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The Management Of Reluctant Discharge / Transfer Of Care To A More Appropriate Care Setting Guidance

Contents

1. Purpose

1.1 This document provides a process for Health Boards and partners to support the management of individuals who decline to participate in either the discharge planning process or the transfer to a more appropriate care setting.

1.2 The process set out in this document **should only be considered where all other avenues to ensure care is provided in the most appropriate setting have been considered and not been possible** for a range of reasons.

1.3 In all circumstances when implementing this Guidance the focus should be on the individual, understanding what matters to them and on ensuring their needs are met safely and appropriately. The risks of remaining in an inpatient setting when this has been assessed as not appropriate are significant and the Guidance also includes actions to ensure the person is fully aware and informed of the additional risks to themselves and the consequences of remaining in an inappropriate setting.

1.4 The process refers to the principles to be adopted, allowing for local systems and arrangements to be shaped in a way that provides local/regional partners with the most effective operational process for local implementation.

1.5 It is based on relevant current national guidance and includes recognition of locally developed processes already in place where these have been available.

2. Definition

A reluctant discharge is when a person has been assessed as no longer in need of care or treatment in the hospital setting they currently occupy. They will either have been assessed as able to transfer on to the next appropriate stage in their episode of care e.g. from an acute bed to a rehabilitation/reablement bed in an alternative setting or that they no longer require any form of inpatient care. These individuals will have been assessed as clinically optimised for discharge and have been reviewed in relation to their ongoing needs; with safe and appropriate arrangements confirmed as in place where required.

3. Background

3.1 When a person no longer requires care in the hospital setting there are significant risks associated with loss of independence and exposure to risks, such as hospital acquired infections and falls. **The aim must always be to ensure that care to meet assessed needs is provided in the most appropriate setting without delay.** If it is no longer necessary for the person to remain in hospital, they are then ready to move to the next stage of care.

3.2 On a wider level, both health and social care partners have a responsibility to ensure resources are used to best effect and a range of services are available for those who need them. From this perspective transferring or discharging a person to a more appropriate setting releases acute capacity for those in need of that level of care and treatment and maintains system flow and balance.

3.3 On occasion a person may, for a range of reasons, decline to participate in the process of transferring them to the next stage of care. This is much more likely if the person's needs are more complex and/or the setting for the next stage of their care pathway is not one they wish to consider. Whilst generally low in number, such circumstances can lead to significantly extended lengths of stay that threaten what can already be quite fragile independence for the person involved. They can also take up a disproportionate amount of management and operational time to resolve.

3.4 Understanding what matters to them and why they are choosing to decline participation is key, though sometimes very hard to establish. The person needs to be fully informed not just on the next stage of care, but on the risks of remaining in hospital.

3.5 Ensuring people receive care in the most appropriate setting to meet their needs requires all stakeholders to work together to ensure that:

- National policy requirements reflect and support the discharge and transfer process;
- Actions are in place between partners to ensure discharge planning is a managed process that begins at the point of admission;
- Arrangements are in place and implemented in a timely manner to ensure that any situation where a person is in a care setting inappropriate to their needs is managed and addressed.

