PARTNERSHIP PROCEDURES
GUIDANCE
TO BE READ IN CONJUNCTION
WITH JOINT ADMISSION,
TRANSFER AND DISCHARGE
POLICY

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| Policies replacing | Admission and Discharge Policy – The Highland Partnership  
|                   | Admission and Discharge Policy – Argyll and Bute Partnership CHP |
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1. Key Stages of Admission, Transfer and Discharge

**Prevention**
- Consider options for prevention to admission:
  - Anticipatory Care Plan
  - Advanced Care Plan
  - Telehealthcare
  - Support from District Nurses
  - Day hospital
  - Hospital Social Work
  - 24/7 rapid response team
  - Social work support
  - GP
  - Crisis Team
  - Day unit medicine
  - Community Team
  - Direct Line GP telephone number
  - Reablement teams

**Decision to admit/discharge**
- Single Shared Assessment (POP) started
- Length of stay/planned date of discharge
- Patient given orientation/induction information re environment they will be going into, what will happen to them regarding procedures
- Management Plan commenced
- Emergency admission should be completed within 4 hours
- Identify carer/next of kin
- Consent
- Referral if appropriate for discharge

**Transfer to speciality ward or discharge**
- Start discharge planning process including pharmacy
- Review Planned Date of Discharge (PDD)
- Care according to Management Plan or ICP
- Key Worker allocated
- Discharge Plan commenced including identifying resources required – including housing issues
- Patient/carer involvement and also involvement of others already involved in patient case
- Appropriate assessments
- Medical review – PODs
- Plan transport for discharge
- Contact SW, DN, GP and others re admission giving PDD

**During admission**
- PDD – Review
- Key Worker allocated
- Confirm diagnosis
- Continuity update Management Plan
- Pathway of Care
- Onward transfer point established
- Discharge Plan active e.g. referral to social work
- Patient/carer involvement
- MDT review involving patient/carer/ SW/specialist teams as appropriate
- Patient care/education – enablement model
- Home visit to include community staff if appropriate

**Specific treatment or care**
- Engage with staff where patient being discharged to and include voluntary sector
- Ensure adaptations are complete
- Review PDD
- Confirm medically fit for transfer
- Follow up arrangements consider different options for follow up e.g. day hospital, day services
- Patient/carer involvement including any information about discharge
- MDT review
- Discharge Plan updated
- Fast Track palliative care process for resources
- Document discharge medication requirements

**Prior to PDD**
- Patient confirmed as ready to go to discharge lounge or onward transfer point
- Involve community staff, inform time of discharge etc.
- Give patient follow up details
- Discharge/Transfer letter to patient/GP/DN/SW/Community Hospital as appropriate
- If required follow process for notification of death
- Handover documentation completed including specific equipment

**Day of PDD**
- Patient ready to leave hospital
- Patient Discharged
2. Admission, Transfer and Discharge Pathway

Living at home in the Community –
- Anticipatory Care
- Self Management
- Health Promotion
- National Screening Programmes
- Reablement
- Community and Family Carers Support

Crisis or Deterioration of condition or need for acute care intervention

Admission Planning

Emergency Response
- Consideration of all options to avoid hospital admission
- Carer support
- Reablement

Admission to Hospital
- MDT Assessment
- Patient’s ability to self manage
- Carers support
- Nurse led discharge - planning
- PDD
- Medication review
- Liaison with community teams

Discharge to Care Facility (if no other option possible) e.g.
- GP services
- Care Home
- Step Down Facility, Community Hospital
- Interim Placement etc.

Day of Discharge
- Discharge lounge
- Pharmacy
- Communication with community teams
- Agreed plan for discharge arrangements checked
- Transport
- Home care, Telehealthcare etc
- Discharge documentation

Appropriate Hospital interventions
- Review of PDD
- SW engagement
- Arrangements and Plan agreed for discharge
- Options on discharge – homecare, Telehealthcare
- MDT review

Discharged Home
- Care at Home
- Telehealthcare
- Community Nursing
- GP services
- Re-ablement Package
- Carer support
- Community Services
- Voluntary Services
3. **Anticipatory Care Planning**

3.1 All efforts should be made to prevent admission to hospital where possible, community based services should be considered including use of equipment, telehealthcare, day hospitals, crisis intervention teams, ambulatory care and the Anticipatory Care Plan. Staff should confirm that hospital admission is required and alternative support within the community has been explored before requesting admission into hospital.

3.2 An anticipatory care planning approach should be adopted at all stages of the individual’s pathway, where, in liaison with the individual and their family/carers, alternative options to admission should be considered prior to making the decision to admit.

3.3 If admission to hospital is required, any Anticipatory Care Plan in place should accompany the individual to hospital and remain with them in their notes throughout their stay. The information in the Anticipatory Care Plan should be updated as appropriate and any changes to the plan communicated to the Lead Professional identified on the Plan.

3.4 The single point of contact will be identified. Communication should be established through a Lead Professional as soon as possible to ensure their active involvement in the discharge planning process.

3.5 If no documentation has accompanied the individual to hospital, receiving wards/units will soon be able to check whether an individual has an Anticipatory Care Patient Alert (ACPA), Advanced Statement or Palliative Care Summary in place when checking the Emergency Care Summary (ECS) information for the individual.

3.6 All Health and Social Care professionals should be involved in anticipatory care planning. A multi disciplinary approach to anticipatory care planning must involve the individual and their family/carers being partners in discussion about their aims, values and choices for remaining at home, wherever it is safe to do so, and ensuring appropriate support to prevent avoidable admissions.

3.7 The Primary Care Team should be informed of any discussions on anticipatory care planning started in a hospital setting.

3.8 **Anticipatory Care Planning Hyperlinks**

Anticipatory Care Patient Alert and Guidance Notes
http://intranet.nhsh.scot.nhs.uk/Projects/LongTermConditionsProgramme/Pages/Default.aspx

Palliative Care Summary
http://intranet.nhsh.scot.nhs.uk/Organisation/PalliativeCareNetwork/Pages/default.aspx

Emergency Care Summary
https://ecs.mhs.scot.nhs.uk/ecs/home/login.aspx

*(Please note that only a small number of staff in health can access this page)*
Advanced Statement

Adults with Incapacity (Scotland) Act 2000
http://www.scotland.gov.uk/Publications/2008/03/25120154/1
http://www.highland.gov.uk/socialwork/olderpeopleservices/adultswithincapacity/
4. Assessment

4.1 It is acknowledged that the majority of patient admissions will not require multi agency involvement or a community care intervention, but where community care needs are anticipated this section relates to the consideration to be given to offer and respond to requests for a statutory community care assessment.

4.2 In cases where community care needs have been predicted or highlighted prior to, or on admission to a hospital setting or when a community care assessment is already in place, professionals will work in collaboration to achieve the agreed outcome with the patient.

4.3 On admission to hospital for patients with complex needs, an Anticipatory Care Plan or GP Patient Alert Form may already have been completed. This will support the medical team in considering further involvement or arrangements as outlined; this information may also be the baseline detail to start a statutory community care assessment (Personal Outcome Plan).

4.4 On admission the medical team will consider if any community care needs are apparent or if there are any concerns or indicators that the person is at risk or posing a risk of harm.

4.5 Where a Single Shared Assessment (Personal Outcome Plan) is available this will give some insight to the degree of complex need and vulnerability of the person or provide an outline of proportionate and appropriate information to support consideration given to reablement or rehabilitation interventions.

4.6 The purpose of the assessment is to ensure the agreed data for sharing is accessible, will avoid unnecessary duplication, reduce time spent on basic information gathering, and enables the patient, carer/s and practitioners to make a holistic and informed decision to agree the intended outcomes during planning for discharge arrangements.

4.7 For patients where community care needs have been identified on admission and no previous or current assessment is available, the multi disciplinary team will decide who the appropriate Lead Professional will be to start the Single Shared Assessment (Personal Outcome Plan) process. This usually begins with a named nurse and during the discharge planning stages the role of Lead Professional may change to another agency or professional.

4.8 Where an unpaid carer is identified a Carer’s Support Plan is offered and can be a parallel process. The carer will have a single point of contact throughout.

4.9 Where there are concerns for the individual’s safety or at risk of harm the Adult Support and Protection procedures must be followed.

4.10 At the time of this protocol being written the Single Shared Assessment (SSA) is the current statutory record being used if community care needs are identified or interventions required.

4.11 The following list describes the key principles of Standardised Assessment and information sharing:
• The assessment is person centred with the views and wishes of the person recorded.
• An assessment is a process not an event.
• The level and type of assessment must be proportionate to the person’s presenting circumstances and anticipated needs – see 4.12 to describe level and type of assessment.
• People who use or require services, their carers and relevant others should be actively involved, with their views and wishes considered and be supported or enabled to participate in the agreed plan arrangements to achieve the intended outcomes.
• Where appropriate, consult with relevant professionals and coordinate their contributions to the agreed outcomes.
• The assessor to be appropriately skilled and qualified to deal with the type and level of assessment.
• Specialist and complex level of assessment to be agreed and undertaken by the most appropriate Lead Professional.
• Ensure informed consent from the person or person’s representative to support the information sharing protocols.
• A simple or complex assessment must facilitate access to all community care interventions and services.
• That other professionals and agencies accept the results of the assessment.
• The assessment formulates a Personal Outcome Plan describing the intended outcomes as agreed with the person and their carer/s.
• The Personal Outcome Plan is coordinated by a single point of contact or Lead Professional responsible for coordination of all contributions from involved persons and professionals.
• The single point of contact /Lead Professional will ensure the Personal Outcome Plan outcomes have been achieved and progress is monitored and reviewed with regularity.

4.12 Assessment Level /Type

**Supported Self Assessment**
This requires minimum data to promote quick and direct access for one off requests through a professional or service contact.

**Simple Assessment**
This requires minimum data to promote quick and direct access facilitated by a professional for short or one off community care interventions or service.

**Comprehensive Assessment**
This requires detailed proportionate data to promote direct access led by a professional for planned or emergency short /longer term interventions or service.

**Specialist Assessment**
This requires a detailed full assessment proportionate to the presenting circumstances to promote direct access to Lead Professionals for statutory assessment or interventions - in addition to the Personal Outcome Plan other assessment forms may be required, it is only the Personal Outcome Plan information that will be shared between professionals unless there is a legal requirement to submit additional specialist information.
5. Admission

5.1 It is very important that care is taken to ensure that newly admitted patients are treated in ways which help them to feel as safe, welcomed and well cared for as possible with information readily available and accessible. This includes taking account of any additional support needs the patient may have arising from pre-existing disability or impairment.

