# Abertawe Bro Morgannwg University Health Board
# Neath Port Talbot, Bridgend & Swansea Local Authorities
# Choice of Accommodation Policy

**Equality Impact Assessment Statement**

This policy has been screened for relevance to equality. No potential negative impact has been identified so a full equality impact assessment is not required.

**Approved by : Unscheduled Care Supporting Delivery Board**

**Date Approved : September 2016**

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# Section One – Policy Guidance for Patients Who Have Been Assessed As Ready to Move to Their Next Place of Care

## 1. Scope

1.1 This policy has been written to address the needs of all patients whose future place of care from hospital, will be in a residential or nursing home setting. It does not apply to people whose care needs could be met in their own home. It therefore will encompass people who will be placed in residential or nursing home care and will be financially assisted by the Local Authority, in accordance with the National Assistance Act 1948 (Choice of Accommodation) Directions 1993; those whose future care will be funded by the Local Health Board; and those who will pay for their own future place of care.

1.2 This Policy can be applied to all patients, including those people have been deemed not to have capacity to make choices about their future place of care, in accordance with the principles of the Mental Capacity Act 2005. The principles of this policy should be applied when working with patients with or without capacity.

1.3 As outlined by WHC (2004) 54 NHS Responsibilities for meeting Continuing NHS Health Care needs: guidance 2004, the application of choice will not always be applicable to patients whose primary need is assessed as health. As stated and in accordance with the guidance, the view of the individual and their carers should be taken into account when making the decisions as to where care will be provided. In all cases the decision on the location of care will be taken in the context of the needs of, and risk of, the individual and their informal carer, the risk of staff and the availability of the appropriate services.

## 2. Introduction

2.1 The Policy sets out the process for the safe and permanent placement of patients in an appropriate care setting and in a manner which is commensurate with the rights of the individual patient under the National Assistance Act 1948 (Choice of Accommodation) Directions 1993 and the right for every individual to be treated in accordance with the Human Rights Act and the Articles of the Human Rights Convention. It requires careful consideration by the patient (or their LPA if applicable), their advocate and their family and/or carers. Obtaining good advice from health care and social care professionals is essential, to ensure that the process is done effectively and efficiently. As outlined in the WAG Guidance on the National Assistance Act 1948: (Choice of Accommodation) Directions 1993, "The Trusts and Local Authorities should have clear policy guidelines about how they will address the situation if individuals refuse to make choices".

2.2 Social Services organisations have responsibility to fund the care of individuals whose care needs are incidental and ancillary to their health needs. Funding for such care is means tested and will depend on individuals' circumstances. People whose primary care need is because of

their "health needs", can when eligible be funded for their care by the Health Board. Other people's circumstances are such that they will fund their own care, however, they too need the support and advice of health and social care professionals to select the appropriate place for their future care, and this policy is intended to assist in that process.

2.3 Refusal to agree to a hospital discharge and/or to make a choice of accommodation is unlikely to prevent the discharge processes from proceeding and alternative solutions may have to be explored. Alternatively where a place in the particular home chosen by the patient is not currently available and is unlikely to be available in the near future, it will be necessary to assist people to identify a transitional care home as an interim measure until a place is available.

2.4 The principles and guidance of the Mental Capacity Act 2005 and the Code of Practice must be taken into account to determine in each case whether the patient has the capacity to make decisions about their future care arrangements and what support each patient may need in order to be able to do so. Where a patient does not have capacity then the requirements of the Act and the Code must be followed. Further information is provided at paragraphs 6.7 to 6.27 of this Policy.

2.5 This policy should in no circumstances be taken as authorising the forcible removal of a patient from a hospital bed to secure discharge from the hospital, as this may amount to an assault.

2.6 A patient with capacity may prefer to be represented by a family member or carer and a record should be made of the identity of the representative. Throughout this Policy reference to "the patient" therefore includes reference to the patient's representative including, where the patient does not have capacity, the patient's appropriate family member or carer or a person who holds an appropriate Lasting Power of Attorney or in certain circumstances an IMCA.

2.7 Each stage of the discharge planning process should be approached in a supportive atmosphere of mutual trust. The patient (or their LPA where applicable) and their family/carer/advocate should be offered explanations verbally and in writing, there should be counselling and further support throughout the process.

## 3. Aim

3.1 The aim of this policy is to recognise the right of a patient to be cared for in the setting which is most appropriate to meet their assessed needs and which takes into reasonable account their preferred choice of accommodation subject to certain conditions. It aims to reduce the length of time a patient has to wait in an acute hospital bed prior to transferring to a more appropriate environment. It is not in a patient's interest to remain in an acute hospital setting after an episode of ill health and the patient has the right for his/her assessed needs to be met promptly where appropriate, whether by the Local Authority the NHS, or by assisting them, or their families, to arrange their future care. When a multidisciplinary assessment indicates that care in a nursing or residential

home is the most appropriate place to meet all the patient's care needs, the patient, their advocate, family and/or carers should be assisted and supported to choose a suitable and available home of their choice. It may not always be appropriate nor in their interest to remain in an acute hospital bed until such time as a bed in a particular home becomes available, and transitional arrangements may need to be agreed and arranged to meet the patient's needs.

3.2 The NHS is under great pressure to only use hospital beds for those who need specific hospital services due to their physical or mental illness. If beds are occupied by people waiting for arrangements outside the hospital to be made to meet their assessed needs, including waiting for a place in a chosen home to become available, this effectively denies access to these hospital beds for people who need them.

3.3 Those responsible for arranging discharge care for patients, (nurses, discharge liaison nurses, doctors, therapists, and social workers), have the difficult task of finding the right balance between the rights of the patient and the often competing pressure to release a hospital bed. This policy is designed to offer guidance to support them and the patient through this process.

## 4. Delayed Transfer of Care Definition (Emergency Pressures Planning Guidance 2003-2004)

4.1 A delayed transfer of care is experienced by an inpatient occupying a speciality / significant facility bed in a hospital, whose needs are such that he/she is ready to move on to the next stage of care but is prevented from doing so by one or more reasons for delay in transfer of care**.** This will *include* a delay in discharge. The "next stage of care" covers all appropriate destinations within and out of the NHS (further inpatient episode, patient's home, nursing home etc).