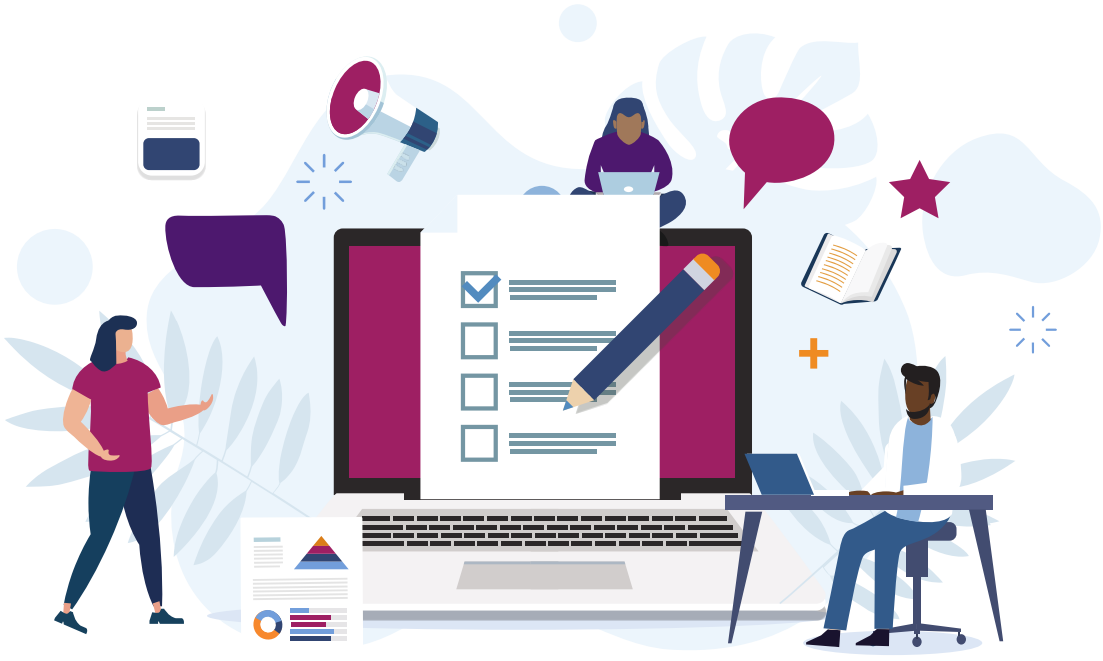
3.6 Delivering on these requirements will minimise the threats to independence that a prolonged hospital stay can bring and ensure all partners are able to use their resources to best effect.

4. Discharge Planning

4.1 National policy guidance and regional/local discharge processes operate to ensure that a person's identified and assessed needs on discharge are met and that the person maintains all opportunities for independent living. This is the case for both simple discharges and those more complex. For the purposes of this Guidance the focus is on the more complex discharges where a person is likely to require either ongoing access to rehabilitation and reablement or is assessed to be in need of a package of care and support on discharge.

4.2 Each Health Board will have detailed discharge policies in place that have been developed and are delivered with their local authority partners. Whilst certain key roles and actions will be reflected in the following text, it is not the intention to duplicate in full local discharge policy arrangements. Instead, it is expected that local arrangements are in place that deliver timely and effective discharge or transfer to another care setting.

4.3 The role of the care co-ordinator is pivotal in the discharge process. Whilst the nurse in charge of each ward is responsible for the overall coordination of effective discharge planning, the person's named care co-ordinator is responsible for overseeing the discharge plan for each person they are responsible for. This includes the assessment, communication and active management of the discharge process, including explaining that transfer to a more appropriate care setting is anticipated if the person has ongoing care and support needs but no longer requires care in the current hospital setting.



5. The Management of Reluctant Discharge

5.1 Some people and/or their family/carers may refuse to engage with the discharge process despite having been assessed as clinically optimised for discharge and agreement from the MDT that it is safe for discharge to the next stage of care to proceed.

This can be for a range of reasons including, but not confined to:

- Concerns regarding the location of care, for example a reluctance to receive ongoing rehabilitation and reablement care in a non-hospital setting such as a residential care home;
- Previous negative experiences;
- Anxiety at moving to a different care setting;
- Concerns regarding any financial contributions that may apply to care provided post discharge from hospital.

5.2 This Guidance aims to assist multidisciplinary teams to manage these circumstances.

5.3 In implementing the Guidance specific attention should be given to:

- Where an individual lacks capacity to make a decision about matters concerning their daily life and future accommodation needs, an assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, in accordance with the principles of the Mental Capacity Act (2005) and documented.
- For people who have been assessed as lacking capacity to make decisions about their care needs, or place of discharge, a Best Interest Meeting will need to take place.
- If the person has a Lasting Power of Attorney for Health and Welfare, the named attorney must be involved, and in this case is the decision maker (subject to any restrictions in the Mental Capacity Act 2005). Evidence (in the form of a copy) of an authorised LPA for Health and Welfare from the Office of the Public Guardian should be obtained, reviewed and retained in the patient's notes.
- If the person has a Court Appointed Deputy in place (for Personal Welfare or Property and Financial affairs) then the Deputy may also need to be involved in any discharge planning and be the decision maker for that person subject to the express terms of the Court Order, subject to any restrictions in the Mental Capacity Act 2005. A

copy of the Order from the Court of Protection should be obtained, reviewed, and retained in the patient's notes.