5.2 The above noted principles would apply to all out of area patients, with an expectation that the assessment process is commenced on admission in a timely manner, at the point of receipt of care.

5.3 On arrival, new patients and their carers or relatives will be greeted by hospital staff and the admission process commenced as soon as possible. If it is not possible to complete the admission process immediately, the patient will be advised of the reason for the delay and offered somewhere comfortable to wait.

5.4 The patient may have children under 16, for whom alternative care arrangements must be made during admission, and/or the patient’s primary carer may be a young person under 16 years. Arrangements should be made to provide additional assistance for patients/carers in this situation.

5.5 On admission, patients will be shown: their room or bed space, the toilets, the bathrooms, the nurses’ station, and told: who their named nurse is, about arrangements for meal times, medication and visitors and whom to go to if they need help or information.

5.6 If the patient lacks capacity then the arrangements for including carers in the assessment and care planning process will be explained. Welfare Guardians and Welfare Attorneys will have often have powers granted to them under the Adults with Incapacity (Scotland) Act 2000 to give consent for medical treatment, have access to health records and information and to be fully involved in the decision making processes. The extent of powers granted to Welfare Guardians and Attorneys should be established prior to, or at, the time of admission.

5.7 The named nurse will check with the patient and/or their carer, including any young carers, the essential medical information about the patient’s current health to assist with diagnosis, provide any immediate care or identify any social care issues to determine the planned date of discharge (PDD).

5.8 Patients will be given the opportunity to have someone with them while they are being admitted; this includes language or interpretation assistance. Some people may require ongoing support throughout the time of their admission and the arrangements for this should be discussed with the patient and carers.

5.9 Time and opportunities will be given to allow patients, relatives and carers to ask any questions that they may have. For people who have impaired communication this may include the provision of information in accessible formats and the use of communication aids (talking mats, pictures, etc) to assist patients to ask questions.
5.10 Should patients have any caring commitments that require to be covered; the Lead Professional will explore and assist the patient to arrange cover, in liaison with community staff. If any potential risks are identified, e.g. child/young person taking on inappropriate caring roles during patient’s treatment and recovery, Getting it Right for Every Child Guidance (indicated below) will be followed.

5.11 Highland Council
www.forhighlandschildren.org

Argyll and Bute Council
http://www.argyll-bute.gov.uk/content/socialworks/services/abcpc/

Privacy, Dignity and Respect for NHS Highland
http://intranet.nhsh.scot.nhs.uk/projects/privacy.dignityandrespect/Pages/Default.aspx
6. Planned Admissions

6.1 Where possible for planned admissions, discharge planning should commence in the pre admission assessment clinics; (where available) this could be in defined pre operative assessment clinics or at individual appointments.

6.2 At the time of pre admission assessment consideration should be given to any adjustments needed to address additional and specific support needs that the person may have. This could include the provision of orientation visits, single room accommodation, communication assistance and/or equipment or additional staffing to support the person.

6.3 In the case of adults with learning disabilities there are a range of support services available that will be able to assist with planning the admission. This includes a Learning Disability Liaison Nurse based at Raigmore and Community Learning Disability Nurses based throughout the North NHS Highland. In Argyll & Bute the Joint Learning Disability Service is hosted by Argyll and Bute Council; Learning Disability Nurses can be contacted through the Network on 01546 605605. They can assist by providing additional information through completion of Hospital Admission Form, accessing health passports and personal plans.

6.4 Patients will also be given the opportunity to register their spiritual care needs with the named nurse. A copy of the spiritual care policy can be accessed at: http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Policy%20for%20Spiritual%20Care.pdf
7. Adults at Risk of Harm (aged 16 years or older)

7.1 The following three Acts are relevant where there may be questions regarding an adult’s ability to make decisions on their own behalf.

7.2 The Adults with Incapacity (Scotland) Act 2000 (The Act) provides a framework for safeguarding the welfare and managing the finances/property matters of adults (aged 16 and over) who, lack capacity to act or make some or all decisions for themselves as a result of mental disorder or an inability to communicate due to a physical condition.

7.3 About capacity
The law in Scotland generally presumes that an adult is capable of making decisions for themselves and managing their own affairs unless found to lack capacity. The concept of lacking capacity may not necessarily relate to a global difficulty, and people who experience fluctuating capacity with respect to decision making around their welfare, finances and/or property, can still be offered assistance under the Act.

7.4 For the purposes of the Act, ‘incapable’ means incapable of:
- Acting on decisions; or
- Making decisions; or
- Communicating decisions; or
- Understanding decisions; or
- Retaining the memory of decisions.

7.5 Someone can be diagnosed with a particular condition where they are beginning to experience some difficulties in the above areas, but the diagnosis in itself does not mean that they are automatically lack capacity. This may be the case even if the adult appears to be acting unwisely, and the provision of formal or informal support or intervention under a different piece of legislation, may be more appropriate.

7.6 The concept of capacity is acknowledged for its complexity. The following guidance may assist assessors:

http://www.mwcscot.org.uk/web/FILES/Publications/Consent_to_Treatment.pdf
http://www.scotland.gov.uk/Publications/2008/02/01151101/2
http://www.mwcscot.org.uk/web/FILES/Publications/Autonomy%2C_benefit_and_protection_FULL.pdf

7.7 Guiding Principles
The Act aims to protect people who lack capacity to make particular decisions, but also to support their involvement in making decisions about their own lives as far as they are able to do so. Anyone authorised to make decisions made on behalf of someone with impaired capacity must apply the following principles:
- Benefit.
- Minimal Intervention.
- Take account of the wishes of the person.
- Consult with relevant others.
- Encourage the person to use existing skills and develop new skills.

7.8 How can the Act assist?
The Act provided several routes to safeguard a person’s welfare and manage their financial/property affairs or both, although certain decisions can never be made on behalf of another person who lacks capacity, such as consent to marriage or making a will. The Act also imposes certain restrictions on what a person with powers (proxy) can do, for example they cannot place a person in a psychiatric hospital against his/her will or consent to certain types of treatment on their behalf.

7.9 Power of Attorney
This is the means by which individuals, whilst they have capacity, can grant someone they trust, powers to act as their continuing (financial) an/or welfare attorney. One or more persons can act in these roles. A continuing (financial) power of attorney continues or commences when the individual loses capacity, either temporarily or permanently. A welfare power of attorney only comes into effect in the event of the individual losing capacity, either temporarily or permanently. All powers of attorney are registered with the Office of the Public Guardian.

7.10 Access to Funds Scheme
This is a way of accessing the adult's bank or building society account(s) in order to meet their living costs, by means of the setting up of a separate designated account. An application can be made to the Office of the Public Guardian by an individual who knows the adult (usually a relative or carer) or an organisation. The person or organisation appointed is called a 'withdrawer'.

7.11 Guardianship Order
Applications for Guardianship can deal with property and financial affairs and/or personal welfare. It is likely to be most suitable in situations where the adult has long-term needs and requires decisions to be made on an ongoing basis, or where the person has lost, or has never had capacity, to take decisions or actions on these matters. An application for a Guardianship Order may be made to the Sheriff Court by an individual (usually a relative or a carer) or by a Local Authority, where no one else is applying and the adult has been formally assessed as requiring the safeguards provided by guardianship. Before granting a Guardianship Order, the Sheriff would have to be satisfied that the adult is incapable with regard the matters in question, and that there is no other suitable means of safeguarding or promoting the adult's interests. Welfare Guardianship applications for adults with mental disorder, require medical reports from two doctors and one report from a Mental Health Officer.

7.12 Intervention Order
Applications for Guardianship Orders would usually be suitable in cases when one off actions require to be undertaken on behalf of an adult, such as, opening a bank account, signing a tenancy and setting up standing orders. Intervention Orders can be granted with respect to both financial and welfare matters. An application may be made to the sheriff court by an individual or by a Local Authority.
7.13 **Management of (care home/hospital) residents’ funds**
The Act allows authorised care establishments and hospitals to manage a limited amount of the funds and property of residents who are unable to do this for themselves and have no one else available to do so. A certificate of authority (on application) may be granted to a care home manager by their supervising body (care commission, health board, Local Authority for this purpose.

7.14 **Medical Treatment Decisions**
The Act allows treatment to be given to safeguard or promote the physical or mental health of an adult who is unable to consent. The principles apply to medical treatment decisions as to other areas of decision making. Where a Welfare Attorney or Guardian has been appointed and they have powers to make decisions about medical treatment, the doctor must seek their consent where it is practicable and reasonable to do so. In cases where the adult has no one acting on their behalf, the doctor is authorised to provide medical treatment, subject to certain safeguards and exceptions. In cases of disagreement, a second medical opinion must be sought and the Mental Welfare Commission holds a list of specialist doctors who can assist in these cases.

7.15 Medical certificates of capacity can be completed under section 47 of the Act, for adults who cannot give consent to treatment.

7.16 **The Mental Health (Care and Treatment) (Scotland) Act 2003** (the Act) sets out the care, treatment and support arrangements for people who have a diagnosed mental disorder. Its primary objective is to make sure that people with mental disorder, particularly those who are experiencing impaired decision making, can receive effective care and treatment. In situations where a person’s decision-making is impaired by mental disorder, with the result that their health, welfare or safety or the safety of others may be jeopardised and consent to treatment is declined, the Act allows that the individual’s right to self-determination is overridden, within the controls put in place by the legislation. The diagnosis of mental disorder under the Act includes mental illness, learning disability and personality disorder.

7.17 **The Act covers a wide range of issues, summarised below:**
- Principles, roles and responsibilities: how the Act defines the nature, duties and powers of the organisations and individuals involved in mental health law and how they should give effect to the principles of the Act.
- Compulsory powers: how the Act sets out the circumstances in which a person with mental disorder may receive treatment and/or be detained on a compulsory basis, and the procedures which have to be followed.
- People with mental disorder in the criminal justice system: what the Act says about how a person with mental disorder may be dealt with by the criminal justice system, and how they are subsequently cared for, and;
- Rights and safeguards: the additional rights the Act gives to a person with mental disorder, and the safeguards it puts in place.
7.18 **Principles, roles and responsibilities**

**Taking account of the Principles of the Act**
The Act sets out some principles which most people performing functions under the Act have to consider, particularly those professionals involved in implementing relevant sections of the Act, such as Responsible Medical Officers, nursing staff and Mental Health Officers. These include:

- The present and past wishes and feelings of the patient.
- The views of the patient’s named person, carer, guardian or welfare attorney.
- The importance of the patient participating as fully as possible.
- The importance of providing the maximum benefit to the patient.
- The importance of providing appropriate services to the patient; and
- The needs and circumstances of the patient’s carer.