4.2 The date on which the patient is ready to move on to the next stage of care is the ready-for-transfer of care date, which is determined by the clinician responsible for the inpatient care, in consultation with the patient and those nominated by the patient, colleagues in the hospital multi-disciplinary health care team and all agencies involved in the Unified Assessment Process and in planning the patient's transfer of care. Thus, following consultation with the patient, the patient is assessed as ready-for-transfer of care but the transfer of care is delayed, due to one or more:

- Health care reasons
- Social care reasons
- Patient/Carer/family-related reasons
- Legal reasons

## 5. Fundamental Principles

5.1 As a general rule people should not be discharged directly from an acute episode of hospital care to a permanent placement in a care home.

Following active treatment the aim should be to assist the person to recover and rehabilitate to reach his or her full potential. This recovery and rehabilitation phase may take place at hospital, at home or in an intermediate care setting.

5.2 Permanent placement in a care home needs careful consideration by the patient, their advocates and carers as well as advice from health and social care professionals. This process is less likely to succeed where it is rushed with consequences both for the individual and health and social services. NHS and social care commissioners need to make provision for this phase when planning services. Local procedures will need to take account of the individual circumstances of service users, their families and their carers in agreeing time-scales for determining placement decisions. It is good practice for care coordinators to keep in regular contact with advocates and families to ensure that agreed time-scales are met and to keep people advised as to progress.

5.3 The impact and severity of the illness and personal circumstances may mean that there is no alternative but to move some people directly from hospital into a registered care setting. In this instance, individuals should not be placed at a disadvantage when it comes to exercising choice compared to those who move in to a care home from their own home.

5.4 Local policy on choice of accommodation should be firmly embedded in the transfer of care procedures and policies of Abertawe and Bro Morgannwg University Health Board and Swansea. Neath Port Talbot, and Bridgend Local Authorities. The principles of this policy should be presented to individuals on admission to hospital, and the full policy should be available to those who require it. Addressing these issues at the earliest possible point in the patient care pathway will preclude the development of expectations regarding indefinite stays within an acute setting. It is not appropriate for people who are ready for discharge to occupy hospital beds indefinitely. Information should be given verbally to patients, and/or where appropriate their representative and reinforced by an admissions leaflet.

5.5 Consideration of the principles of the of the Mental Capacity Act and the Code of Conduct and the Protection of Vulnerable Adult Procedures must underpin the application of this Choice Policy

## 6. Patient Group

This policy applies to patients in the following circumstances, where:

6.1 Following a multidisciplinary assessment under the Assessment Process, the Multidisciplinary Team (MDT) has identified and agreed that the patient requires Residential / Nursing Home care (self funded placement, social services contracted placement. As required by this process this decision will have been made in consultation with the patient (or their LPA), their advocate, family/ carer who have been provided with appropriate information, advice and support. The outcome of the assessment and the decision of the MDT have been fully documented in

the patient's notes, and the personal plan of care indicates that need for rehabilitation or the patient being cared for at home has been discounted.

6.2 The patient is assessed as not having capacity to make the decision about their future place of care. See section on the Mental Capacity Act below, for actions and responsibilities in these circumstances.

6.3 The patient or their appropriate representative is having difficulty in identifying three homes of their choice within the timescale provided.

6.4 Patients or their representative who have identified three homes of their choice, at which there are no beds available.

6.5 The patient or their appropriate is unwilling for discharge to take place until a placement is available in any one of the three homes of their choice.

6.6 Where an alternative acceptable interim, or potentially long-term**,** placement exists which meets the patient's assessed needs.

**The Mental Capacity Act 2005**

6.7 The Act (MCA) and the Code of Conduct should be considered in implementing this Policy in each case as may be appropriate. The MCA introduced important safeguards for people who lack capacity and the people who work with, support and care for them. In consequence any patient who is assessed to lack capacity should be placed at the heart of decision making and provided with appropriate support to enable the individual to make his/her own decisions where possible. If they are unable to do this, then the patient should be involved in the decision-making process as far as possible.

6.8 What is a lack of capacity:

- *A person who lacks capacity means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken.*
- *Some one can lack capacity to make some decisions for themselves at the same time as they have capacity to make other decisions.*

6.9 A person is unable to make a decision for him or herself if he or she is unable to:

- understand the information relevant to the decision
- retain that information
- use and weigh that information as part of the process of making the decision, or
- communicate his decision (whether by talking, using sign language or any other means)

6.10 The MCA and the Code determines:-

- how decisions should be made for people who are unable to make decisions for themselves;

- who should be consulted about decisions;
- how the patient is to be protected when others are making decisions on their behalf.

The five principles which apply in all circumstances in relation to the implementation of this Policy are as follows:

- A person **must be assumed** to have capacity unless it is proved otherwise that he/she lacks capacity. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability, or because they are of a particular age or appearance.

- A person is not to be treated as unable to make a decision unless **all practicable steps** to help him or her to do so have been taken without success. This means that you should make every effort to encourage and support the person to make the decision for himself/herself.

- People have the **right to make** what others might regard as **unwise decisions**. We cannot say because we think the decision is unwise that the person does not have the capacity to make the decision.

- Anything done for or on behalf of a person who lacks mental capacity must be done in their **best interests**.

- Anything done for, or on behalf off, people without capacity should be **the least restrictive** of their basic rights and freedoms. This means that when you do anything to or for a person who lacks capacity you must choose the option that is in their best interest and least restricts the person's freedom and rights.

6.11 When helping patients make decisions in accordance with this policy you must ensure they have all the relevant information they need, that it is explained and presented in a way that is the easiest for them to understand, and that it is the best time of day for them and they feel at ease making that decision. You should consider whether there is a need to get the assistance of someone else who can help or support the person to understand information or make a choice, e.g. a relative friend or independent advocate.

6.12 You must ensure that everything has been done to help and support the person to make a decision, you must consider whether the decision needs to be made without delay, and if not consider whether it is possible to wait until the person does have capacity to make the decision for themselves.

6.13 Assessment for capacity must be "decision-specific" and that means that the assessment of capacity must be about the particular decision that has to be made by the patient about discharge and future care arrangements and their implementation at a particular time.

6.14 You would not normally make an assessment of capacity without

involving family, friends and/or carers or an Independent Mental Capacity Advocate (IMCA) if one has been appointed.

6.15 If a person has been assessed as lacking capacity then any action taken, or decision made for, or on behalf of that person must be made in his or her best interest.

6.16 The person who has made a decision is known as the "decision maker". The "decision maker" is the person required to assess an individual's capacity and will be the person who has the power to make the decision in respect of, or to act on behalf of the person in question. The "decision maker" will usually be the professional who is directly concerned with the person and responsible for making the discharge decision on their behalf.