Individuals with capacity who are clinically optimised for discharge do not have the right to occupy a hospital bed where the sole reason for doing so is because the person prefers to remain in their current setting against the recommendations of the MDT involved in their care.

5.4 Managing the refusal of discharge process requires co-ordinated strategic and operational actions across both the Health Board and local authority partners. This should include ongoing communication with the person, seeking to understand and resolve the reasons for their reluctance to move to a more appropriate setting and ensuring they are fully informed of the balance of risk in remaining.

5.5 At a strategic level local and regional partners should ensure they have systems and processes in place that:

- Provide clear information on discharge planning arrangements which is provided to people at, or in the case of elective admissions before, admission. This information should include the risks of remaining in hospital when it is no longer necessary and the need to ensure that care is provided in the most appropriate setting.
- Have systems in place to monitor the effectiveness of the discharge arrangements and are able to identify, report and escalate any emerging issues regarding failure to engage with the discharge process to a more senior level.
- Provide ongoing senior scrutiny and support to the MDT and care co-ordinator in striving to achieve a safe and appropriate discharge to the next stage of care.
- Record all discussions and meetings that take place to seek resolution.

5.6 At an operational level the care co-ordinator should:

- Seek to ensure that communication channels remain open and effective with both the person and their family/carers, taking every opportunity to understand the reasons for the refusal and whether any further explanations or discussions may assist to resolve their reasons for refusal. These discussions should be carefully documented.
- Check, confirm and document that the person remains clinically optimised and that the discharge option remains a viable, safe and appropriate option based on the recommendation of the MDT. This

process should include the documentation of any meetings and/or conversations which have taken place.

- Continue to engage with the person/their family/carers to try to resolve the reason for their reluctance to be discharged to a more appropriate setting. This may assist with resolution, particularly if the risks of remaining in the current setting and the benefits of transfer to a more appropriate setting are explained. This should include ensuring the plan of care is up to date and identifies the risks associated with an inappropriately extended hospital stay. The risks should be shared with the person as part of the regular 'what matters to me' conversations to ensure they remain fully informed of the plan of care including the assessed risks. These discussions should be documented in their patient's records.
- Seek to consider any alternative options that the person and/or their family/carers may find more acceptable that would provide an appropriate alternative care setting.
- Be satisfied that the person and/or their family/carers understand that remaining in their current hospital bed is not possible and the consequences of what is happening, including the continuation of the actions involved in the discharge process.
- Be aware of the system in place locally to escalate the matter through to more senior managers for advice, support and guidance and how this can be accessed.

5.7 If this further engagement does not resolve the refusal of discharge then a nominated senior member of the Health Board should take the lead in communicating to the person and/or their family/carers that it is not possible to remain in the current setting as this would not be in the person's best interests, and that the Health Board would now proceed to seek legal advice.

5.8 The person/their representative should be advised they should also consider seeking legal advice specific to the individual case.

Implementing Discharge

5.9 If the steps outlined above do not result in the discharge/transfer to a more appropriate setting then the steps set out below should be progressed. These should only be pursued when:

- All other reasonable options have been considered and discounted;
- The Health Board is satisfied that the person has been made fully aware of the risks associated with a delay in transferring to a more appropriate setting and that these discussions have been fully documented;
- Any specific or exceptional considerations of the individual's circumstances that may indicate it is inappropriate to continue to enforce the discharge have been considered;
- Agreement to proceed to implement discharge has been given by a relevant and appropriate Health Board executive manager;
- The local authority social worker is informed of and aware of the planned approach.