7.19 **The Act also sets out principles relating to the way in which the function must be undertaken, and to do so in a particular way. In particular:**

- That involves the minimum restriction on the freedom of the patient that appears to be necessary in the circumstances.
- Encourages participation.
- If the patient is a child, best secures their welfare and mitigates disruption in child parent relationships when parents are admitted to hospital.

7.20 **Special professional roles and functions**

**Responsible Medical Officer**
The medical practitioner, usually a Consultant Psychiatrist who is responsible for the person’s care and treatment.

7.21 **Mental Health Officer**
Mental Health Officers (MHOs) play a significant role in many parts of the Act. A MHO is an experienced social worker who has undertaken specialist training in mental health law, and understanding mental disorder and treatment.

7.22 **Named Person**
This is someone who can look after the person’s interests if he or she has to be treated under the Act. The Named Person is usually nominated by the person with mental disorder, and has to agree to take on this role. In situations where a person does not have a nominated Named Person, their next of kin can take on this role.

7.23 **Independent Advocacy Workers**
Under the Act, anyone with a mental disorder has a right to access an independent advocacy worker. This person will offer support to assist people to express their own views about their care and treatment.

7.24 **Mental Health Tribunal**
The Mental Health Tribunal for Scotland was set up by the Act to make decisions about the compulsory care and treatment of people with mental disorder.
7.25 **Health Boards**
Health Boards already have wide-ranging duties to provide services for people with mental disorder, mostly set out in the National Health Service (Scotland) Act, 1978, but the Act sets out further duties, including:
- Provide services to meet the needs of any child or young person detained in hospital on an emergency or short-term detention or admitted to hospital for treatment of mental disorder.
- In certain circumstances, provide services and accommodation as necessary to allow a mother with post-natal depression to care for her baby in hospital.
- In collaboration with Local Authorities, ensure the provision of independent advocacy services.

7.26 **Local Authorities**
Like Health Boards, Local Authorities, already have a range of general duties towards persons with mental disorder, mainly set out in the Social Work (Scotland) Act, 1968, but the new Act places further duties including:
- Duties to provide care and support services.
- Duty to inquire into the circumstances of a person with mental disorder where they are at risk of harm of some kind. Under sections 34 and 35, Local Authorities can also apply for a range of warrants to enable them to carry out their inquiries.
- Duty to provide education to children who are subject to the new Act.

7.27 **Mental Welfare Commission**
The Commission has duties to:
- Monitor the operation of the Act and to promote best practice.
- Carries out visits to patients, undertakes investigations, interviews a range of professionals, carers and patients, provides second opinion medical examinations and inspects records.
- Publishes information and practice guidance, and gives advice about the mental health law system and practice.

7.28 **Advance Statement**
This is a written statement, drawn up and signed when the person is well, which sets out how they would prefer to be treated (or not treated) if they were to become unwell in the future. It must be witnessed and dated. The Mental Health Tribunal and any medical practitioner treating the person must have regard to an advance statement but are not bound by it.

7.29 **Compulsory powers**
The Act deals with several forms of compulsion:
- Emergency detention (72 hours).
- Short term detention (28 days, and may be extended).
- Compulsory Treatment Orders (6 months, but subject to review, variation and extension).
- A range of compulsory powers for people with mental disorder within the criminal justice system.
7.30 Legal requirements relating to the admission to and transfer and discharge from hospital, for people who are subject to compulsory powers, are clearly set out in the Act and also in the Codes of Practice, available via the following Scottish Government sites:


7.31 The Adult Support and Protection (Scotland) Act 2007 (ASP) gives powers and duties in relation to protecting adults at risk of harm.

7.32 The Act sets out statutory duties of co-operation for public bodies and their office-holders including:

- Councils
- NHS Boards
- The Police
- The Care Commission
- Mental Welfare Commission and
- The Public Guardian.

7.33 These public bodies and their staff must:

- Report the facts and circumstances to the local Council when they know or believe that a person is an adult at risk of harm and that action may be needed to protect that adult from harm.
- Cooperate with the Council and each other to enable or assist the Council making inquiries.

7.34 Adults are at ‘risk of harm’ when they are:

- Unable to safeguard their own well-being, property, rights or other interests.
- At risk of harm and
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

7.35 All three of the above criteria have to be met for an adult to be identified as an ‘adult at risk of harm’. (Adults are 16 years and older)

7.36 Harm

Harm includes all harmful conduct and, in particular, includes:

- Conduct which causes physical harm.
- Conduct which causes psychological harm (e.g. by causing fear, alarm or distress).
- Unlawful conduct which appropriates or adversely affects property rights or interests (e.g. theft, fraud, embezzlement or extortion).
- Conduct which causes self-harm.

7.37 An adult is at risk of harm if:

(a) Another person’s conduct is causing, or is likely to cause the adult to be
(b) The adult is engaging, or is likely to engage, in conduct which causes, or is likely to cause, self-harm.

7.38 Statutory Duties
Inquiries
Councils have a statutory duty to make inquiries about a person’s well-being, property or financial affairs if they know or believe that the person is an adult at risk and that they might need to intervene to take protective actions.

7.39 Investigations
- Council Officers have the power to carry out investigations through visits and interviews and through examination of records (except health records).
- Health professionals have the power to carry out medical examinations as part of investigations and to examine health records.
- Adults have the right not to answer any questions and to refuse to be medically examined, and must be told of these rights.

7.40 Councils have a duty to consider the importance of the provision of appropriate services to the adult, including, in particular, independent advocacy.

7.41 To download or read the Council’s Adults Support and Protection Procedures 2010 and the multi agency Risk Assessment and Protection Plan go to:

Highland Council
http://www.highland.gov.uk/socialwork/adultssupportprotection.htm

Argyll and Bute Council
www.argyll-bute.gov.uk/content/socialworkservices/abapc/
8. Child Protection Guidance

8.1 The specific arrangements for vulnerable or “at risk” individuals are detailed in the jointly agreed Child Protection Guidance. Where there is a concern that an individual under 16 years old may be “at risk”, a line manager should be advised and an immediate contact made with the relevant person indicated below. Everyone has a responsibility to report concerns for children at risk of harm.

8.2 Child Protection Line Tel: 0800 022 3222.
9. Carers/Young Carers

9.1 The involvement of carers is an integral and essential part of the management of ATD. Each partner organisation acknowledges the importance of involving carers in this process. Carers will be identified and included in the ATD planning from the outset, in collaboration with other agencies.

9.2 A carer is a person **of any age** who provides physical care or emotional support to another person, due to frailty, physical or mental illness, addiction or disability and is not paid for providing that care or support. (Carers Allowance does not count as payment).

9.3 The carer has a right to decide the level of care they are willing or able to provide after discharge and a Carers' Assessment or Carers' Support Plan is a useful tool to help identify potential risks and barriers/solutions to making the caring role sustainable. This should reduce the risk of repeated readmission for individuals with complex conditions.

9.4 Carers under the age of 16 are also entitled to a Carer's Assessment, which should follow the principles and values of Getting it Right for Every Child (GIRFEC). In order to prevent young people from taking on inappropriate caring roles, the relevant named person will be identified to carry out a Child's Plan.

9.5 Where the individual has either given permission or agreed that an individual is (or will be) their unpaid carer or the relative has welfare powers under the Adults with Incapacity Act, the said carers have a right to:
   • Be included in the decision making process regarding the future care of the individual, in conjunction with other agencies.
   • Be consulted about and kept fully aware of discharge arrangements and timescales.

9.6 Useful links for carers
   Highland Council Area
   HCCF website  [www.hccf.org.uk](http://www.hccf.org.uk)
   Carers Information Service  [www.hccf.org.uk/carersinfo](http://www.hccf.org.uk/carersinfo)
   Connecting Young Carers  [www.hccf.org.uk/youngcarers](http://www.hccf.org.uk/youngcarers)
   Carer Training  [www.hccf.org.uk/carerscan](http://www.hccf.org.uk/carerscan)
   Training for Professionals  [www.hccf.org.uk/professionaltraining](http://www.hccf.org.uk/professionaltraining)
   Advocacy for Carers  [www.hccf.org.uk/carersadvocacy](http://www.hccf.org.uk/carersadvocacy)

   Argyll and Bute Council Area
   North Argyll  [www.carers.org/local/scotland/oban](http://www.carers.org/local/scotland/oban)
   Helensburgh and Lomond  [www.carers.org/hlcp](http://www.carers.org/hlcp)
   Mid Argyll/Kintyre/Islay  [www.dochasfund.org.uk](http://www.dochasfund.org.uk)
   Argyll and Bute Carers Network  [www.abcn.org.uk](http://www.abcn.org.uk)
10. During Admission

10.1 When a person is admitted to hospital, a “named nurse or Lead Professional” will be identified from within the multi disciplinary team to check whether the individual has an Anticipatory Care Plan in place and request a copy of the Plan from the Primary Care Team, if it has not accompanied the individual on admission to hospital. This Plan should be placed in the individual’s notes and should become an integral part of the assessment process.

10.2 Staff should always presume in the first instance that the individual will be discharged home. Only after thorough assessments of functional capabilities and discussion with the individual and carer should alternatives be sought.

10.3 Ensure appropriate multi disciplinary (including nursing) assessment of the individual’s pre and post morbid function, this includes cognition and the individuals understanding of their condition including future plans and any unmet care needs. It may include an assessment of their social, housing and care needs.

10.4 If the individual does not have an Anticipatory Care Plan in place, the development of a plan by the hospital multi disciplinary team should be considered in liaison with the individual’s Primary Care Team.

10.5 When required, individual case conferences/discharge planning meetings should be organised ensuring key individuals, including individual and carer are present and involved in the decision making process. This should include the Case Manager if the individual is being actively case managed in the community.
11. Housing and Homelessness

11.1 **Aim**
Wherever possible, no individual will be discharged without planned solutions to address their housing needs.