6.17 In the context of a decision being made by a multi-disciplinary care team, it is not sufficient for the decision to be categorised as a "team decision": The person who has professional accountability for a decision relating to an individual who may lack capacity must be identified and it is that person who must undertake the capacity assessment.

6.18 A formal capacity assessment should be undertaken in respect of any decision where the mental capacity of the person is disputed, or if there is a dispute over the discharge decision. If there is any doubt as to whether a person lacks capacity, this should be decided on the balance of probabilities. Prior to reaching a conclusion that a person lacks the capacity to make a particular decision, the "decision maker" must take all practical steps to help him or her to make the decision. Where the decision is a complex one relating to discharge, the ultimate decision is that of the potential decision maker and not the person who has been consulted to prepare a professional formal report."

6.19 The decision maker must in particular consider:

- the person's past and present wishes and feelings (in particular if they've been written down)
- any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question in any other relevant factors.

6.20 The decision maker must consult with other people if it is appropriate to do so and take account of their views as to what would be in the best interests of the person especially:

- anyone previously named by the person lacking capacity as someone to be consulted
- carers, close relatives or close friends or anyone else interested in the person's welfare
- an attorney appointed under a Lasting Power of Attorney
- any deputy appointed by the Court of Protection to make decisions for the person.

6.21 Where there is no one who fits into any of the above categories the decision maker may in accordance with the requirements of the Act have to instruct an Independent Mental Capacity Advocate (IMCA) for decisions about discharge to a residential or nursing home in accordance

with Sections 38 and 39 of the MCA which should be referred to.

6.22 An IMCA is a specific type of advocate that will have to become involved **if there are no family or friends** who can be consulted. An IMCA will not be the decision maker, but the decision maker will have a duty to take into account the views of the IMCA. For the purposes of this Policy, an IMCA should be involved if:

- it is proposed that a person be moved into long-term care of more than 28 days in hospital or eight weeks in a care home
- a long-term move (eight weeks or more) to different accommodation is being considered, for example to a different hospital or care home

6.23 Lasting Powers of Attorney (LPAs). Any adult is entitled to formally appoint someone to look after their health, welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves.

6.24 There are two different types of LPA:

- a **Health and Welfare LPA** is for the decisions about both health and personal welfare
- the **Property and Financial Affairs LPA** is for the decisions about financial matters

Before an LPA can be used it must be registered with the Office of the Public Guardian; a personal welfare attorney will have no power to consent to or refuse treatment, at any time or about any matter when the person **has** the capacity to make the decision for him or herself.

6.25 If the patient lacks capacity and has created a personal welfare LPA, the attorney will be **the decision maker on all matters relating to the person's care and treatment**. The attorney must make these decisions in the best interests of the person lacking capacity and if there is a dispute that cannot be resolved e.g. between the attorney and a doctor it may have to be referred to the Court of Protection.

**6.26 It is important to read the LPA if it is available to understand the extent of the attorney's power in so far as it relates to decisions as to discharge and future care arrangements.** The LPA may specify limits to the attorney's authority to make personal welfare decisions.

6.27 An assessment of capacity may require the sharing of information amongst health and social care workers. If a person lacks capacity to consent to disclosure then you must consider whether it would be in their best interest to disclose the information. Only as much information as necessary should be divulged.

6.28 Where an attorney under a personal welfare LPA has been appointed **they will determine if information can be disclosed and you must normally consult with them** before sharing any information.

6.29 All decisions in respect of assessments of a person's capacity to make

particular decisions must be recorded in the relevant professional records.

### Ordinarily Resident

6.30 The patient is from within the Swansea, Bridgend or Neath Port Talbot and will be placed within Abertawe Bro Morgannwg University Health Board area. In the case of patients who were residing outside the catchment area before coming into hospital, and where their care is to be met by a social services organisation; the Social Services Authority where they are *ordinarily resident* will be responsible for assessing and arranging their care but may commission Swansea/ Bridgend/Neath Port Talbot Social Services to assist with arrangements on their behalf.

6.31 When NHS nursing home care is required the care will be arranged by the Social Services Departments from where the person is ordinarily resident and by the Health Board Locality where the person is to be placed for their long-term NHS Funded Nursing Care. Where the person's needs are to be met under NHS Continuing Health Care, if the person is to be placed within the catchment areas of Swansea/ Neath Port Talbot/Bridgend, then the respective Health Board Localities will be responsible for arranging and managing the placement.

6.32 Patients from Swansea/ Bridgend/Neath Port Talbot areas placed within neighbouring Health Board areas, will be managed in line with the choice policies of the health Board in which the patient is placed.

6.33 This policy should **not** be applied to patients who are appealing against an NHS Continuing Health Care decision; the Review and Appeal policy should be implemented in this case, and policies and procedures for staff to follow in such instances are outlined within the NHS Continuing Health Care guidance.

6.34 In the event of the patient's condition changing or deteriorating significantly, the application of this process should be suspended and a reassessment should commence once the person is deemed medically fit for transfer of care by the clinician and the MDT Team. In the event of any change taking place which may affect the patient's capacity to make this decision at any stage of the process, then this process will be suspended and the policy for a patient without capacity will be applied.

## 7. Communication

7.1 Discharge planning is an interdisciplinary/agency process that provides continuity of care from planning through to the patient's discharge. The planning process should begin from admission to hospital but this will always be subject to the ability of the patient, their family and carer to participate in the process. Therefore consideration will first be given as to whether a patient has a primary health need requiring a multi disciplinary assessment under the NHS Continuing Health Care policy

and/or a decision as to whether the patient has capacity to make a decision about their future care, as per the definitions in the Mental Capacity Act, or if they may subsequently have capacity to make a decision about discharge.

7.2 Following that the process has five principles:

7.2.1 A comprehensive assessment under the Unified Assessment Process will be carried out; this will include due consideration of the person's home circumstance, and the support required should that be the preferred place of discharge

7.2.2 The MDT, which will include social services, will be responsible for ensuring that there will be good communication throughout this process with all involved.

7.2.3 A continuing process of consultation with and support for the patient, with their family and/or carer throughout the discharge process so that informed decisions and choices can be made

7.2.4 Completion of an appropriate pathway and documentation identifying the discharge plan.

7.2.5 Appropriate and clear communication to other professionals involved in on-going care of the patient following discharge, as well as to the patients, their families and/or carers

7.3 Information

7.3.1 Patients (or their LPAs) their family and/or carers need information on the options open to them if they are to be able to exercise genuine choice. They should be given fair and balanced information with which to make the best choice of accommodation for them.

