STAFF PLANNING

Planning for hospital discharge to interim care

In partnership with the adult social care sector, we have produced this guidance for providers who may have people who have left hospital temporarily moving into their setting until their care packages are ready, and they can return home. It includes good practice examples and helpful checklists to support care home staff to plan care and support for the person during their stay.

Practice examples

"We use a hospital discharge checklist to ensure everything is in place before someone leaves hospital."

"We assessed a person to be discharged from hospital but found that we could not safely meet their needs and so did not agree to proceed as this would have been a poor experience for the individual."

"We encourage independence as much as possible to support people to maintain their skills."

"We have a proactive review timetable to ensure needs are identified and met and future plans progress."

"The person's confidence and physical wellbeing improved while in the care home, and they were able to return home when a package of care was sourced."

"Mr Stuart moved into the care home. The staff talked to him about his needs and wishes. They did lots of check-ups, like how healthy his skin was, using a Waterlow Assessment. They checked his weight and how far he could walk using his walking frame. They looked at his risk of falling, which was high.

"Together, Mr Stuart and the staff set some goals that he wanted to achieve. The big one was to get home, but there were lots of little goals to help him get there. This included risk enablement, where everyone recognised the risk of falling, but balanced that with the importance of promoting independence. Ways to reduce the risks were put in place, like only walking with the walking frame initially. But everyone recognised that to get stronger, Mr Stuart needed to walk as much as he could, and this meant staff wouldn't always be with him.

"The staff organised a review and asked him who he would like to attend. New goals were agreed at the review and Mr Stuart felt closer to his ultimate goal of getting home."

"The lady was determined to go home as she had a dog. She enjoyed being in the care home and found this a more homely environment to recover following being in hospital but remained determined to go home. Once the assessment of her home was carried out, she was able to successfully return home. This was achieved because clear plans were in place."

"We have developed a protected telephone call time that suits the hospital ward and care home so that plans and so on can be discussed with the right people."

Reduce the risk of spread of infection - be outbreak ready

Everyone, including care services, should continue to take measures to minimise the risk of transmitting any infection including Covid-19. We encourage everyone to do their part and use the tools and guidance currently in place to minimise and manage the risk of infection and any associated infection outbreaks to minimise risk to those using the service, visitors and staff.

Read the National Infection Prevention and Control Manual for more information

Supporting people working in social care

We worked together with partners in the adult care sector to support you with this information about staffing. We recognise all that you do in looking after people experiencing care and keeping their families involved and updated. It is important to look after each other.

Visit the Wellbeing Hub for more information

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Ideas for maintaining independence during the placement

- Everyone has different needs and these should be reflected in their care plans.
- Consider self-medication facilities if the person will have this responsibility at home.
- Encourage and support the person to follow the same routines and engage in the same activities they would at home.
- Encourage people to restart community connections. For example, facilitate the person attending day care services or clubs and so on.
- Support the person to continue their normal contact with friends, family and carers.
- Implement Open with care guidance.

Admissions assessment

- Conduct a multi-disciplinary assessment of need prior to someone being discharged from hospital with goals identified and how these can best be supported by the care service.
- Consider if the person's needs can be met and put a clear plan in place.
- Look at what the risks are and how can these best be mitigated.
- What is the legal basis for the move- Power of Attorney or Welfare Guardian? Obtain evidence that informed consent to the placement has been given.
- Ensure that the person or their representative understands the nature of the placement and what to expect from the care home.
- Involve the person and their carer, family and friends, where appropriate.

Coming into the care home and going home

- Use a checklist – this should include pre-transfer information which must be received before the person moves to the care home.
- Accessing personal belongings, medication, aids and adaptations including communication and walking aids.
- Produce an inventory of personal belongings and clothing.
- Make sure that the care plan and medication records are available and transferred. This should be arranged prior to the move or taken to the care home by the person.

Reviews and communication

- Agree a timeline in advance to make sure regular reviews take place. These reviews will ensure that the person's needs continue to be met.
- Provide opportunities to discuss the placement and ensure outcomes are being met.
- Facilitate the person's contact with any professionals, including advocacy.
- Support the person to receive regular updates about their care.

Useful links

https://www.nes.scot.nhs.uk/ https://www.careinspectorate.com/ https://www.cosla.gov.uk/