Escort, Transfer and Discharge Policy

Introduction

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as ‘we statements’, they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes (EFH) will commit to the following quality statements for:

Learning culture

We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Safe systems, pathways and transitions

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Safeguarding

We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people’s lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Involving people to manage risks

We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

Safe environments

We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

Safe and effective staffing

We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people’s individual needs.

Medicines optimisation

We make sure that medicines and treatments are safe and meet people’s needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

Assessing needs

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, well-being and communication needs with them.

How staff, teams and services work together

We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.

Consent to care and treatment

We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Kindness, compassion and dignity

We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

Treating people as individuals

We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Independence, choice and control

We promote people's independence, so they know their rights and have choice and control over their own care, treatment and well-being.

Person-centred care

We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.

Care provision, integration, and continuity

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Providing information

We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.

Listening to and involving people

We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.

Equity in access

We make sure that everyone can access the care, support and treatment they need when they need it.

Governance, management and sustainability

We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Partnerships and communities

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Scope

Wherever possible, every resident who leaves our care should do so as part of a planned process and should be supported to ensure that the move or transfer to a new provider or setting is managed as safely as possible.

This policy and procedure are provided for the regulated activity of accommodation for people with personal care and nursing.

Equality Statement

EFH is committed to equal rights and the promotion of choice, person-centred care and the promotion of independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

Policy Statement

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Escort of residents

This policy provides guidance for all staff involved in the planning and implementation of escorted activities of residents who require a professional escort as a consequence of their:

- Individual risk management plan
- Clinical need
- Cognitive status.

This policy is commensurate with the NICE Guideline NG27 - Transition between inpatient hospital settings and community or care home settings for adults with social care needs

EFH works on the basis that its residents should be able to maintain contacts with their families, friends, representatives and local community groups and volunteers as they wish, with no official restrictions placed on visits by the home, with appropriate support from the home and with appropriate arrangements made for privacy. We understand that some residents will be able to maintain this contact only if they are escorted by care home staff. We also understand that residents will sometimes need accompanying to hospital appointments and to other healthcare-associated appointments.

This policy is intended to set out the values, principles and policies underpinning EFH approach to the escort of residents on trips outside of the home and to hospital and healthcare appointments. The prime objective of the policy is to maintain the wellbeing of any escorted resident and to provide optimal care during any escort period.

Discharge / Transfer

Effective discharge/transfer planning may reduce the likelihood of a resident being admitted or readmitted to hospital or receiving poor outcomes.

A discharge/transfer plan should be developed with the resident (or their representative), family members and carers as well as care manager (if applicable).

Working with families, friends and carers is also an important part of delivering person-centred care. When services work well with families, the outcomes for residents can be improved.

The discharge plan should be signed by a care manager or a representative.

EFH is committed to meeting residents' assessed needs; however, residents have a right to engage an alternative provider of their choice.

EFH is committed to meeting the needs of residents as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In the event of a resident transferring or being discharged to another setting, residents must be supported throughout the process to achieve good outcomes and continuity of their care.

Residents have a right to engage an alternative provider of their choice and to be fully involved in any planning considerations together with their family and carers.

This policy should be read and followed by staff supporting residents and the managers within the organisation.

The Policy

EFH aims to achieve the best outcomes for residents, wherever possible. Therefore, transfers or discharge to another provider should be planned although EFH accepts that, at times, there may be an urgent need to discharge a person to another provider e.g. Accident & Emergency or a medical ward.

Residents should be provided with adequate information and discussion to support their decision making and sign posted to the availability of ongoing support services best able to meet their needs.

Through effective planning, our organisation is committed to providing continuity of care when transferring or discharging residents to the care of another provider.

When a resident is transferred or discharged to another provider, the following should apply:

A transfer or discharge plan should be jointly drawn up with the resident, family, carers, Social Services Care Manager and a member of the service management team e.g. Registered Manager or Deputy.

The date of transfer should be agreed in advance with the resident and family, carers so that the staff can plan accordingly.

The Registered Manager, or designate, should contact the resident's family, carers to agree and verify the date of transfer and ensure that all the arrangements for safe transfer of care have been put in place.

Confirm that any medicines and/or prosthetic devices/worn aids/rehabilitation aids that the resident are accounted for.

The transfer or discharge plan should address the following matters as a minimum:

- The resources available to the person upon transfer.
- The reason for the transfer.
- A summary of the services that were being provided.
- An evaluation of the achievements/goals of the resident whilst using our service.
- Medication that is required will also be checked to ensure that the person has sufficient supplies for at least the next 7 days.
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All care documents that belong to the service will be retained and archived in line with the information management and record retention schedules (NHS and social care records guidance 2016).

Self Discharge at short notice

In the event of a resident wishing to discontinue the provision of our services at short notice the following should apply:

Resident lacking capacity

Where the resident lacks the capacity to make the decision in line with the Mental Capacity Act 2005, arrange a Best Interests Meeting with the appropriate stakeholders and agree best interest actions (see our Mental Capacity Policy). In the intervening period the service will be continued, unless requested by the commissioner, Lasting Power of Attorney for Health & Welfare, or the Court Appointed Deputy for Health & Welfare, and alternative care provision is in place e.g. family or alternative social care provider.

Resident with capacity

Respect the resident's legal right to self-determination where the resident has the mental capacity to make the decision.

Do all that we can to advise and encourage the person to remain in the service while we plan their transfer in collaboration with all stakeholders (management, relatives, advocates, friends, care managers, commissioners) and the permission of the resident.

In the event of a resident insisting on the transferring from our services, ask them to sign a declaration stating that they are taking this action against advice.

Inform the person's care manager (if applicable), social worker, relative or representative, community nurse and GP (if applicable).

If there is a cause for concern regarding the health and safety of the resident or others, management should notify, as soon as possible, the care manager, GP, family members or representative or the police should this be relevant.

Emergency Transfer

On transferring a resident to an emergency setting the EFH will:

Have an up-to-date '999 Sheet' in each resident file, with the relevant information regarding care, health, medical conditions and medication for transfer to A&E or secondary care e.g. medical ward.

Send a copy of the Medication Administration Record listing medication dosage, frequency and allergies.

Keep in touch with the receiving provider and share any information that might affect discharge/transfer planning the resident's return to the community.

Document all communication on Access and Clinical Communication forms as appropriate.

Support residents who need end-of-life care or have complex needs with details of who to contact in case there are problems with medicines or equipment within 24 hours of discharge.

On discharge from the hospital back into the care of EFH, residents will have a review of their care and support plan, risk assessments (e.g. moving and handling), medication and other relevant documentation. This will take place within 24 hours of discharge.

EFH is committed to meeting needs of residents admitted to our service. In the event of a resident being referred for discharge back to our care from an emergency transfer, the Registered Manager or senior representative must assess that the service can meet the needs of the resident whose condition and needs may have changed.

Training

Care staff are provided with training regarding Transfer and Discharge at all suitable stages of their employment from induction onwards.

Seeking Feedback about

EFH will seek feedback from people, families, staff, involved professionals and volunteers about their experiences of Transfer and Discharge of a resident where it is appropriate to do so. We will seek feedback in person during conversations and via surveys and meetings. We will respond to feedback and tell people about changes and improvements we make because of their feedback.

References

https://www.nice.org.uk/guidance/qs136/chapter/Quality-statements

https://www.nice.org.uk/guidance/ng27

Review date	Next Review Date
May 2024	May 2027