7.3.2 Where a patient's future place of care is to be funded by the Local Authority, the social services authority will explain to individuals their rights to funding and future financial support, and the implications in respect of charges for social care services. Social services organisations will provide information to people (or their LPAs), their family and carers in ways appropriate to their particular circumstances; and they will supply copies of the *Directions on Choice* guidance if requested, and in appropriate formats as required. This information will be provided and delivered in partnership with primary and secondary care providers.

7.3.3 Where funding is to be arranged by the Health Boards, there will be similar arrangements whereby information on NHS Continuing Health Care funding and NHS Funded nursing home care will be provided.

7.3.4 The Health Board will ensure in partnership with social services that patients (or their representative) who are responsible for

funding their own care will get access to the same information and advice in an appropriate and timely manner.

7.4 Patients (or their representative) should be told:

7.4.1 About the type of care they require and that they are free to choose any accommodation that is likely to meet their needs subject to the constraints of their different funding arrangements

7.4.2 Establish eligibility for future funded care

7.4.3 Patients' contribution to their care, except NHS Continuing Health Care, will be subject to their agreement to a financial assessment. As part of the Assessment Process, where a Local Authority will arrange a person's care, a financial assessment will be undertaken, which will determine the patient's contribution to their care costs.

7.4.4 That they may choose to allow the authority to assist with making placements on their behalf.

7.4.5 That if they are not funding their own care they may choose from a list of care home providers who are registered under the Care Standards Regulations.

7.5 Patients (or their representative) should also be told what will happen if their preferred accommodation is not available. Wherever possible, the patient representative should be encouraged to have a family/carer/or advocate present during the conversation. A written record of the conversation should be kept, in particular, recording any decision taken or preferences expressed by the patient. This record should be shared with the patient.

## 8. Key Steps in Discharge Planning Arrangements

8.1 Discharge planning should start on admission to hospital and an expected date of discharge (EDD) given. The patient (or their representative), will be given copies of:

8.1.1 The Supporting Discharge Information Leaflet, which contains advice regarding the discharge planning process, and the timescales and expectation of the patient or their representative covering the discharge process.

8.2 As appropriate, when the patient is medically stable and ready to be moved on to the next stage of care; and their capacity and primary health needs have been assessed and agreed, the patient (or their LPA) or their family/carer/advocate, in conjunction with the patient Supporting Discharge Information Leaflet, will be given:-

8.1.1 **Letter One** – *Welcome Letter*

8.3 The Assessment Documentation, including any specialist assessments required, such as nursing and therapies, will be completed by the MDT and if the recommendation is for future care in the residential or nursing

home setting, the outcome of the assessment will be forwarded to the appropriate Local Health Board for funding approval (if appropriate), and/or to social service who will progress the appropriate contractual arrangements and secure funding. Where a person is privately funding their own future care, depending on their circumstances they or their representative will be assisted as required to arrange a placement by the appropriate members of the multidisciplinary team.

**Stage One of the Process (Days 1 - 14):-**

8.4 Following the Assessment Process and where it is identified that the patient requires a 24-hour supportive care setting, both the patient and/or their representative must be approached by the ward staff responsible for the patients care, and where appropriate the social worker who will discuss the options available and the process to be followed. The ward staff responsible for the patients care will provide or facilitate the patient (or their representative) with copies of:

8.4.1 **Letter Two** – *Moving from Hospital into a care home.*

8.4.2 A list of local registered Residential and Nursing Care Homes which will meet the patients' needs will be provided by the appropriate professional.

8.5 The patient (or their representative) will be advised, where able, to visit a selection of Care Homes, and identify up to three homes that are suitable to meet their needs and provide for their future care. The patient (or their representative) should also be advised about how to get access to the Care and Social Services Inspectorate for Wales (CSSIW) & its relevant inspection reports. A timescale of 15 working days will be provided to the patient (or their representative) to visit and identify the homes of their choice.

8.6 In circumstances where a patient does not have a family or carer to support the selection process, the patient will be offered support or advocacy to help them, and a reasonable time frame will be agreed by the MDT and applied accordingly. If the patient does not have capacity to make a decision about their future place of care then the Mental Capacity Act and Code must be considered and in accordance with the requirement of the Mental Capacity Act an IMCA must be appointed to support the patient and in accordance with paragraphs 6.19 and 6.20 of this Policy.

8.7 Once up to three or more Care Homes have been identified, the homes should be ranked in order of preference by the patient (or their representative) but all choices should be pursued simultaneously by the DLN and/or Social Worker/or advocate for self funding patients as appropriate.

8.8 Where a nursing home placement is required the ward staff responsible for the patients care will complete the assessment for the NHS Funded Nursing Care contribution to their care, this is to ensure the NHS contribution for the nursing part of their care is agreed.

8.9 Where the patient is eligible for funding, and where it has been agreed, either jointly between the Health Board and Social Services, or unilaterally by either organisation, and a discharge date to the home of choice has been confirmed for the patient to move within two to four weeks, the patient will continue to be cared for as an NHS patient in a hospital bed. This will not necessarily be the same bed whilst discharge is being expedited and will be subject to the Discharge Policy Guidelines.

8.10 If a discharge date to the home of choice has not been confirmed or it is likely that the patient will need to wait longer than 4 weeks for a bed to become available, the MDT will invite the patient (or their representative) to a meeting to discuss consider and agree an appropriate transitional care home that will meet the assessed needs of the patient.

8.11 If agreement is reached at the MDT meeting, the ward staff responsible for the patients care will follow **Stage Four** of the process and where applicable arrangements for the patient to be discharged to a transitional care home will be expedited.

8.12 If agreement is **not reached** with the patient (or their representative), the ward staff responsible for the patients care will follow **Stage Five** of the process, and the DLN should be notified. The DLN should, after discussing the case with the Consultant/MDT and Service Delivery Unit (SDU) Operational Group, brief, in writing, The SDU Nurse Director / Service Director on the situation.

**Stage Two of the Process (Days 14 - 21):-**

8.13 If the MDT considers that the patient (or their representative) have not been proactive in identifying and choosing alternative care homes of their choice within the timescale provided, **Letter Three** (–3a Choices made, 3b Choices made but not in a home with a vacancy, 3c No choices made – please choose appropriate letter), will be given to the patient (or their representative). This letter should be hand delivered by the ward staff responsible for the patients care and the patient (or their representative) should be requested to sign on receiving it, and a copy placed in the patient's medical notes. The DLN should be notified that Letter 3 has been given.