11.2 At admission, nursing staff will be aware of an individual’s housing circumstances.

11.3 If an individual is on Care Programme Approach (CPA) follow the Protocol and Procedures for Providing Accommodation and Support to People who are, or are likely to become homeless. Click on the following link for these: [http://www.highland.gov.uk/NR/rdonlyres/4BB0000D-6178-4A45-A65A-2CD74EB9AFA3/0/200911protocolhomeless.pdf](http://www.highland.gov.uk/NR/rdonlyres/4BB0000D-6178-4A45-A65A-2CD74EB9AFA3/0/200911protocolhomeless.pdf)

11.4 If any other individual is likely to be homeless or threatened with homelessness on discharge contact the Local Authority in your area. For the Highland Partnership click on the link above and follow the flow charts on pages 18 and 19. You will find contact details for each of the Highland Council’s area offices on the flow charts.

11.5 If the individual has a tenancy contact should be made with their landlord.

11.6 Contact details are listed at **Appendix 4**.

11.7 The individual may occupy a private let and they should be able to tell you who their landlord is.

11.8 If an individual has other housing needs, contact should be made with the Social Work Services team associated with the hospital.

11.9 When a patient is admitted the follow Housing issues need to be consider/explored with the individual:
- **Property**
  - Is the house secure?
  - Is the house unoccupied?
  - Who has keys?
  - Is the property a sheltered house?
  - If there is a warden service does the warden know the tenant is in hospital?
  - Does the water system need to be drained down? (applicable in winter)
  - Is there a gas supply in the property? For safety reasons the landlord may wish to cap the gas supply.
  - Who is the landlord?
  - Is the property owned by the patient?

11.10 If a property is unoccupied for a period of time and the landlord is unable to make contact with the tenant he/she may start court proceedings thinking the property has been abandoned. This process legally entitles the landlord to relet the property.
11.11 Rent
- How is the rent paid?
- Have arrangements been made to continue payments?
- If Housing Benefit is being claimed contact the Council’s Finance Service
- Is any action being taken by the landlord due to rent arrears?

11.12 As above, if contact isn’t made with the landlord court proceedings may take place in the patients’ absence that will allow the landlord to repossess the property and relet it.

11.13 It is imperative that contact is made with the landlord if it is likely that the patient will be in hospital for more than 2 weeks.

11.14 What a landlord can do may depend on what type of tenancy the patient has.

11.15 Discharge from hospital
- Has water been turned back on, if it was drained down?
- If the gas supply was capped this will have to be restored – 48 hours notice will be required.
- Are keys available?
- If Housing Benefit is being claimed, have they been notified of the discharge date?
- Where applicable, is the landlord aware that the tenant will be returning home? This is particularly important where an individual is living in sheltered housing with a warden service, the warden should also be informed.
- On discharge from hospital, is the property going to be suitable for the individuals needs? E.g. if there is a stair into the property will the individual be able to manage to negotiate the stairs.

11.16 If an individual has family then all of these issues should be considered in discussion with them. It is highly likely that a family member will take responsibility for many of the arrangements, e.g. keys, Housing Benefit notification. However, if an individual lives alone it is important to ensure that all relevant issues are addressed.

11.17 Adaptations:
How requirements for adaptations are considered and assessed will vary depending on whether the tenant lives in Highland or Argyll and Bute Council Areas.

11.18 There are three main routes for assessment of an adaptation:
1. Through direct provision (without a formal assessment)
2. Through self assessment
3. Through an expert assessment such as an OT.

11.19 Highland Council Housing and Property Services Contact Details
Please use the CPA web link previously given.

11.20 For a list of housing associations please see Appendix 4.
11.21  Argyll and Bute Council Housing Services Contacts

Service Officer – Homelessness  Phone: 01546 604 785
Senior Admin Officer  Phone: 01631 572 180
Out Of Hours Emergency Number  Phone: 0800 587 7285
12. Monitoring and Reviewing

12.1 Monitoring and review of the individual’s condition and the support they need is a central part of self management, treatment and care. Individuals, carers or relatives (where an individual consents to information being shared) should be fully involved in the assessment process and decisions about the most appropriate care and treatment at all stages. The monitoring will take account of the individuals living situation, social, emotional and information needs as well as their medical condition.

12.2 Individuals will be seen by the Doctor on admission to hospital. Nursing staff will carry out an initial assessment of the individual’s care needs on admission and will inform other staff e.g. physiotherapists, occupational therapists, etc., where their input is required. A full medical and nursing assessment will be carried out within the agreed standard timescales. Individuals, identified carers and relatives will be given an explanation if there is any delay in seeing the Doctor or if the monitoring is not completed.

12.3 Individuals will be given the opportunity to have someone of their choice with them during assessments. Individuals, carers (where the individual agrees they are or will be their carer) and relatives (with the individual’s consent) will be involved in the assessment taking place, have assessment procedures explained to them and be given the opportunity to discuss and influence the assessment including the opportunity to introduce changes or refuse care or advice. Individuals, carers and relatives will agree the intended outcomes of the plans and assessments. Where there is proxy with welfare powers under the Adults with Incapacity Act (Scotland) 2000 (Welfare Guardian or Power of Attorney) the proxy must be included in the discussions that take place around the care of the individual.

12.4 In addition to regular reviews, individuals, carers and relatives will be encouraged to ask for information or for a review of care, treatment or progress at any stage throughout the individual’s stay in hospital or future care planning. Staff recognise that those providing care, such as relatives, may also need help and support and staff are encouraged to assist carers in completing a Carer’s Assessment.

12.5 Regular meetings of all staff involved in an individual’s care are held for the purpose of sharing information and monitoring the individual’s progress. The named nurse will ensure individuals, carers or relatives are aware of when meetings are being held, enquire if individuals, carers or relatives wish to have any issues raised at the meeting and of any decisions made.

12.6 If it is considered that the individual will require the provision of, or increase in existing levels of support and/or care, to facilitate a safe and timely discharge from hospital, other partners in care and key professionals need to be involved as soon as possible. The individual and family or carer will be involved in any assessment or process planning. The carer will be informed of their right and encouraged to request assessment of his/her needs at any point in the process. There may be further specialist assessment required.
13. Transfer

13.1 Information will be made available in each ward and information will be available from your Senior Charge Nurses.

13.2 Between Wards – Handover of care should be well managed to ensure optimal individual care and individual safety:
   - Ward to ward
   - Inter hospital transfer
   - Out of area transfer
   - Unplanned emergency transfer
   - Hospice

13.3 All documentation should follow the individual during transfer to another healthcare setting and relevant members of the extended community care team, including Case Managers and carers should be notified of the transfer.
14. Discharge

14.1 All those relevant to supporting ongoing care needs require being involved in the discharge plan, which will be agreed prior to discharge. Discharge plans will be in place prior to discharge; this should also include the notification of care homes and all those who support the individual’s continuing care needs, including family/carer.

14.2 The Immediate Discharge Letter (IDL) – the individual, community care teams and all partners in care require knowing what the individual and family/carers have been told regarding their condition while in hospital, as well as information regarding medication changes, known and outstanding results and planned follow up.

14.3 A discharge letter should be completed for all individuals discharged from hospital at time of discharge and sent to the GP and other partners in care as appropriate.
15. NHS Continuing Healthcare

15.1 When planning an individual’s discharge, an assessment should take place of that individual’s continuing healthcare needs. If these needs are identified as complex the continuing healthcare criteria and assessment process should be followed.

15.2 NHS Responsibility for Continuing Health Care (CHC) CEL 6 (2008) 

16. Delayed Discharge

16.1 A Delayed Discharge is a hospital patient who has been judged clinically ready for discharge to their next stage of care by the responsible clinician, in consultation with all agencies involved in planning that patient’s discharge, and who continues to occupy the bed beyond the clinically ready for discharge date.

16.2 The individual’s ready for discharge date, but the discharge is delayed due to:
   - Social care reasons
   - Healthcare reasons
   - Patient/carer/family related reasons

16.3 More detailed information on current definitions can be found at: 
http://www.isdscotland.org/isd/5966.html

17. Choice – Care Home

17.1 Where it is identified that an individual will require a care home placement on discharge, the NHS Highland Policy on Choice will apply.

17.2 As there may be a delay in moving from a hospital bed to a care home, individuals will be reviewed by an appropriate member of Social Work staff and placed on a waiting list for a bed in a care home of their choice. They will be asked to name three care homes, and list these in order of preference. They will be asked to consider an interim arrangement e.g. transfer to another care home if there are no vacancies at their care homes of choice.

17.3 All individuals will be transferred to the first available bed that meets the level of care required. While not in the first choice accommodation, an individual’s name will be recorded on a displacement list awaiting transfer.

18. Admission, Transfer and Discharge (ATD) Outcome Pathway

18.1 The ATD outcome pathway on the following two pages is to be used to facilitate discharge planning in all NHS Highland hospital sites. The outcome pathway will also be utilised for audit purposes to allow performance management of the implementation of the ATD policy.
Affix addressograph label below or complete details below:
Name: ____________________________
Address: __________________________
Postcode: __________________________
CHI No: ____________________________
DOB: ______________________________

Consultant: __________________________
Ward: ______________________________

Has agreement for consent for treatment and information sharing been discussed with patient/relatives/carers and other statutory services? Y/N

Time of Admission: ____________________

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>Comments</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient have an Anticipatory Care Plan?</td>
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<tr>
<td>Does the patient have a Welfare Attorney or Welfare Guardianship?</td>
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<tr>
<td>Planned date of discharge</td>
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<tr>
<td>Discharge destination</td>
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</tbody>
</table>
  * At pre Admission
  * on ward
| Actual date of discharge | | | |
| Is the patient a main carer or has a main carer been identified? | | | |
| Notification of Pharmacy Issues | | | |
| Has the patient's initial spiritual care needs been discussed and recorded? | | | |