5.10 In the event that all actions set out above do not result in engagement with the discharge plan the following staged actions should be progressed:

Stage 1:

A meeting should be held between: a senior member of the medical team; senior members of the nursing team including Ward Manager, Senior/Divisional Nurse or the Strategic Lead for Patient Flow; the person's allocated social worker (if applicable); their lasting power of attorney or court appointed deputy (if applicable); the person and, if appropriate, their family and/or carers. The purpose of this meeting would be to explore the issues that they have in relation to discharge including any concerns that they may have about the discharge and attempt to seek resolution. This should include setting out the risks associated with a delay in moving to a more appropriate setting.

Appropriate copies of any assessments or reports undertaken by specialists such as therapists or social workers would need to be made available for senior staff prior to any meeting, to refer to and clarify any questions that may be raised; it may be relevant for therapy staff to also attend the meeting depending on the nature and extent of their involvement. This would be particularly relevant for any reablement/rehabilitation planned under Discharge to Recover then Assess (D2RA).

During this meeting it should be explained to the person, or their representative if applicable, that it is not appropriate for them to continue to occupy a hospital bed when they no longer have a clinical need to do so; remaining in the current setting could place them at additional risk of harm. The person should be given a discharge time and date and informed they will be expected to leave the hospital by this time. In the case of those requiring ongoing care and support the date and time provided should align with the commencement of care planned to be provided in a different setting.

It should also be stressed sensitively but firmly in the meeting that unless the person is discharged on the given date, the Health Board would seek legal advice that could result in making an application to the Court to seek an order that would require them to leave the premises.

An appointed person should carefully document the discussions and agreed actions and a copy should be retained in the person's clinical records.

Individuals and their families have the rights to raise concerns through the NHS Wales "Putting Things Right" process. This would not of itself delay the reluctant discharge process if it is the continued opinion of the MDT that the discharge/next stage of care arrangements remain appropriate and safe.

Stage 2:

Following the meeting a letter from the Health Board should be given to the person confirming the date that any ongoing needs were assessed and how those needs are intended to be delivered in an alternative care setting. A sample letter is attached as **Appendix 1** to this document.

The letter should address any of the concerns raised and make it clear that the person has been assessed as ready for discharge and the Health Board should specify the date and time by which the person will be discharged.

The letter would also reiterate the fact that, under section 3(1) of the NHS (Wales) Act 2006, the Health Board must provide to such extent as they

consider necessary to meet all reasonable requirements, hospital accommodation or other accommodation for the purpose of any service provided under the Act. [1] The provision of accommodation is temporary and linked to a persons assessed health need.

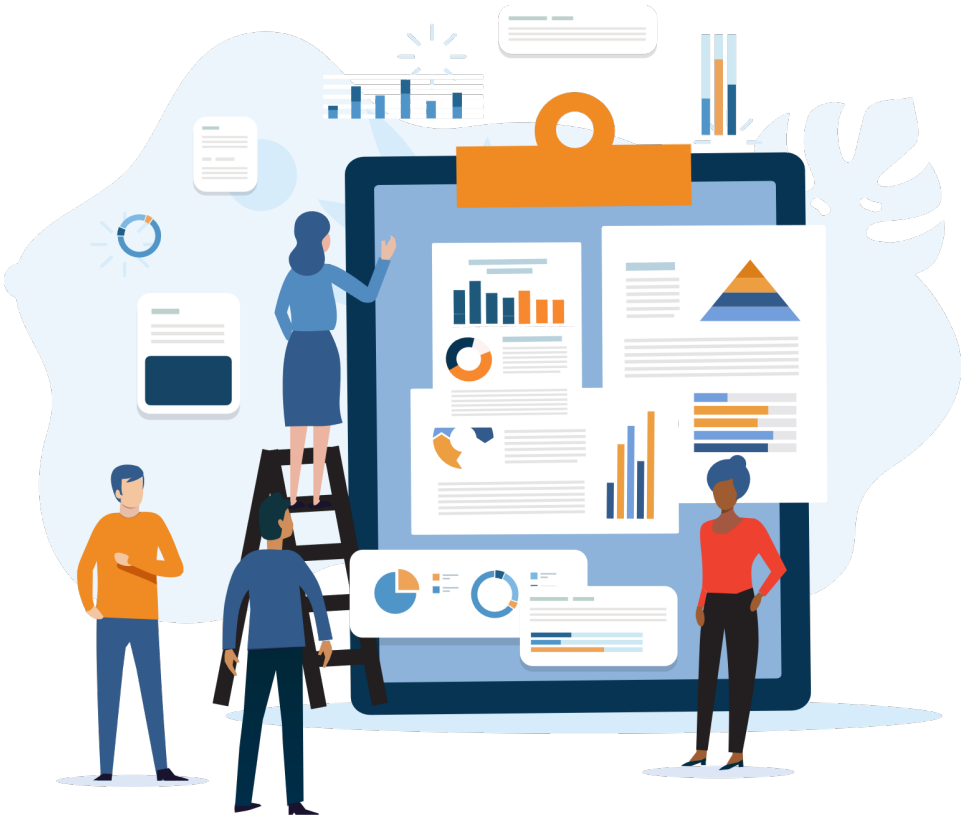
Patients are accommodated in a hospital bed as a licensee. The Health Board as the owner of the hospital grants the patient a licence to be on its premises. This licence exists for such time until the Health Board deems it appropriate for the licence to be revoked i.e., the person is deemed clinically optimised for discharge. A person does not have an enforceable legal right to occupy a hospital bed indefinitely and Health Boards are under no legal duty to accommodate them where other alternative safe discharge venues have been identified.