8.14 The ward staff responsible for the patients care should emphasise the urgent need for co-operation on this matter. Staff should also reinforce that it is not always appropriate for patient to remain in an acute hospital bed. In circumstances where a patient does not have a family or carer to support them, the patient will be offered support or advocacy. A further one week will be provided to the patient (or their representative) to identify and choose a care home of their choice.

8.15 The ward staff and discharge liaison nurse (DLN) responsible for the patients care and social worker or advocate should work closely with the patient (or their representative) from week two – week three to try and resolve the situation. If not already involved in the DLN should be informed at this point about the discharge, if it is considered that the discharge is either complex or likely to become a dispute.

8.16 Details of the patients discharge status should be discussed in detail at the weekly Discharge Planning Group meeting and reported to the monthly SDU Operational Group if it looks unlikely to be resolved.

**Stage Three of the Process (Days 21 – 28):-**

8.17 When the extension of a further week for the patient (or their representative) to identify and choose a care home has been undertaken, and a discharge date has been confirmed for the patient to move into the preferred home of choice, within two weeks but less than four weeks, the patient will continue to be cared for in a hospital bed. Discharge will be expedited in accordance with the Discharge Policy Guidelines.

8.18 If a discharge date has not been confirmed and it is likely that the patient will need to wait longer than 4 weeks for a bed to become available in the preferred home of choice, the MDT will invite the patient (or their representative) to meet to discuss and agree an appropriate transitional care home that will meet the assessed needs of the patient. In circumstances where a patient does not have a family or carer to support them, the patient will be offered support or advocacy.

8.19 If agreement is reached by the patient (or their representative), the ward staff responsible for the patients care will follow **Stage Four** of the process and where appropriate arrangements for the patient to be discharged to a transitional care home will be expedited.

8.20 Where the patient (or their representative) have still not identified and chosen alternative preferred homes of choice, the MDT will invite the patient (or their representative) to meet to discuss and agree an appropriate transitional care home that will meet the assessed needs of the patient.

8.21 If agreement is reached by the patient (or their representative), the ward staff responsible for the patients care will follow **Stage Four** of the process and where appropriate arrangements for the patient to be discharged to a transitional care home will be expedited.

8.22 If agreement is **not reached** with the patient (or their representative), the ward staff responsible for the patients care will follow **Stage Five** of the process, and the DLN should be notified. The DLN should, after discussing the case with the Consultant/MDT and SDU Operational Group, brief, in writing, The SDU Nurse Director, Service Manager and Medical Director on the situation.

**Stage Four - If Agreement is Reached to Transfer the Patient to Transitional Care Home:-**

8.23 Following consultation with the Nurse Director, the Director should arrange for **Letter Four** – *When arrangements are made for an interim placement based on letter 3(b) or 3 (C)*, to be hand delivered by the ward staff responsible for the patients care and the patient (or their

representative) should be requested to sign on receiving it, and a copy placed in the patient's medical notes.

8.24 Following the delivery of Letter Four, and where the patient (or their representative) has consented, ward staff should arrange transport for the patient to the agreed transitional care home for the agreed date. The aim will be to complete arrangements within a further 1 week.

8.25 A Health Board member of staff will be nominated to once again make the patient (or their representative), aware of their right to follow the Health Board complaints procedure if desired.

8.26 One day prior to the agreed discharge date, the ward staff responsible for the patients care should ensure that all documentation is complete and that all stages of the process have been applied following the Policy. The DLN should be notified of the patients transfer to a transitional care home.

8.27 The Consultant will need to agree and document that the patient is medically fit for discharge, a member of the ward and Social Care staff, has confirmed that they are ready for transfer and is safe to be discharged. This should be documented in the patient's medical notes.

**Stage Five - If Agreement is Not Reached to Transfer the Patient to a Transitional Care Home:-**

8.28 A Senior level MDT meeting should be arranged. This will include the Consultant responsible for the patient, SDU Nurse Director or nominated representative and Senior Representatives from Social Services. The patient (or their representative) should be formally invited to attend to discuss their refusal to agree to the transfer to a transitional care home. In circumstances where a patient does not have a family or carer or identified advocate to support them, the patient will be offered support or advocacy.

8.29 The Health Board legal team will be advised about the intended meeting by the nurse director and medical director, and provided with a full brief of the case and supporting documentation as evidence to demonstrate that the Policy has been followed.

8.30 The meeting with the patient (and or their representative) should involve clear advice on the best environment to meet the patient's care needs, it should also address the reasons for refusal and determine whether there are any short term options to enable discharge that have not been considered.

8.31 If agreement is reached regarding either the acceptance to identify three homes or other transitional arrangements, timescales must be established at the meeting and the actions agreed should be confirmed in writing immediately afterwards. Discharge arrangements should be made following the discharge policy guidelines within the timescales agreed at the meeting.

8.32 If agreement is not reached regarding either of the above, the SDU Nurse Director, Service Director and Medical Director will seek legal advice from the Health Board solicitors. Depending on Legal advice received the Health Board will then consider what further action is to be taken.

## 9. Principles for the use of Transitional Care Homes

9.1 Any transitional care home must meet the patients assessed future care needs. Waiting for a place in one of the preferred home of choice should not mean that the patient's care needs are not met in the interim, or that they wait in a setting that is unsuitable for their assessed needs. This includes occupying a hospital bed.

9.2 If the three preferred homes of choice have no bed availability, then placing the patient in a transitional care home with their agreement will be considered and pursued following the Abertawe Bro Morgannwg University Health Board's Choice of Accommodation Policy.

9.3 Where a patient is known to Social Services, and/or Social Services, has contracted for the placement in the transitional care home, an allocated Social Worker will maintain contact with the patient, and will ensure that, when a place becomes available in their preferred home of choice funding arrangements will be made either by social services and/or the Health Board /or the patient (or their representative), to transfer the patient to that care home, if that is still their wish. Arrangements will need to be put in place for self funding patients, who arrange and pay for their own care but who have no family/carer/advocates, to arrange for appropriate advocacy and ensure that nominated advocates have the appropriate information and advice, to arrange their care. These arrangements which can include health and social care professionals supporting the individual will be agreed within the multidisciplinary team and prior to discharge. For other self funding, patients (or their representative), will be required to make arrangements, but will also be able to access appropriate information and advice from the multidisciplinary team to support them in completing appropriate arrangements. In the event of a dispute, the engagement of an independent advocacy service would be preferable.

