Admission, Transfer and Discharge Protocol for Individuals in our Services

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# Background

This template provides recommended key points that should be contained in a joint, locally agreed Admission, Transfer and Discharge (ATD) protocol for use in Care Stream.

The aim is to offer guidelines on practice to healthcare professionals with the emphasis throughout on multi-disciplinary, inter-agency working and collaboration.

Partnerships must endorse the completed protocol with the Director of Care Stream and all relevant Local Authorities signing it off.

# Introduction

This section should recognise the importance of a jointly agreed protocol for discharge from Care Stream facilities.

* + It should direct staff into a consistent coordinated approach with multi- disciplinary, multi-agency input while maintaining the individuals interests as central to the discharge planning process.
  + It should remind staff that this is a working document and as services and practices develop, it will require to be reviewed to improve or add to ways of working and to accommodate new service developments.
  + The Admissions Transfer Discharge protocol should have a date of issue and a review date.
  + Good practice indicates that an admission, transfer and discharge steering group should be established to launch, implement, evaluate, monitor, review and audit this working document.
  + Completed protocols should be well publicised and promoted to ensure all relevant staff are familiar with the document and encouraged to use it.
  + It is vital that each stage of the discharge process has agreed maximum timescales for completion.

# Policy Context

## Local policy

Any specific local issues or policies should be detailed in this section.

It is recommended that locally, an Admission Transfer Discharge protocol is devised.

# Principles and Values

This section would include the principles and values, which are drawn in part from work within Care Stream.

It should outline the aims of the protocols, which might include ensuring:

* + Individuals receive the right care in the right place at the right time.
  + Safe and timely discharge from our facilities to a more appropriate setting.
  + Effective use is made of public resources.
  + Individuals and their carers are involved and supported in the discharge process.
  + All managers and staff know what to do and where, when and how to do it.

# Roles and Responsibilities

**None of the lists in the following sections are exhaustive and should include anything pertinent to local areas.**

**Relevant web links should be included where appropriate**.

**The lists are not exclusive to any one part of the process and may be applicable throughout the service users’ pathway.**

This section should clearly identify and describe the roles and responsibilities of all stakeholders involved, for example:

* + People being supported including family/carers
  + Care Stream Service Staff
  + Director of Operations
  + Community Health/Care Partnerships
  + Acute Sector/Primary Care Services (where required)
  + Other Care Stream Staff
  + Local Authorities including learning disabilities services
  + Mental Health Professionals
  + Enabling and Rehabilitation Services
  + Pharmacists and GP’s
  + Independent Advocacy Services
  + Benefits agencies

## Admission

The admission process should be well defined and consistent for each type of admission/specialty. This section should provide evidence that discharge planning has commenced. This should include the following:

* + - Recorded consent to information sharing between organisations and systems
    - Communication plan
    - Planned admission criteria
    - Unplanned admission criteria
    - Planned assessment/initial assessment of need - this should be inclusive of functional cognitive screening
    - Early identification of adults in need of support or protection
    - Early identification of adults with incapacity
    - Early identification of issues relating to homelessness
    - Estimated/Planned Date of Discharge should be agreed, recorded and reviewed as required ensuring that the individual and support staff as well as Care Stream are consulted at all times
    - Documentation should be agreed locally and consider the principles of single shared assessment
    - Consent/information sharing should be in alignment with local and professional standards
    - Evidence of a clear communication strategy for each individual that takes into account of their needs, abilities and appropriate means of communication
    - Communication with other agencies/multi professionals to ensure effective individual admission and discharge pathways
    - Mental Health – Advanced Statement

## Post assessment

Following the outcomes from assessment, the information identified could be used to inform the discharge plan below:

* + - Choice of accommodation
    - Care Home information including access to Care Quality Commission reports
    - Agreement to local authority charging policies
    - Provider assessment
    - Adults with Incapacity issues
    - Care Stream Care and Support Planning policy
    - End of life care
    - Equipment and adaptations needed in the home for the individual
    - Assistive Technology (where needed)
    - Housing within Care Stream Properties
    - Benefits, Rents and funding (Universal Credit)
    - Advocacy services

## Transfer

The transfer process should be well defined and consistent for each type of transfer. The processes, procedures and authorisation required should all be outlined in this section:

* + - Transfer of assessment information and other details
    - Transport issues to be addressed
    - Examine options for intermediate care
    - Transfer within Care Stream homes (where possible voids exist)
    - Consideration of legal aspects for vulnerable adults/adults without capacity

## Discharge

Effective planning facilitates a safe, appropriate, and timely discharge into the community to another facility. This section should include:

* + - Current/ongoing risk assessment and management plans that should facilitate an effective move to the community setting
    - Provider Strategy
    - A completed discharge checklist that is signed and dated in partnership with all concerned

# Monitoring, Review and Audit

The completed Admission, Transfer and Discharge Protocol must have an agreed monitoring and review procedure and an audit tool in place to evaluate its effectiveness.

The following are some examples of how this may achieved:

* Failed or poorly executed admissions, transfers and discharges
* Measuring actual journeys against agreed timescales as set out in the Protocol
* A review of procedures where systems have failed
* Management of both formal and informal complaints procedure

* Effective and relevant Audit tool
* Reports from the specified services
* Date for review and update of the Protocol

# Training and Development

This section should evidence the importance of induction and ongoing training and development for all Partners involved in the Admission, Transfer and Discharge process. Consideration must be given to the following:

* + Care and support staff
  + Multidisciplinary Team
  + Bank staff
  + Volunteers
  + Leadership
  + Understanding other professionals, organisations, and other services
  + Documentation, Record Keeping
  + Local Policy
  + Professional Development Plans
  + Knowledge and Skills Framework
  + Annual Development Reviews
  + Self-assessed training needs