursing Services, HSE
Maureen Howley	Discharge Co-ordinator, Sligo/Leitrim
John Wickham	Organisation Development, HSE West
Ms. Liz Lees	Consultant Nurse, NHS and External Advisor

## Appendix 2: List of Key Stakeholder Groups

Key Stakeholder Groups	Key Stakeholder Groups
Irish Directors of Nursing and Midwifery Association	Royal College of Physicians of Ireland
Royal College of Surgeons of Ireland	Department of Health and Children
Association of Occupational Therapists of Ireland	National Council for Nursing & Midwifery
Psychological Society of Ireland	Patient Focus
Irish Association of Speech & Language Therapy	Irish Advocacy Network
Medical Social Workers Group	Patients Together
Irish Chiropodists/Podiatrists Organisation	Patient Partnership
Irish Society of Chartered Physiotherapists	Hospital Pharmacists' Association of Ireland
Irish Nutrition and Dietetic Institute	Irish Association of Emergency Medicine
Irish Patients Association	Irish Gerontological Society
National Casemix Programme	The Federation of Irish Nursing Homes
Irish College of General Practitioners	Public Health Nursing Association
Ambulance Association	Bed Managers Association
Irish Medication Safety Network	Irish Pharmacy Union
Irish Hospital Consultants Association	