9.4 Patients transferred to a transitional care home may choose to remain there, even when a place becomes available in their preferred home of choice. If the transitional care home is able to accept the patient on a long term basis, the patient should be removed from the waiting list of the preferred accommodation.

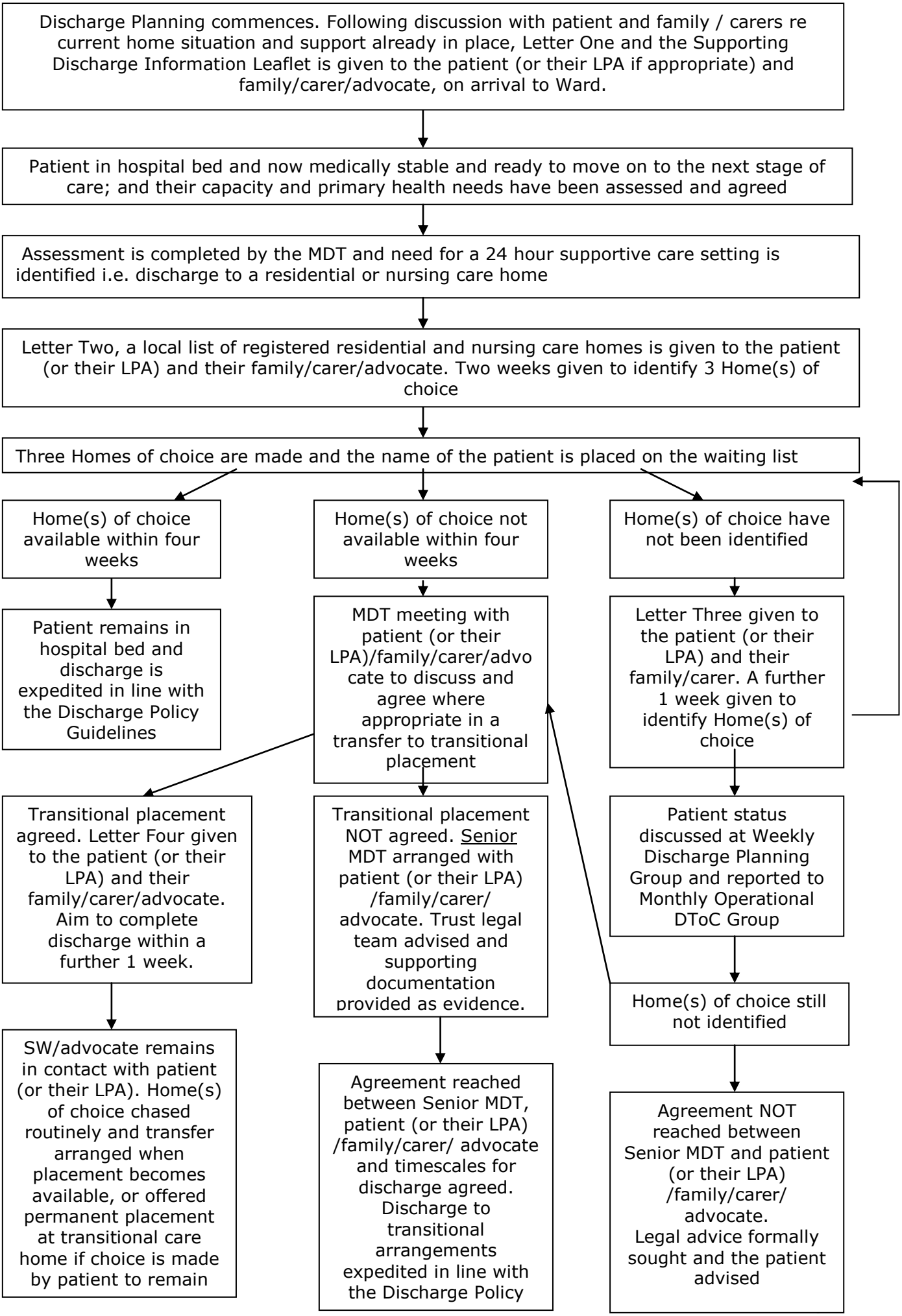
9.5 For people where social services have contracted for their placement in the transitional care home, normal funding responsibilities and arrangements will apply, unless an individual local authority chooses to exercise discretion. For example, if a third-party funding agreement is normally required for the transitional home, this may be deferred for an agreed period or be subject to more favourable terms, particularly if the placement in a patient's preferred home would not require such an agreement or a lower third-party contribution

## 10. Complaints Procedure

10.1 Patients (or their LPA) and their representative should be given, at any time during the discharge process, a copy of the Health Board Complaints Procedure. This should be available for them in the form of a leaflet or in an appropriate format as required.

10.2 It should be identified during the discharge procedure, and especially with the failure to agree process, that the Complaints or Legal Departments in the Health Boards and social services are informed of any disagreements and kept aware of developments and the likelihood of their advice being required.

# Section Two - Discharge Planning – Flow Chart



# Section Three - Supporting the Discharge Letters

NB: - For **each stage of the process it should be made clear that the patient's representative will also receive a copy and be involved in the discussions?**

There are 4 Letters supporting this process for patients with Capacity the 'Patient's Copy ' should be issued. For patients formally assessed as lacking Capacity the 'Relative's Copy should be issued.

- Welcome Letter
- Letter 2 – Moving from Hospital into a Care Home.
- Letter 3a – Choices Made
- Letter 3b – Choices made but not in a home with a vacancy.
- Letter 3c – No Choices Made
- Letter 4 - When arrangements are made for interim placement based on letter 3b or 3c.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Dear Miss/Mr/Mrs/Ms

**Welcome letter**

Abmu Health Board would like to welcome you to our hospital, our dedicated staff will be working hard to ensure that you receive the best possible care and treatment and to make your stay here as comfortable and safe as possible.

Your individualised care/treatment plan will include your expected date of discharge. This will be regularly discussed with you and any individual you have nominated to be involved with your discharge planning. It is very important that, as soon as possible following your admission you inform us of any actual or potential problems relating to your discharge so that we can commence discharge planning with you.