<table>
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<th>Within 24 Hours of Admission</th>
<th>Comments</th>
<th>Date</th>
<th>Signature</th>
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<tr>
<td>Reason for Admission</td>
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<tr>
<td>Are present admission records and nursing assessment completed?</td>
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<tr>
<td>Is nursing care plan complete and discussed with patient?</td>
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<tr>
<td>Is there a SSA (Personal Outcome Plan) completed or required?</td>
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<tr>
<td>Is it necessary to make contact with or make a formal request to the following services?</td>
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<tr>
<td>GP</td>
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<tr>
<td>Mental Health</td>
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<td>Social Work</td>
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<tr>
<td>Housing</td>
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<tr>
<td>Community Nurse/PHN/AHP’s</td>
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<tr>
<td>Learning Disability</td>
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<tr>
<td>Emergency Out of Hours Adult Support and Protection</td>
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<table>
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<tr>
<th>Checklist</th>
<th>Comments</th>
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<th>Signature</th>
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<tr>
<td>Discussed with patient</td>
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<td></td>
<td></td>
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<tr>
<td>Date:</td>
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<td></td>
<td></td>
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<tr>
<td>Discussed with family/Welfare Guardian/Attorney</td>
<td></td>
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<tr>
<td>Date</td>
<td></td>
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<tr>
<td>Patient leaflets been given out?</td>
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<tr>
<td>When is the patient being discharged?</td>
<td></td>
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</tbody>
</table>
  AM | PM | Evening
| Has transport been confirmed? | | | |
| Own/Relative/Carer | | | |
| Taxi | | | |
| Hospital Transport | | | |
| Ambulance booked on: | | | |
| Patient transport no: | | | |
| Name of staff booking ambulance | | | |
| Patient/family/carer notified | | | |
| Receiving hospital aware of transfer on day of transfer | | | |
  Yes | No | N/A

<p>| Discharge Notification | | | |
|------------------------| | | |
| GP | | | |
| Social Work (if applicable) | | | |</p>
<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Community Nurse/PHN/AHP’s/Community Pharmacist</td>
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<tr>
<td>Mental/Learning Disability Team</td>
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<td>Housing</td>
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<td>Home Care</td>
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<td>Care Home</td>
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<tr>
<td>Inter hospital Transfer</td>
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<tr>
<td>Patient medical notes</td>
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<tr>
<td>Patient original drug kardex</td>
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<tr>
<td>Nursing kardex</td>
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<tr>
<td>Anticipatory Care Plan</td>
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<tr>
<td>Allied Health Professional Letter</td>
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<td></td>
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<tr>
<td>Dietary and nutritional regime</td>
<td></td>
<td></td>
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<tr>
<td>Follow up arranged</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<td>SSA (Personal Outcome Plan) for all Delayed Discharge patients?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>Pre Discharge 24 Hours prior to discharge</td>
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<tr>
<td>Immediate discharge letter initiated?</td>
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<tr>
<td>Date:</td>
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<tr>
<td>Immediate discharge letter completed?</td>
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<tr>
<td>Date:</td>
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<td></td>
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<tr>
<td>Date sent to GP:</td>
<td></td>
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<td></td>
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<tr>
<td>Have medical sundries been ordered?</td>
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<tr>
<td>Is the equipment installed in the patient’s home?</td>
<td></td>
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<tr>
<td>Has the patient been informed both verbally and in writing of their condition and treatment plan?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Day of Discharge</td>
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</tr>
<tr>
<td>Have the patient’s valuables/belongings been returned?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>Has information re nutritional status, special dietary requirements and follow up arrangements been shared with patient/carer and GP?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Has outpatient’s appointment been made?</td>
<td></td>
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<tr>
<td>Has patient’s medication arrived, has this been explained to them or carer/family member and do they have the necessary supply of medication?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Has the carer/community hospital/care home been notified that the patient has left hospital?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Has the patient been given a contact number for post discharge enquires?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Has patient/carer’s information leaflets been given?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Has the patient:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>* clothes</td>
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<tr>
<td>* door key</td>
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<tr>
<td>* heating on in house</td>
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<td></td>
<td></td>
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<tr>
<td>* food in house</td>
<td></td>
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</tr>
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</table>
Roles and Responsibilities

19. Scottish Ambulance Service and other Transport Options

19.1 The Scottish Ambulance Service provides Emergency, Urgent and Planned Transport using both land Ambulance and Air Ambulance resources.

19.2 **Accident and Emergency Ambulance Service:**
Emergency transport is available 24/7 and consists of an Accident and Emergency Ambulance crewed by a Paramedic and Technician although in some cases a Technician and Technician, Paramedic and Driver Grade or Technician and Driver Grade. These resources primarily attend 999 emergency calls as well as GP, NHS 24 and hospital emergency, urgent and planned calls.

19.3 Emergency calls are defined as Category A calls (8 min response time 75% of the time) for life threatening emergency calls such as cardiac arrest, chest pain and breathing difficulties. Category B calls (21 min response 95% of the time) for serious but not life threatening calls such as overdose, maternity etc.

19.4 Urgent and planned transport is ordered by a health care professional within an agreed time frame which the service aims to meet within 95% of the agreed uplift time. These patients should be assessed as requiring clinical care or observation en route otherwise other alternative means of transport should be considered.

19.5 Calls in the majority of NHS Highland are received in the North of Scotland Emergency Medical Dispatch Centre in Inverness and local resources are dispatched using satellite tracking and mobile data communications. In Argyll and Bute calls are received in the West of Scotland Emergency Medical Dispatch Centre in Glasgow and local resources dispatched using satellite tracking and mobile data communications.

19.6 The following numbers should be used by GP and Hospital clinicians:

- North EMDC Emergency line 01463 667564 (stating emergency request)
- West EMDC Emergency line 0141 810 6313
- North EMDC Urgent line 01463 667562 (stating urgent request)
- West EMDC Urgent line 0141 810 6314
- North Planned (routine) 01463 667564 (stating routine request)
- West Planned (routine) 0141 810 6317
- West/North GP Urgent line 0845 602 3999

19.7 **The Patient Transport Service**
The Patient Transport Service (PTS) is for individuals who require transport on medical grounds. Eligible patients are those:
- Where the medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient’s condition or recovery to travel by other means.
- Where the patient’s medical condition impacts on their mobility to such an
extent that it would be detrimental to the patient’s condition or recovery to travel by other means.

19.8 A patient’s eligibility for PTS should be determined either by a healthcare professional or by non-clinically qualified staff who are both:
- Clinically supervised and/or working within locally agreed protocols or guidelines, and employed by the NHS or working under contract for the NHS.

19.9 Useful Link Eligibility Criteria for PTS
www.dh.gov.uk/publications

19.10 Requests for discharge/transfer transport should be made by telephone, or can be booked through the Area Service Office using the appropriate Scottish Ambulance Service (SAS) ordering form.

19.11 The Area Service Office must receive these requests no later than 1200hrs on the day prior to transport (1200hrs Friday for Monday requests).

19.12 Late requests after this time may be accepted if there is space on an appropriate resource.

19.13 Requests for long distance journeys, i.e. outwith the Health Board area, do take longer to plan and organise and usually are handled at a mutually agreed time and may include additional costs.

19.14 The Ambulance Service require information regarding the patient’s mobility and of any other special arrangements (e.g. movement of a terminally ill patient; need for oxygen therapy or wheelchair that may be required). The following list is to assist ward when ordering ambulances.

19.15 **Mobilities**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>“C1”</td>
<td>A patient who requires some help with mobility. Can walk onto ambulance with minimal help, and manage ambulance steps with assistance of 1 person. Can manage steps at home address with some assistance.</td>
</tr>
<tr>
<td>“C2”</td>
<td>A patient who requires help with mobility. Has many stairs at house and requires help of 2 persons. Cannot manage steps of ambulance.</td>
</tr>
<tr>
<td>“WChair”</td>
<td>This is when a patient has their own wheelchair with them at the hospital. This has to be specified at time of booking.</td>
</tr>
<tr>
<td>“Zimmer”</td>
<td>This should be stated at time of booking. A zimmer takes up a space in the ambulance and has to be secured properly.</td>
</tr>
<tr>
<td>“Stretcher”</td>
<td>This is when a patient has to lie down in the ambulance. Ambulance stretchers do not normally go into home addresses. They are fixed trolley cots and cannot be taken to a house with any stairs. The door...</td>
</tr>
</tbody>
</table>
and hallway both have to be wide enough to accommodate the stretcher. If a patient has to travel lying down, and the home address does not accommodate the stretcher, they will have to transfer in the street. The stretcher comes out of the ambulance and the crew will lift the patient onto a chair. This is obviously not an ideal situation, and in these cases it should be considered for the patient to travel in a chair, especially if it is for a short journey.

“Palliative” It should be stated at the time of booking if the patient is receiving palliative care. Points to be considered are if patient can travel comfortably in chair, as to transfer the patient can be distressing for the patient. It also has to be stated if ward requires the patient to be put into either a bed or a chair in the house, and whether this would be upstairs or downstairs.

“I.D.” Ambulance Service requires to know if patient is being barrier nursed i.e. airborne MRSA, C Diff. We have to know if the patient has to travel alone, in order for us to plan correctly, and for vulnerable patients not to be put onto an ambulance with a patient with MRSA.

“Oxygen” This should be ordered at time of booking, and how many litres of oxygen are required. Patients requiring oxygen therapy will travel in a two manned ambulance.

“Luggage” Luggage should be kept to a minimum. i.e. 1 bag per patient maximum, as this takes up space in the ambulance and can be difficult to secure.

“Keys” Before the patient has left the ward, it should be checked if the patient has family in the house, or has keys for their house.

“Drugs” Patients medication must be ready for the patient’s ambulance arriving. If the patient is being transported early the ward will be informed, however, as a rule the patient should be ready to travel from 1000 onwards, unless it has been stated at time of booking the reason for any delay.

19.16 The following telephone numbers should be used:
Area Service Office (Raigmore) 01436 667566
Area Service Office (Vale of Leven - for Argyll) 0141 810 3512
Area Service Office (Inverclyde - for Cowal and Bute) 0141 810 3511
Area Service Office Supervisor 0141 810 3510

19.17 Air Ambulance
The Scottish Ambulance Service operates two helicopters 24/7 based in Inverness and Glasgow along with two 24/7 fixed wing planes based in Glasgow and Aberdeen.

19.18 Air Ambulance missions should be initially triaged by GP’s and hospital clinicians and these resources used appropriately. The service has introduced a Triage and Tasking Standard Operating Procedure with additional clinical decision making
involving paramedic advisors and air wing managers. Whenever possible patients should be transported by road.

19.19 Any of the EMDC’s will take requests for air ambulance transport although the National co-ordinating centre (air desk) in the West of Scotland EMDC will co-ordinate all missions. Air ambulance transport should be requested through the numbers listed dependent upon the clinical urgency of the patient.

