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
Additional Resources and Appendices

Contents

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

General *	Yes (Y)/No (N)/ Not Applicable (NA)
☐ Patient understands findings and treatment plan	
☐ Observations within normal limits	
☐ Pain control satisfactory	
☐ Adequate nutrition and fluid intake	
☐ Passed urine	
☐ All dressings checked	
☐ 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)
☐ Own medications (once reviewed)	
☐ Own equipment	
☐ Own X-Rays	
☐ Valuables	

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

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

Transport	Time Booked (24 hour)
☐ Relative/friend	
☐ Taxi	
☐ Ambulance	
☐ Community transport provider	
☐ Other (please specify)	

Follow up appointments	Yes (Y)/No (N)/ Not Applicable (NA)
☐ General Practitioner (GP)	
☐ OPD (please specify)	
☐ Medical specialist/other hospital (please specify)	
☐ Other (please specify)	

Signature/Printed Name	Date	Time (24 hour)

KEY TASKS FOR STANDARD ADMISSION AND DISCHARGE PROCESS

Pre admission

- ☐
  - Patient assessment
  - Explain procedure, risks, expected outcomes
  - Discuss options and preferences for hospital care and treatment
  - Discuss patient concerns
  - Assessment concerning—social issues/rehabilitation/delivery of PCCC services/availability of carer
  - Standardised, up-to-date, healthcare records available
  - Common Assessment Process (CAP) and Common Summary Assessment Record (CSAR) should be undertaken, where appropriate
- ☐
  - Identify estimated length of stay (ELOS)
  - Discuss ELOS with patient/family/carers
  - Record ELOS in the patient's healthcare record
  - Communicate ELOS to PCCC service providers
- ☐
  - Gather information regarding pre-admission abilities (potential discharge issues)
  - Discuss discharge plan with patient/family/carer
  - Communicate discharge plan with PCCC service providers
  - Discharge plan recorded in the patient's healthcare record
- ☐
  - Referral to other members of the multi-disciplinary team
  - Referral to PCCC services
  - Referral to diagnostic services
  - Document receipt of referrals on discharge planning tracking form
- ☐
  - Establish pre-admission medication list, if necessary in consultation with the patient's GP and community pharmacist
  - Commence pre-admission medication/treatment as appropriate
- ☐
  - Communicate planned admissions to PCCC service providers
  - Provide information and education to the patient/family/carer in the appropriate language, verbally and in written form

On admission

- ☐
  - Patient assessment
  - Explain procedure, risks, expected outcomes
  - Discuss options and preferences for hospital care and treatment
  - Discuss patient concerns
  - Assessment concerning—social issues/rehabilitation/delivery of PCCC services/availability of carer
  - Standardised, up-to-date, healthcare records available
  - Common Assessment Process (CAP) and Common Summary Assessment Record (CSAR) should be undertaken, where appropriate
- ☐
  - Identify estimated length of stay (ELOS)
  - Discuss ELOS with patient/family/carers
  - Record ELOS in the patient's healthcare record
  - Communicate ELOS to PCCC service providers
- ☐
  - Patient treatment plan available
- ☐
  - Co-ordinate and implement discharge plan
  - Discuss discharge plan with patient/family/carer.
  - Communicate discharge plan with PCCC service providers
  - Document discharge plan in the patient's healthcare record
- ☐
  - Referral to other members of the multi-disciplinary team
  - Referral to PCCC services
  - Referral to diagnostic services
  - Document receipt of referrals on discharge planning tracking form
- ☐
  - Obtain an accurate medication history
  - Review admission medication in consultation with patient's GP, the community pharmacist and other relevant clinicians
  - Develop and co-ordinate a medication discharge plan
- ☐
  - Notify PCCC service providers of unplanned admissions
  - PCCC service providers contact hospital to discuss premorbid health status

During in patient stay

☐	● Patient assessment
☐	● Monitor treatment plan on a daily basis ● Communicate changes to the patient ● Communicate changes to PCCC service providers ● Document changes to treatment plan in the healthcare record
☐	● Manage ELOS against treatment plan ● Communicate changes to the patient/carer ● Communicate changes to PCCC service providers ● Document changes to the ELOS in the healthcare record
☐	● Manage discharge plan against treatment plan ● Communicate changes to the patient/carer ● Communicate changes to PCCC service providers ● Document changes to the discharge plan in the healthcare record
☐	● MTD agree suitability of patient for nurse (or HSCP/Other) facilitated discharge ● Identify nurse (or HSCP/Other) to facilitate discharge within one hour of admission ● Document the name of the nurse (or HSCP/Other) to facilitate discharge in the healthcare record
☐	● Advise PCCC service providers/carer of planned discharge (at least 2 days prior to discharge)
☐	● Arrange 2 way communication between the hospital, the GP, the community pharmacist and other PCCC service providers

24 hours before discharge

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

On day of discharge

- ☐ ● Confirm that patient is clinically fit and safe for discharge
- ☐ ● Discharge patient to place of residence/transfer healthcare facility or discharge lounge
- ☐ ● Discharge to be effected by 12 noon
- ☐ ● Ensure transfer/discharge communication has been communicated to the healthcare provider(s) nominated by patient
- ☐ ● Confirm with PCCC service providers that patient has left the hospital and that service provision needs to commence
- ☐ ● Provide patient with information pack
  ● Provide information and education to the patient/family/carer in the appropriate language, verbally and in written form
- ☐ ● Determine if the patient needs follow-up

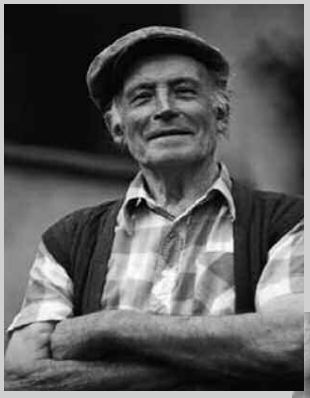
If follow-up is required...

1. Determine who should telephone the patient post hospitalisation
2. Obtain the patient's/carer's consent for the follow-up call
3. Ask them to nominate a call time
4. Check that telephone details are correct
5. Check language skills and record any special needs for the telephone follow-up

Post discharge

- ☐ Reinforce teaching initiated in the hospital
- ☐ 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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13. New South Wales Department of Health (2006). **NSW: A new direction for Mental Health.** www.health.nsw.gov.au/policies/pd/2008/PD2008_005.html

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 mamber 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	