When our Multi-disciplinary team have agreed that you are ready to be discharged we will aim that you are discharged promptly. There are numerous risks associated with delaying your discharge which a member of staff would be happy to discuss with you if required.

Most people who are admitted to our hospitals will complete all their care and treatment with us and then return home. However some patients may be ready to leave hospital but not quite ready to return to their own home. For example, they may need more time to recover; they may require a care package or alterations to their own home or be awaiting a care home of choice. In these cases discharge to an appropriate, alternate or interim care setting will be arranged.

Where your primary need on discharge is a health need as assessed in line with the Welsh Governments Continuing NHS Framework 2014, you may be eligible for an NHS funded placement. Alternatively you may need care that is primarily for social or personal care which will be funded by yourself or the Local Authority as appropriate.

If you have any concerns or questions regarding your discharge plans or the contents of this letter, please talk to a member of the care team as soon as possible

Yours Sincerely

**Ward Sister / Charge Nurse.**

Welcome Letter for Patient.

Dear Mr/Mrs/Miss/Ms

**Welcome letter**

Abmu Health Board would like to welcome you to our hospital, our dedicated staff will be working hard to ensure that your relative receives the best possible care and treatment and to make their stay here as comfortable and safe as possible.

Your relatives individualised care/treatment plan will include the expected date of discharge. This will be regularly discussed with you to ensure you are fully involved with discharge planning. It is very important that, as soon as possible following admission you inform us of any actual or potential problems relating to discharge so that we can commence discharge planning.

When our Multi-disciplinary team have agreed that your relative is ready to be discharged we will work to expedite this as soon as possible. There are numerous risks associated with delaying your relative's discharge which a member of staff would be happy to discuss with you if required.

Most people who are admitted to our hospitals will complete all their care and treatment with us and then return home. However some patients may be ready to leave hospital but not quite ready to return to their own home. For example, they may need more time to recover; they may require a care package or alterations to their own home or be awaiting a care home of choice. In these cases discharge to an appropriate, alternate or interim care setting will be arranged.

Where your relatives primary need on discharge is a health need as assessed in line with the Welsh Governments Continuing NHS Framework 2014, they may be eligible for an NHS funded placement. Alternatively they may need care that is primarily for social or personal care which will be funded by yourself or the Local Authority as appropriate.

If you have any concerns or questions regarding your discharge plans or the contents of this letter, please talk to a member of the care team as soon as possible

Yours Sincerely

**Ward Sister/Charge Nurse**

Welcome Letter for Patients Relatives.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Dear Miss / Mr /Mrs / Ms

**Moving from hospital into a care home.**

Following ongoing discussions you have had with the team caring for you on the ward, your health and social care assessment has been completed and you will be ready for discharge shortly. The assessments undertaken have shown that your ongoing care needs will be best met in a care home setting.

I am sure that you will understand that acute hospital beds are in great demand and we need to ensure that they are available for patients who need urgent treatment. You should have received an information pack from the social worker team – if you have not yet please ask for one; this includes information on registered nursing and residential homes and financial information.

We need to organise your discharge from hospital as quickly and smoothly as possible. We will do all that we can to help and support you at this time. We now ask you to select up to 3 homes you would like to be considered for, 1 of which should have a current vacancy, and do this in the next 14 working days. In the event of no decision being made or the care home of choice does not have a vacancy, hospital staff will begin the process of finding an interim short term placement

You may wish to talk things through with a relative or friend who can help and support you at this time and we can support you to access advocacy support if required, please do not hesitate to contact a member of the ward team if you need any further information.

Thank you for your co-operation.

Yours sincerely,

**Ward Sister / Charge Nurse.**

Letter 2 – Moving from Hospital to Care Home Patient's Copy.

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Dear Miss / Mr /Mrs / Ms

**Moving from hospital into a care home.**

Following ongoing discussions you have had with the team caring for your relative. The health and social care assessment has been completed and your relative will be ready for discharge shortly. The assessments undertaken have shown that ongoing care needs will be best met in a care home setting.

I am sure that you will understand that acute hospital beds are in great demand and we need to ensure that they are available for patients who need urgent treatment. You should have received an information pack from the social worker team – if you have not yet please ask for one; this includes information on registered nursing and residential homes and financial information.

We need to organise your relatives discharge from hospital as quickly and smoothly as possible. We will do all that we can to help and support you at this time. We now ask you to select up to 3 homes you would like to be considered for, 1 of which should have a current vacancy, and do this in the next 14 working days. In the event of no decision being made or the care home of choice does not have a vacancy, hospital staff will begin the process of finding an interim short term placement

You may wish to talk things through with the ward staff that will be able to support you to access advocacy services if required. Should you require any further information please do not hesitate to contact a member of the ward team.

Thank you for your co-operation.

Yours sincerely,

**Ward Sister / Charge Nurse.**

Letter 2 – Moving from Hospital to Care home. Relatives Copy

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Dear Miss / Mr / Mrs

**Moving from hospital into a care home.**

Thank you very much for providing the ward team with your three choices of care home. The home with a vacancy will be invited in to meet you as soon as possible so that they can discuss whether they can meet your needs. Following this a discharge date will be arranged

If in the meantime you have any more questions about moving from hospital into a care home please do not hesitate to contact one of the ward team

Yours sincerely

**Ward Sister/Charge Nurse**

Letter 3 (a) – choices made Patients copy

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Dear Miss / Mr / Mrs

**Moving from hospital into a care home.**

Thank you very much for providing the ward team with your three choices of care home. The home with a vacancy will be invited in to meet your relative as soon as possible so that they can discuss whether they can meet their needs. Following this a discharge date will be arranged

If in the meantime you have any more questions about moving from hospital into a care home please do not hesitate to contact one of the ward team

Yours sincerely

**Ward Sister/Charge Nurse**

Letter 3 (a) – Choices made Relatives Copy

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Dear Mr/Mrs/ Miss /Ms

**Transfer to an interim placement, whilst waiting for a preferred care home**

Thank you very much for providing the ward team with your three choices of care home. We understand that you are ready to leave hospital and move to a care home, however, the care homes you have chosen do not have a vacancy at this time. We do not wish to cause you or your family anxiety but you will not be able to remain at this hospital whilst you continue to wait for a vacancy in the care homes you have chosen. The ward team will find an interim placement for you until a vacancy at your preferred care home becomes available.

If you have any further queries regarding your discharge please do not hesitate to contact a member of the ward team.