North EMDC Emergency  01463 667564 (stating emergency request)
West EMDC Emergency  0141 810 6313
North EMDC Urgent    01463 667562 (stating urgent request)
West EMDC Urgent    0141 810 6314

19.20 The Scottish Ambulance Service is not the only means of transporting an individual between hospitals, clinics or home; unless their medical condition dictates that ambulance transport is required. Family, friends and the numerous volunteer transport schemes throughout Argyll and Bute should be considered as viable and possibly preferable alternatives.

19.21 The Health Care Transport Framework states “Under the Transport (Scotland) Act 2005, Regional Transport Providers have a legal requirement to develop a Regional Transport Strategy for their area which, as well as identifying accessibility, environmental, social and economic objectives, should seek to facilitate access to hospitals and other healthcare facilities. These strategies will identify current transport gaps and opportunities within each Health Board and provide a mechanism to deliver and monitor these objectives. The Regional Transport Strategies (Health Boards) (Scotland) Order 2006 places a statutory duty on each Health Board to, so far as possible, perform their functions and activities consistently with the Regional Transport Strategies in their area”

19.22 Some Useful Numbers

Red Cross Scotland HQ      0141 891 4000
Red Cross Highlands       01463 231 620
Red Cross Argyll and Bute 01546 602 386
SPT                        0141 332 6811
HiTrans                    +44 (0) 1667 460 464
20. Pharmacy

20.1 • Ensure safe, effective and appropriate use of medicines by individual/carer through explanation and education.
• Assess and advise ability of individuals/carers to comply with prescribed drug regime.
• Ensure individuals have timely access to appropriate medication prior to discharge.
• Ensure arrangements are in place for continued supply and monitoring of medication.
• Provide information to Primary Care Team to enable ongoing monitoring of medication where required.

20.2 Medication is an important part of an individual’s stay in hospital and input by pharmacy is required throughout the admission. Pharmacy has a role in medicine reconciliation, monitoring and education during admission and on discharge. The section below outlines the roles of staff in medicine reconciliation and the more specific input by pharmacy at the end.

20.3 Medicine Reconciliation
Medicines reconciliation will help ensure that all intended medication is given, all unintended medication is avoided and the information transferred is accurate and contemporaneous.

20.4 Aims of medication reconciliation process:
• To obtain, and verify, an accurate medication history for all adults on admission to hospital.
• To maintain a contemporaneous record of current medicines and the reasons for additional, discontinuation or alternative of the individual’s medicines during the inpatient stay.
• To provide accurate information of current medicines prescribed, including any changes, upon transfer of care e.g. GP/patient/carer upon discharge.

20.5 Role of the Prescriber (to include medical staff and non medical prescribers)
• To take a full, accurate medication history at the point of medical assessment on admission (including viewing Emergency Care Summary (ECS) for those who are unscheduled admissions).
• To communication with the individual/carer with regard to their usual medicines to ensure that there are no discrepancies between the information obtained from the information sources and the individual/carer.
• To establish an allergy status and record this on the medication chart and on the alert sheet in the medical notes as per NHS Highland policy.
• Only prescribe once the medication history is complete and accurate as doing so without this information is potentially hazardous.
• To document the reasons for any alternation in dose/frequency or for discontinuation of medication on admission in the individual’s notes.
• To maintain accurate, contemporaneous records for the additional/discontinuation/alteration of any medicines during the individual’s in patient stay within the individuals’ notes.
• To document any change/discontinuations/additions of medicines on the
individual’s discharge summary, using the individual notes as a guide.

20.6 Role of the Pharmacy Team
- To verify the medicines reconciliation process has been undertaken by the prescriber as soon as possible after the individual’s admission to hospital. This is normally within the first working day following admission.
- To ensure the medication history is complete and clinically coherent.
- To ensure the medication written on the current inpatient prescription and administration record matches that of the medication history, where appropriate.
- To ensure any discrepancies are documented appropriately in the individuals’ notes.
- To clarify any undocumented discrepancies with the prescriber.
- To confirm and document allergy status, where appropriate.
- To record any information obtained in the individual’s notes.
- To inform the prescriber of any discrepancies detected.
- To confirm and document allergy status, where appropriate.
- To educate patients (or carers) about their medication.
- To make any arrangements required for continuity of medication supply and monitoring in next sector of care.

20.7 Role of the Nursing Staff
- To highlight to a member of the medical or pharmacy team if they recognise any discrepancies between the inpatient prescription and administration record and the individual’s regular medication.
- To ensure any information obtained is documented in the individual’s notes.
- To ensure allergy status has been confirmed and documented on the front of the inpatient prescription and administration record prior to administration of any medicines (unless in an emergency situation).
- To ensure any medicines prescribed are appropriate, after considering any allergy status.

20.8 Interventions by pharmacy have been shown to improve the process; however, the service is not available in all areas. Therefore in the absence of pharmacy input, the role should be carried out by medical or nursing staff.

20.9 Communicating medication changes at discharge or transfer
All significant changes to the medication that have occurred during an individual’s stay, including medicines stopped on admission must be recorded in the discharge summary with reasons for those changes. This information is obtained from the individual’s notes and, where applicable, the inpatient prescription.
21. Hospital Medical Staff

21.1 Confirms that a medical diagnosis supports the admission to hospital.
• As soon as possible, discuss a planned date of discharge with individuals, staff and family/carers. Note this clearly by the individual’s bed and review in accordance with medical needs.
• Identify and document a medical treatment plan.
• Should this include Referral to multi disciplinary team (MDT) for any assessment required?
• Where appropriate, in consultation with the multi disciplinary team, agree the clinically ready for discharge date.
• Ensure full compliance with the immediate discharge document, SIGN 65 with full discharge information available within 7 days of discharge.
• Involve the individual and where appropriate, family/carers in decision making regarding the future care of the individual in conjunction with other agencies.
• Advise the potential length of stay in hospital and ensure this is communicated to relevant team members.
• Ensure take home prescription is ready to ensure 24 hours minimum readiness.
• Complete an advance care plan to indicate further treatment required.
• Anticipated discharges should be communicated in advance to individual’s registered practice and the management plan regarding what the GP and other primary care professionals roles are should be clearly communicated.
• Ensure family/carers are informed of the information/training/advocacy available to support them in their caring role and advise them of their right to request a Carer’s Assessment.

21.2 Effective ATD management requires input from a range of people from health, social care, housing and carers at different stages in the discharge management process.
22. Named Nurse/Lead Professional/Single Point of Contact

22.1

- Notify relevant services of the admission.
- Check whether an Anticipatory Care Plan is in place and obtain a copy of the plan from the Primary Care Team if it has not accompanied the individual on admission.
- Collate all necessary information and commence the process of planning for discharge within 24 hours of admission.
- Act as an advocate for vulnerable individuals for whom early discharge is inappropriate.
- Coordinate the process of discharge management on behalf of the multi disciplinary team.
- Discuss goals/intended outcomes for transfer/discharge with the individual and family.
- Ascertain whether the individual requires to undertake self care of technical tasks e.g. care of catheter.
- Ascertain if the individual can manage to undertake any technical task competently and safely. If not, ascertain whether a family member/carer is willing to carry out the task with appropriate training.
- Consider whether telehealthcare equipment might support self care on discharge and refer to relevant service in local area.
- When required, discharge planning meetings should be organised to ensure key individuals including the individual, their family/carer are present and involved in the decision making process and that their views and wishes are taken into consideration and that a Lead Professional is identified, particularly when complex needs have been identified.
- Ensure effective communication is undertaken adhering to the information sharing protocols with internal and external agencies.
- Whilst working with multi agency team members, and/or significant others, which includes unpaid carers as partners, the individual will be fully involved in the decision and planning process and intended outcomes. These will be agreed, with roles and responsibilities for achieving progress clearly stated.
- Ensuring that a comprehensive discharge summary is completed reflecting the agreed intended outcomes. Roles and responsibilities of each person involved in the plan for progressing the outcomes and a single point of contact responsible for monitoring and reviewing the outcomes once discharge plans have been implemented.
- If the person requires an ambulance home, ensure that the appropriate level of transport is ordered within the specified timeframe.
- Ensure the checklist for effective discharge planning is completed.
- Ensure family/carers are informed of the information/training/advocacy available to support them in their caring role and offer carers an assessment of their support needs e.g. Carers Plan.
23. Senior Charge Nurse

23.1  
- Ensure a named nurse/Lead Professional is identified to the individual and family/carer on admission.
- Support the multi disciplinary team in discharge management and continuity of care, facilitating discharge planning where this is likely to be complex.
- Where requested by the multi disciplinary team support the named nurse/Lead Professional to organise discharge planning meetings involving individual, carer and all relevant agencies to ensure complex needs are addressed and to facilitate a safe discharge.
- Liaise with community teams and ward staff to facilitate smooth safe transfers.
24. Allied Health Professionals

24.1 Allied Health Professionals (AHP) carry out the assessment and intervention as part of the multi disciplinary team. Assessments will be conducted at the earliest opportunity.

24.2

- Where appropriate act as the Lead Professional for individuals
- The AHP will participate in the planning of a discharge date in consultation with the individual, family/carer and the multi disciplinary team.
- Treatment plans will be communicated through documentation and clear communication routes within the multi disciplinary team.
- Advice, information and training will be given to the individual, and where appropriate, to their family/carers.
- Ensure family/carers are informed of the information/training/advocacy available to support them in their caring role and advise them of their right to request a Carer’s Assessment
- Any requirement for ongoing intervention by AHP staff will be communicated to the appropriate services and clearly documented in the individual’s notes.
- Where it is necessary for individuals to be provided with aids, minor adaptations or equipment to facilitate discharge or transfer, AHP staff will assess and arrange for this to be provided and train individual/family/carer/representatives as appropriate.
- Where necessary a home visit will be conducted with the appropriate team members, prior to discharge to assess the safety of the home environment and advise/arrange any equipment, appliances or adaptations that may be necessary for appropriate safe activities of daily life or manual handling requirements.
25. The Dietitian

25.1 All individuals discharged from NHS Highland hospitals should have their weight, height and BMI recorded along with a Malnutrition Universal Screening Tool (MUST) score in their discharge documentation. If they require nutritional supplements they should have 7 (10 days maybe required in some areas) days supply prescribed to take with them along with any appropriate nutritional information that relates to their diagnosis.