Stage 3:

If following the letter the person still then refuses to leave, the Health Board should seek additional legal advice that is specific to the individual and the circumstances around the refusal of discharge.

Stage 4:

The final resort for the Health Board is an application to the court for an order for possession, with the associated legal costs in applying for such an order being claimed from the person. This stage **must** be subject to and informed by specific and additional legal advice.



6. The legal position

6.1 This Guidance reflects the legal position that should be considered when managing a reluctant discharge from hospital. In addition, Health Boards are advised to seek specific further legal advice tailored to each individual case, particularly if a case reaches Stage 3 and 4 of the process set out above.

Before proceeding with enforcing discharge and seeking legal advice, the Health Board should ensure all discharge policies have been complied with. The following key points should be considered and confirmed before a referral for specific legal advice is made.

- Ensure the discharge planning processes in operation reflect the Welsh Government policy guidance and confirm that all local discharge policies and resolution processes have been followed and can be evidenced.
- Ensure all formal and informal discussions relating to the specific person's discharge planning are detailed and documented. This must include the regular 'what matters to me' discussions and confirm the person has been made aware of the risks to their health and wellbeing of remaining in hospital when that is no longer necessary.
- Review all necessary case conferences, discharge planning meetings or round table meetings with person and their families/carers where concerns have been raised or issues arise and ensure that all opportunities to resolve the matter have been exhausted.
- Ensure the actions set out in this Guidance have all been undertaken.
- As a last resort, once the above steps have been taken, legal action can be pursued to enforce the discharge process. This should clearly be considered when all other options have been exhausted and it is inappropriate for the person to continue to occupy the in-patient bed. **Such a decision should only be taken when the Health Board has sought additional specific legal advice that will reflect the circumstances of each individual case.**

In the event that a Health Board determines that all the stages set out in this Guidance have been taken and there is a need to proceed to make an application to the Court for a possession order, **the Health Board must also seek additional legal advice before any application is made to the Court**.

7. Application in practice

7.1 Whilst the number of reluctant discharges is low in the context of total discharges from NHS Wales these individuals can occupy a significant number of bed days unnecessarily and take up a disproportionate amount of management time. It also places the person at risk as the care setting is no longer appropriate to their needs.

7.2 This guidance is intended to provide regional and local partners with additional information and processes to support refusal of/reluctant discharge or transfer of care to a more appropriate care setting when a person has been assessed as clinically optimised and ready to move on to the next stage of care.

7.3 It is not intended to require regional and local partners adopting alternative approaches where these have already been developed locally and are able to have a positive impact in transferring people to a more appropriate care setting in a timely manner.

7.4 Addressing refusal of/reluctant discharge is a challenging issue that requires firm but sensitive management with a focus on the risks to health and wellbeing associated with a hospital stay when that is no longer assessed as appropriate. Regional and local partners are encouraged to share any processes developed and implemented locally so that learning can be shared and adopted more widely to support the principles in this guidance.