Yours sincerely

**Ward Sister/Charge Nurse**

**cc Senior Nurse**

Letter 3 (b) - Choices made but not in a home with a vacancy. Patients Copy

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Dear Mr /Mrs/ Miss /Ms

**Transfer to an interim placement, whilst waiting for a preferred care home**

Thank you very much for providing the ward team with your three choices of care home. We understand that your relative is ready to leave hospital and move to a care home, however, the care homes you have chosen do not have a vacancy at this time. We do not wish to cause any anxiety but your relative will not be able to remain at this hospital whilst you continue to wait for a vacancy in the care homes you have chosen. The ward team will find an interim placement for you until a vacancy at your preferred care home becomes available.

This temporary placement should be accepted as this will meet your relatives needs better than a hospital setting. Unfortunately, we are unable to offer your relative the option of remaining in hospital once a suitable placement has been found

If you have any further queries regarding your discharge please do not hesitate to contact a member of the ward team.

Yours sincerely

**Ward Sister/Charge Nurse**

**cc Senior Nurse**

Letter 3 (b) – Choices made but not in a home with a vacancy. Relatives Copy.

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Dear Mr /Mrs /Miss /Ms

**Moving from Hospital into a Care Home**

Following discussion with the team caring for you, I note that you have not, as requested, identified three choices of care home. We have explained to you that as our hospital beds are in great demand we need to make sure they are available for patients who need urgent treatment. This means that we need to work with individuals and their families to support discharge from hospital as soon as the individual is medically fit to move on to the next phase of care.

As you have not identified homes yourself the ward team will now make arrangements for a care home with a vacancy to attend the ward to assess your relative. If the care home is able to meet your needs then we will make arrangements for transfer into the care home on an interim basis, until you identify your choice of care home, and a place becomes available. We will keep you informed of progress with this.

Please do not hesitate to contact me or another member of the ward team if you need any further information

Yours sincerely

**Ward Sister/Charge Nurse**
**Cc Senior Nurse**

Letter 3(c) – No Choices Made Patients Copy

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Dear Mr /Mrs /Miss /Ms

**Moving from Hospital into a Care Home**

Following discussion with the team caring for your relative I note that you have not, as requested, identified three choices of care home. We have explained to you that as our hospital beds are in great demand we need to make sure they are available for patients who need urgent treatment. This means that we need to work with individuals and their families to support discharge from hospital as soon as the individual is medically fit to move on to the next phase of care.

As you have not identified homes yourself the ward team will now make arrangements for a care home with a vacancy to attend the ward to assess your relative. If the care home is able to meet your relative's needs then we will make arrangements for transfer into the care home on an interim basis, until you identify your choice of care home, and a place becomes available. We will keep you informed of progress with this.

Please do not hesitate to contact me or another member of the ward team if you need any further information

Yours sincerely

**Ward Sister/Charge Nurse**
**Cc Senior Nurse**

Letter 3(c) – No Choices Made Relatives Copy

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Dear Mr /Miss / Ms / Mrs

**Moving from hospital to an interim placement.**

We are pleased to confirm that the ward team have advised that your inpatient treatment at this hospital is complete and you are now ready for discharge. We are now in a position to confirm that an interim placement has been arranged for you at ……. Care Home. Transport will be arranged to take you there on .....

During this time you (or a representative) will have the opportunity to view other homes, or whilst you are waiting for a place to become vacant in the home of your choice.

You might decide that you would like to stay permanently at..... In this case you can make arrangements to do so with the care home manager who will liaise with the appropriate professionals.

Yours sincerely,

**Senior Nurse**
cc: Unit Directors
Social Worker
Long Term Care Team

Letter 4 – When arrangements are made for an interim placement based on letter 3(b) or 3 (c). Patients Copy

Dear Mr /Miss / Ms / Mrs

**Moving from hospital to an interim placement.**

We are pleased to confirm that the ward team have advised that your relatives inpatient treatment at this hospital is complete and they are now ready for discharge. We are now in a position to confirm that an interim placement has been arranged at ……. Care Home. Transport will be arranged for .....

During this time you will have the opportunity to view other homes, or whilst you are waiting for a place to become vacant in the home of your choice.

You might decide that your relative would like to stay permanently at..... In this case you can make arrangements to do so with the care home manager who will liaise with the appropriate professionals.

Yours sincerely,

**Senior Nurse**
cc: Unit Directors
Social Worker
Long Term Care Team

Letter 4 – When arrangements are made for an interim placement based
On letter 3 (b) or 3 (C) Relatives Copy.

Patient Addressograph

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

# Abertawe Bro-Morgannwg University Health Board
# Choice of Accommodation audit checklist

| Letters | Ward | Appropriate Health Board Staff Signature | Designation of Health Board staff | Relatives Signature | Relationship To patient/client | Comments From relatives/advocate | Date |
|---|---|---|---|---|---|---|---|
| Letter 1 | | | | | | | |
| Letter 2 | | | | | | | |
| Letter 3 | | | | | | | |
| Letter 4 | | | | | | | |

COIN clinical online information network

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Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

# Abertawe Bro-Morgannwg University Local Health Board

## Authorisation form for items to be published onto COIN

| | |
|---|---|
| Title of Guideline | Choice of Accommodation Policy |
| Name & Signature of Author / Chair of Group or Committee * | Sian Gwynn / Sian Gwynn |
| Coin ID: | |
| Library on which you wish the guideline to be launched | Clinical Coin 'Corporate' |
| Document: Is the Document New, Modified, Reviewed, Supersedes another Document. List Version | New |
| Effective Practice Approval Committee (EPAC)<br>All Policy Documents or if<br>• The document relates to primary care or both primary, secondary care and specialist care<br>• Multiple directorates/ teams within secondary care are highlighted in the document<br>• The document relates to a new service or a new way of working<br>There are cost or safety implications associated with adopting the document | Not Applicable |
| Equality Statement on all Policies:* | Applicable |
| Is this document relevant to the GP portal? | Not Applicable |
| Published | October 2016 |
| Keywords to assist with searching * | Nursing Home placements / Continuing Care Funding |
| Last Review: | Not Applicable |
| Next Review / Guideline Expiry: | September 2018 |
| Name of Group or Committee * | Corporate Nursing |
| Name & Signature of Lead Pharmacist* | Not Applicable |

* Mandatory. All policies need to comply with the Guideline Policy located on the Home Page of COIN. This should include Title of Document, guideline author, review date. All documents must have a footer giving title and date of the current copy to ensure the most recent copy is used.