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Hospital Discharge and Community Support: Staff Action Card

How your role helps to implement best practice outlined in the Hospital discharge and community support guidance.

Key messages for all staff

- Early discharge planning is required from admission (for emergency admissions) and prior to admission (for elective admissions). This enables people and their family members/carers to ask questions and receive timely information to support them in discussions and decisions about their discharge. For those likely to require health and/or social care and support post-discharge, early discharge planning must involve the person and any unpaid carers (including young carers), where appropriate, as per the duty in the Health and Care Act 2022.
- All people who no longer meet the clinical criteria to reside for inpatient care in acute hospitals or who no longer need inpatient care in community hospitals should be discharged **as soon as it is possible and safe**. Local areas should adopt discharge processes that best meet the needs of the local population. This could include the Discharge to Assess model and Home First approach.
- Every local health and social care system based around an acute hospital site should have a Single Coordinator, reporting to an Executive Lead, to lead and drive the discharge agenda across the system.
- Where Discharge to Assess is implemented, discharge home should be the default pathway (Pathways 0 & 1). People may also be transferred to non-acute settings (Pathways 2 & 3). A Case Manager may be assigned to all those requiring health and/or social care and support post-discharge to aid their recovery prior to any assessments of ongoing needs (Pathways 1, 2 & 3). A Transfer of Care Hub based around an acute hospital site should link services to coordinate care and support to aid discharge, recovery and admission avoidance.
- People should be discharged as soon as it is possible and safe following a medical decision to discharge. People on all pathways should be discharged as early in the day as possible, ideally before 5pm, as agreed with people and their family members/carers and any providers of onward care and support.
- Staff training is available via the Home First Act Now eLearning Programme. For the latest information on COVID-19 requirements for people discharged to care homes, please see Infection prevention and control in adult social care settings and Infection prevention and control in adult social care: COVID-19 supplement.

CASE MANAGER

- **A Case Manager may be assigned to each person requiring post-discharge health and/or social care and support to aid and monitor their discharge and recovery**
- **Where Discharge to Assess is implemented, the Transfer of Care Hub should decide which pathway (1, 2 or 3) is the best for the person and assign the Case Manager**
- **The Case Manager may be employed by any organisation in the system and can be from any professional background – they may change throughout a person's journey depending on the person's needs**

Where Discharge to Assess is implemented, you should be assigned to people on Pathways 1, 2 & 3 to aid and monitor their discharge and recovery.

Discharge from the ward

- Ensure the person and any carers, family or friends are involved in and informed about what is happening and when. Patient leaflets are available for people being discharged home or to a care home. A leaflet for carers is also available including information about a carer's right to a carer's assessment.
- Ensure transport home, or elsewhere, has been organised and any medications to take out (TTOs) have been ordered and will be ready at the point at which the person will be leaving the hospital. Confirm any safety netting with the ward.
- If using a 'settling-in' service, liaise with the provider about timing and duration.
- Confirm the details of the pathway provision with the Transfer of Care Hub, including the location, contact details, nature of provision, etc.
- Work with the Transfer of Care Hub to ensure an initial safety and welfare check takes place on the day of discharge, liaising with family members/carers and relevant care providers.

Monitoring

- In liaison with the multi-disciplinary team providing support to the person, closely monitor and document progress against the recovery and support plan.
- Ensure adjustments are made to the support provided as required and in a timely way and the support is ended when it is no longer needed.

Assessment of long-term needs

- Where Discharge to Assess is implemented, after a sufficient period of recovery, where it appears a person may need support on a long-term basis, liaise with appropriate professionals to ensure timely assessment, e.g. a Care Act (2014) assessment, and/or NHS Continuing Health Care assessment. Case Managers would not usually carry out these assessments.