8. Appendix 1. Confirmation of Discharge Letter

(To be given by the Ward Manager following the reluctant discharge meeting and adapted to reflect the discussions of the meeting) If a person refuses to accept this letter, it should be read out to them and a copy left at their bedside and a copy included within their medical records.

Insert Date

Insert Person's Name and Address

Dear

As you will know from discussions with the team caring for you since you were admitted to (INSERT NAME OF HOSPITAL) hospital on (INSERT DATE OF ADMISSION), you have now been assessed and deemed clinically optimised and ready to leave hospital.

The initial reason for your admission was (INSERT REASON FOR ADMISSION). (INSERT DRS NAME) confirmed in our meeting on (INSERT DATE OF MEETING) that this episode of care has now resolved, and your ongoing care and support needs no longer require you to be an inpatient for these needs to be met.

After consultation with you and after careful consideration of the health and social care assessments that are available in relation to your assessed needs, the Health Board now considers it appropriate for your ongoing care and support needs to be met in (INSERT AS APPROPRIATE). Remaining in hospital when assessments indicate this is inappropriate, places you at additional risk of harm and could impact on your health and wellbeing. It is therefore now necessary to ask you to: DELETE FOLLOWING AS APPROPRIATE

Transfer to another setting appropriate to meet your needs for the next stage in your care. IF THIS OPTION IS SELECTED INCLUDE A SHORT SUMMARY OF THE FOLLOW ON CARE THAT IS TO BE PROVIDED

Vacate the hospital (INSERT DATE AND TIME BY WHICH THE PERSON IS EXPECTED TO LEAVE) as you have been assessed as no longer requiring an inpatient bed.

Under section 3(1) of the NHS (Wales) Act 2006 the Health Board must provide, to such extent as they consider necessary to meet all reasonable requirements provide hospital accommodation or other accommodation for the purpose of any service provided under the Act. [2] The provision of hospital accommodation and/or accommodation is temporary and linked to a persons assessed health need.

A person is accommodated in a hospital bed under a licence. This licence, granted by the Health Board, exists for such time until the Health Board deems it appropriate for the licence to be revoked, for example in circumstances where a person is deemed clinically optimised to leave

hospital and a safe and appropriate place of discharge for them to go to has been identified. A person does not have an enforceable legal right to occupy a hospital bed indefinitely and Health Boards are under no legal duty to accommodate a person where other alternative safe discharge venues have been identified.

Leaving hospital as soon as you are clinically optimised has a number of important benefits for you and your wellbeing:

You are more likely to have opportunities to be more mobile, strengthening your muscles and regaining your confidence and greater independence.

You will have a reduced risk of infection.

Being away from a busy hospital ward will give you chance to rest and sleep better, helping with your recovery.

In addition, your engagement with the discharge process will create additional capacity on the ward and allow the Health Board to admit and treat patients in need of acute medical treatment.

We appreciate that this may be a difficult time for you. We will continue to keep you informed and support and assist with your discharge/transfer arrangements, including the provision of medication to take home (if appropriate) and transport arrangements should they be required.

In the unfortunate event that you continue to refuse discharge, the Health Board will seek legal advice as to its options to effect your discharge. This may include making an application to the Court for a possession order requiring you to leave the hospital. We would hope that such action will not be necessary, and that you will engage with us to effect your discharge at the earliest opportunity.

I hope this letter clearly explains the Health Board's position and provides clarity regarding next steps in the facilitation of your discharge.

If you have any queries regarding the content of this letter please let me know and I would be happy to discuss them further.

Yours sincerely

To be signed by Health Board representative at executive level

9. References

[1] The duty placed upon the Welsh Minister by section 3(1) of the NHS (Wales) Act 2006 is delegated to the relevant Local Health Board by the Local Health Boards (Directed Functions) (Wales) Regulations 2009.
[2] The duty placed upon the Welsh Minister by section 3(1) of the NHS (Wales) Act 2006 is delegated to the relevant Local Health Board by the Local Health Boards (Directed Functions) (Wales) Regulations 2009.