25.2 Individuals who have complex feeding needs, and are fed via an enteral feeding tube i.e. PEG, will require to have height, weight, BMI and MUST score recorded in their documentation. Individuals transferred to NHS hospitals or care homes should be cared for by the staff in these establishments who have had the appropriate level of training and support. The transfer should be planned in advance and every care taken that everything is in place for the individual before they are transferred or discharged. A comprehensive hand over should be given by the transferring ward before discharge.

25.3 All equipment and 7-10 days (depending on the area they are going to), supply of feed will go with the individual on discharge and written information required for the staff/patient/carer to ensure safe ongoing nutritional support.

25.4 Individuals who are going home on Total Parenteral Nutrition (PN) will be cared for by BUPA in North Highland. Individual patient arrangements will be made for those being discharged to Argyll and Bute CHP. Planning for discharge on PN should start at the earliest available opportunity. This should be organised from the discharging hospital and everything in place before the discharge date.
26. The Community Nurse

26.1 Community nurses work at the interface of health and social care delivery, in partnership with individuals, carers and other health care professionals including statutory, voluntary and private agencies.

26.2 Referrals are taken from all sources but can only be accepted for individuals who have a nursing need that requires the assessment of a qualified nurse and nursing care under the direction of a qualified nurse.

- The community nurse will assess, plan, implement and evaluate nursing care to meet the needs of the individual and family/carers in the community.
- Referral on to all appropriate services/agencies e.g. social work department, Marie Curie, physiotherapy, day care etc.
- Provide information, advice and support to family/carers and advise them of their right to request a Carer’s Assessment.
- It is important that the community nurse is involved as soon as possible, especially for individuals who have complex care and/or palliative care needs. The community nurse is the lead practitioner for all individuals with palliative care/terminal care needs.
- Following admission to hospital, communication and involvement between the community nurse and receiving ward or discharge coordinator will alert staff to the care the individual was receiving at home or concerns about future care which may include telehealthcare monitoring.
27. Discharge Planning for Palliative Care Needs

27.1 For discharge planning and palliative care there will be two groups – those going home for end stage palliative care and those at an earlier stage in the disease process. The process will be similar but there may be more urgency for people who are the end stage of their disease and it may not be possible for every detail to be completed. Risk assessment should be part of the process but should not prevent the discharge unless risk is severe. Discussion with the family to support them in accepting possible risks will be required.

27.2 Marie Curie resources may be utilised to assist with discharge where available.

27.3 Seek assistance from relevant Clinical Nurse Specialist (CNS) who may know the family very well – cardiac/respiratory/MacMillan/stroke.

27.4 Community nursing staff working with ward staff and AHP’s agree the allocation of tasks to ensure responsibility taken for completing task. This is recorded in discharge plans.
- Discuss with family and secure their assistance, agree date to aim for, check suitability of house.
- Book equipment and arrange delivery.
- Discharge drugs; consider changing need for routine medication.
- Just incase drugs either from hospital or community, if end stage terminal care.
- Inform GP and CNS of discharge, if not already involved.
- Register individual with Marie Curie service if individual agrees. Request service if needed immediately.
- Request to social work teams – priority DS 1500.
- Complete special alert for Out of Hours – tell individual special alert on if they need to contact NHS 24.
- Anticipatory Care Plan information shared.
- End of life plan completed if dying.
- Commence Liverpool Care Pathway in hospital – documentation should go with individual.
- Arrange first community visit following discharge – inform family.
- Give contact information for District Nurse, GP and CNS.
28. Community Based Professionals focused on Rehabilitation/Reablement

28.1 Where possible all assessment and intervention will take place in the community/home environment. The Professional will:

- Where appropriate act as the Lead Professional for individuals on their caseload.
- Assess, plan and provide interventions which will meet the needs of the individual and will be driven by goals set in collaboration with the individual/carer/family.
- Provide information, advice and support to family/carers and advise them of their right to request a Carer’s Assessment
- Ensure effective communication in relation to ATD with internal and external agencies is undertaken verbally and in writing, this may include, hospital teams, GP, District Nurses and Social Work Services.
- Notifying relevant services of the ATD plan for the individual and assist in planning this.
- Ensuring all aspects of individual's ATD are communicated to all involved.
- Ensuring a safe transition for the individual from home to hospital or other care provision.
- Where admission to hospital is necessary, communicate with the receiving ward or discharge coordinator and alert staff to the care the individual was receiving at home or concerns about future care.
- Treatment plans will be communicated through documentation and clear communication routes within the MDT.
- Any requirement for ongoing intervention by AHP staff will be communicated to the appropriate services and clearly documented in the individual’s notes.
- Ensure that a discharge summary is completed which will indicate goals attained by the individual.
29. General Practitioner

29.1 General Practitioners (GP) work in a multi disciplinary primary health care team which is progressively being extended to become an integrated extended community team. Their role is pivotal in ensuring that individuals move effectively through the healthcare system and that there is clear informed communication between all aspects of the system within primary and secondary care.

- Be aware of and use alternatives to admission to hospital that are available in the locality.
- Identify the appropriate care pathway and best practice guidance for managing the individual’s condition.
- Identify availability of any previously agreed Anticipatory Care Plan and if none is available to identify the need for the development of one. There should be clarity regarding the individual’s referral routes.
- Ensure Emergency Care Summary updated with correct medications and Out of Hours information is regularly updated.
- The GP along with the Primary Care Team will assess, plan and provide care to meet the needs of the individual in the community.
- Provide information, advice and support to family/carers and advise them of their right to request a Carer’s Assessment.
- Ensure follow up review of an individual is agreed and where this should be carried out.
- The GP will often be the clinical Lead Professional for, individuals who have long term conditions, complex care and/or palliative care needs.
- Where admission to hospital is necessary, communication with the receiving ward to alert staff to the care the individual was receiving at home or concerns about future care.
30. Social Work Service

30.1 Social Work Service (SWS) are responsible for coordinating with other parties to ensure that the assessment of care needs is completed, working with both primary and secondary care teams and the voluntary sector as appropriate and ensuring that the views of the individual and their family/carers are at the centre at all times. They will utilise the assessment to complete appropriate care plans and provide or commission the relevant service as agreed.

- They will, where appropriate, make the arrangements for a community care assessment to be carried out by the most relevant worker/agency as appropriate to the service user’s needs and circumstances.
- Ensure the community care assessment is completed within the agreed timescale.
- Liaise with multi disciplinary healthcare team and agree on the need and timing for case conferences, agreed on contact with the family and familiarise all concerned with the current demands and pressures on the service.
- Where care needs are assessed identify appropriate resources according to locally agreed criteria and make arrangements for provision to facilitate discharge within an agreed timescale in consultation with the individual, their family and service providers.
- Ensure family/carers are informed of the information/training/advocacy available to support them in their caring role and advise them of their right to request a Carer’s Assessment.
- Document any unmet needs with appropriate interim measures.
- The Local Authority will have the lead responsible for Adult Support and Protection and for Adults with Incapacity Act, working closely with other agencies as appropriate.
Policy context

The main **National Guidance Documents** regarding Admissions Transfer and Discharge protocols are listed below:

**Community Care Needs of Frail Older People: Integrating Professional Assessments and Care Arrangements SWSG 10/98**  
http://www.scotland.gov.uk/library/swsg/index-f/c216.htm

**Delayed Discharges in Scotland Report**  

**Choice of Accommodation – Discharge from Hospital**  

**Framework for the Production of Joint Hospital Discharge Protocols**  

**The Planned Care Improvement Programme; Individual Flow in Planned Care; Admission, Discharge, Length of Stay and Follow-up**  
http://www.scotland.gov.uk/Publications/2007/09/13094244/0

**NHS Responsibility for Continuing Health Care (CHC) CEL 6 (2008)**  

**Scottish Executive Response to the Care 21 Report, HDL 22/2006: Guidance on NHS Carer Information Strategies**  

**Prevention of Homelessness Guidance – June 2009**  
http://www.scotland.gov.uk/Publications/2009/06/08140713/0

**NHS QIS - Promoting Access to Healthcare for People with a Learning Disability - Best Practice Statement**  
http://www.nhshealthquality.org/nhsqis/2175.html

**NHS QIS – Admissions to Adult Mental Health Inpatient Services – Best Practice Statement**  
http://www.nhshealthquality.org/nhsqis/5688.html

**Adults with Incapacity (Scotland) Act 2000 – Part 5 (Medical Treatment and Research) Code of Practice**  
http://www.sehd.scot.nhs.uk/mels/CEL2010_34.pdf

**Adult Support and Protection (Scotland) Act 2007 Code of Practice**  

**A Guide to Named Persons**  
A number of **Local documents** have been produced including Highland and Argyll and Bute Single Shared Assessments, Carers and Young Carers Assessments, and Community Care Assessments. Management guidance is a key component of the discharge process. The SSA (Personal Outcome Plan) is available from the appropriate Local Authority and provides full details of the procedures to be followed regarding the assessment of care needs, the care planning process and how to access the care services in the community. In this context, the SSA (Personal Outcome Plan) to be the agreed process to be followed when planning discharge from hospital where the individual will need support in order to return home or to another community setting (and consent).

Other key documents include the following:
- Carers Strategy
- Pre-admission clinics
- Young Carers Strategy
- Anticipatory Care Assessment
- Telehealthcare Strategy
- Long Term Care Strategy and
- Other key local documentation

**Local Resources**

**NHS Highland and Highland Council Assessment of Capacity Guidelines**

**NHS Highland and Highland Council Adults with Incapacity (Scotland) Act 2000 Medical Treatment and Research Guideline**
http://www.highland.gov.uk/socialwork/olderpeopleservices/adultswithincapacity/medtreatmentandresearch.htm

**Record Keeping in NHS Highland**

**Highland Data Sharing Partnership Information Sharing Policy**
Argyll and Bute Council
http://www.argyll-bute.gov.uk/content/socialworkservices/3282484

Highland Council
http://ntintra1/cx/infomanagement/hdsp/index.htm

**NHS Highland**
The Adults with Incapacity (Scotland) Act 2000 (AWIA)

The Adults with Incapacity (Scotland) Act 2000 (AWIA) provides a legal framework for decision making for those who lack capacity. Part 5 of AWIA deals with medical treatment and research and specifies the steps that must be taken to lawfully treat adults who do not have capacity to consent to medical treatment themselves. AWIA defines capacity as being present when an adult over the age of 16 is incapable of:

1. Acting; or
2. Making decisions; or
3. Communicating decisions; or
4. Understanding decisions; or
5. Retaining the memory of decisions

By reason of mental disorder or inability to communicate because of physical disability, may be deemed to lack capacity, even if only one of the above applies.

The medical practitioner primarily responsible for the care of the person with incapacity has the duty to complete a certificate stating the person is incapable of consenting to the treatment proposed, more than one treatment can be covered if a treatment plan is attached to the certificate. Guidance around the assessment of capacity is available here. The medical practitioner must apply the principles of AWIA in deciding whether to grant the authority to treat the adult. If the person has a proxy (Welfare Guardian or Welfare Attorney) with powers to consent to medical treatment then the proxy may consent to treatment on the person’s behalf. An incapacity certificate must still be completed by the medical practitioner even if a proxy has given consent. The medical practitioner must consult with other people who have interest in the welfare of the person, if it is reasonable and practicable, and take into account their views prior to make decisions around treatment.
Appendix 3

Glossary

Housing

Role of the Housing provider

Private rented landlords and both the Councils and the Housing Associations mentioned in this document are landlords.

The role of the landlord is to allocate any vacant property, collect rent, ensure repairs (as agreed in the tenants lease) are carried out and the property is safe to live in. The tenant has a right to have reasonable repairs done to his/her property.

The tenant is the person named on the lease. In accepting a tenancy the tenant has responsibilities, these include ensuring the rent is paid on time and the property is kept in good condition. The tenant can if they are eligible claim Housing Benefit (Council or Housing Association House) or Local Housing Allowance if the property is rented from a private landlord. It is the tenant’s responsibility to complete the relevant forms to claim Housing Benefit or Local Housing Allowance and to provide all the verification documentation required for these forms to be processed.

Both Highland and Argyll and Bute Councils have a duty to accept and assess homeless applications.

Therefore if there are issues with an existing tenancy the appropriate landlord should be contacted.

If a tenant believes there are medical issues affected by their housing situation they can apply for alternative housing. The Housing Medical Service can provide an assessment of the applicants housing needs. In both the Highland Council and Argyll and Bute Council areas, this assessment is carried out by an Independent Housing Medical Adviser based within the Public Health Directorate of NHS Highland.

If an individual will not have a home to go to on discharge from hospital they should be referred to either Highland or Argyll and Bute Councils (depending on where they stay) at the earliest opportunity so that arrangements can be made for them on discharge. It is likely that temporary accommodation will be made available to them initially.

Someone is homeless under section 24 of the Housing (Scotland) Act 1987 Act if he or she has no accommodation in the United Kingdom or elsewhere which he or she (together with any person who normally resides with the applicant as a family member, or in circumstances in which the Local Authority considers it reasonable for that person to reside with the applicant) is entitled or permitted to occupy in one of the following ways:

- Is entitled to occupy by virtue of an interest in it (for example as an owner or tenant) or by virtue of a court order.
- Has a right or permission, or an implied right or permission, to occupy (for example as a lodger or an employee with a service occupancy) or
• He or she cannot secure entry to it.
• An attempt to continue living in the accommodation would be likely to be met with violence or threats of violence likely to be carried out from someone else living in it, or from someone who previously lived with the applicant, whether in their present accommodation or somewhere else.
• He or she has a mobile home, caravan, houseboat or other moveable structure but has no place where he or she is entitled or permitted both to put it or moor it and to live in it.
• The accommodation is both overcrowded to the extent that it may endanger health.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>a process whereby the needs of an individual are identified and their impact on daily living and quality of life evaluated.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidable admission</td>
<td>admission to an acute hospital, which would be unnecessary if alternative services were available.</td>
</tr>
<tr>
<td>Care management</td>
<td>a process whereby an individual’s needs are assessed and evaluated, eligibility for services is determined, care plans drafted and implemented, and needs are monitored and reassessed.</td>
</tr>
<tr>
<td>Care manager</td>
<td>a practitioner who, as part of their role, undertakes care management.</td>
</tr>
<tr>
<td>Care package</td>
<td>a combination of services designed to meet a person’s assessed needs.</td>
</tr>
<tr>
<td>Care pathway</td>
<td>an agreed and explicit route an individual takes through health and social services.</td>
</tr>
<tr>
<td>Care planning</td>
<td>a process based on an assessment of an individual’s needs that involves determining the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved.</td>
</tr>
<tr>
<td>Care programme approach</td>
<td>the formal process (integrated with care management) assessing the needs for services for people with severe mental health problems.</td>
</tr>
<tr>
<td>Carer</td>
<td>should be understood to mean someone who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help.</td>
</tr>
<tr>
<td><strong>Delayed Discharge</strong></td>
<td>a hospital inpatient, who is clinically ready to move on to a more appropriate care setting but is prevented from doing so for various reasons.</td>
</tr>
<tr>
<td>----------------------</td>
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<tr>
<td><strong>Independent sector</strong></td>
<td>includes both private and voluntary organisations</td>
</tr>
<tr>
<td><strong>Multidisciplinary</strong></td>
<td>when professionals from different disciplines, such as social work, nursing and therapy, work together</td>
</tr>
<tr>
<td><strong>Multidisciplinary assessment</strong></td>
<td>an assessment of an individual’s needs that has actively involved professionals from different disciplines in collecting and evaluating this information.</td>
</tr>
<tr>
<td><strong>Palliative care</strong></td>
<td>can be for patients with any life limiting diagnosis and can in fact be required for many years. End of life care may include the last few weeks to months of a person’s life.</td>
</tr>
<tr>
<td><strong>Planned Date of Discharge (PDD)</strong></td>
<td>following assessment, this is the predicted date when the patient could leave hospital or move to a more appropriate service.</td>
</tr>
<tr>
<td><strong>Ready for Discharge Date</strong></td>
<td>the date on which the patient is clinically ready to move on to the next stage of care</td>
</tr>
<tr>
<td><strong>Rehabilitation</strong></td>
<td>Is a process of aiming to restore personal autonomy to those aspects of daily live considered most relevant by patients or service users, their family or carers.</td>
</tr>
<tr>
<td><strong>Enablement</strong></td>
<td>Is an umbrella term covering a continuum of services from prevention through reablement, intermediate care, rehabilitation to ongoing/long term care services. It is concerned primarily with support of someone’s ability to live independently and the functions of daily living for themselves.</td>
</tr>
<tr>
<td><strong>Reablement</strong></td>
<td>Is one element within an enabling or promoting independence approach. It is time limited and is concerned with the restorations of these functions and requires teams to have skills in assessment and goal setting</td>
</tr>
<tr>
<td><strong>Zero delay</strong></td>
<td>is defined as a patient whose ready-for-discharge date is within 3 working days from the census date.</td>
</tr>
<tr>
<td>Housing Association Landlords Contact Details</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Albyn Housing Society Ltd</strong></td>
<td><strong>Cairn Housing Association Ltd</strong></td>
</tr>
<tr>
<td>• Head Office, 98-100 High Street, Invergordon, IV18 0DL</td>
<td>• Cairn House, 30 Waterloo Place, Inverness, IV1 1NB</td>
</tr>
<tr>
<td></td>
<td><strong>Phone</strong>: 01349 852978</td>
</tr>
<tr>
<td></td>
<td><strong>Phone</strong>: 01463 712516</td>
</tr>
<tr>
<td></td>
<td><strong>Phone</strong>: 01397 702530</td>
</tr>
<tr>
<td><strong>Lochaber Housing Association Ltd</strong></td>
<td><strong>Lochalsh &amp; Skye Housing Association Ltd</strong></td>
</tr>
<tr>
<td>• 101 High Street, Fort William, PH33 6DG</td>
<td>• Morrison House, Bayfield, Portree, Isle of Skye, IV51 9EW</td>
</tr>
<tr>
<td></td>
<td><strong>Phone</strong>: 01397 702530</td>
</tr>
<tr>
<td></td>
<td><strong>Phone</strong>: 01397 702530</td>
</tr>
<tr>
<td><strong>Pentland Housing Association Ltd</strong></td>
<td><strong>Hanover (Scotland) Housing Association Ltd</strong></td>
</tr>
<tr>
<td>• 37/39 Traill Street, Thurso, KW14 8EG</td>
<td>• 95 McDonald Road, Edinburgh EH74NS</td>
</tr>
<tr>
<td></td>
<td><strong>Phone</strong>: 01847 892507</td>
</tr>
<tr>
<td></td>
<td><strong>Phone</strong>: 0131 557 0598</td>
</tr>
<tr>
<td><strong>Key Housing Association Ltd Savoy Tower</strong></td>
<td><strong>Link Housing Association Ltd</strong></td>
</tr>
<tr>
<td>• 77 Renfrew Street, Glasgow G23BZ</td>
<td>• Watling House, Callendar Business Part, Falkirk FK1 XR</td>
</tr>
<tr>
<td></td>
<td><strong>Phone</strong>: 0141 332 6672</td>
</tr>
<tr>
<td></td>
<td><strong>Phone</strong>: 0845 140 0100</td>
</tr>
<tr>
<td><strong>Margaret Blackwood Housing Association Ltd</strong></td>
<td><strong>Trust Housing Association Ltd</strong></td>
</tr>
<tr>
<td>• Craigievar House, 77 Craigmount Brae, Edinburgh EH12 8XF</td>
<td>• 12 New Mart Road, Edinburgh EH14 1RL</td>
</tr>
<tr>
<td></td>
<td><strong>Phone</strong>: 0131 317 722</td>
</tr>
<tr>
<td></td>
<td><strong>Phone</strong>: 0131 444 1200</td>
</tr>
</tbody>
</table>
Appendix 5

Admission, Transfer and Discharge Group Members
Argyll and Bute Council
Michelle Armour
Margaret MacGregor
Ronnie McIlquham
Susan Spicer
Pat Trehan
Douglas Whyte

The Highland Council
Ivor Forsyth
Margaret Laird
Bob Silverwood
Eunice Wilkie
Larry Wilmot
Janice Wilson

NHS Highland
Jan Baird
Margaret Brown
Maggie Clark
Annelise Dickie
Jonathan Gray
Hilda Hope
Alison Hudson
Theresa James
Una Lyon
Alexa MacAuslan
Alison Mackay
Christine Norval
Kate Patience Quate
Shirley Ritchie
Christina West
Diane Woodward

Voluntary Organisations
Marie Close
Marion MacNeil
Tricia Morrison
Sheena Munro
Frances Nixseaman

Scottish Government
Jane Davidson

Scottish Ambulance Service
R Downie
Garry Fraser
D Mochrie
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