G32	Standard	Discharges and transfers M&H

Systems are in place to facilitate **transfers** and plan successful **hospital discharges**.

Justification

The patient journey through integrated pathways (health and social care systems) should be as seamless as possible to avoid unnecessary hold-ups which have financial, psychological and social implications. Delays in the discharge and transfer process cause problems in a system which is overstretched, with other people needing care and waiting for a place.

Common documentation such as patient assessment forms should be considered.

Discharge planning should start on admission to avoid delays.

Any equipment supplied should maximise independence, provide the best quality of life and needs to be provided in time for discharge. Costs must be appropriately allocated with clear lines of responsibility.

Patients/ service users purchasing their own equipment will need to know how comfortable it is, what support systems are required, such as servicing and training, how compatible it is with existing equipment and the home environment, and how to use it.

Authorising Evidence

HRA (1998); MHOR (2004)

Links to other published standards & guidance

CSP (2008); COT (2006); DoH[1] (2003); DoH[2] (2003); DoH (2008); NCGS (2008); NPSA (2008); Ruszala et al (2010)

Cross reference to other standards in this document

B3; D6-9,11; K1-3; G2,8-10,14-18,30,39,40

Appendices

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Verification Evidence

- requirements for compliance to achieve and maintain this standard

- Care pathways are formulated to deal with common 'flows' across organisational boundaries
- Risk assessments (for M&H) that are 'suitable and sufficient', robust and balanced
- Safe systems of work and standard operating procedures
- Individual person assessments where necessary – readily accessible and regularly reviewed
- Training for family/ home carers
- An environment as far as possible conducive to good care (space, layout, etc.)
- Handling and other equipment that is suitable (fit for purpose) and readily available
- Investigation of and learning from adverse events, using root cause analysis to locate the cause and prevent a recurrence SFAIRP
- Monitoring, audit and review of the verification evidence
- Points learnt from audit, and accident/ incident investigations and reports are disseminated and discussed withal concerned, with subsequent learning
- In the case of discharges home, equipment is ordered and in situ in good time prior to discharge
- Home visits are arranged as necessary

G32 Protocol – Discharges and transfers (M&H)

Author: Amanda Hart

This protocol looks at issues that affect the moving and handling of an individual being discharged/ transferred to another care facility/ home.

1. Introduction and background

With professional planning by multidisciplinary teams re-admission to hospital can be avoided. Effective and timely discharge requires the availability of alternative, and appropriate, care options to ensure that any rehabilitation, recuperation, and continuing health and social care needs are identified and met (DoH, 2003[1]). Delayed discharges can be due to poor procedures in hospital, lack of communication between social services and the hospital services or lack of capacity in post-hospital care (National Audit Office, February 2003). The delayed discharge fines were introduced under the Community Care (Delayed Discharges) Act which received royal assent in April 2003. From 5th January 2004, social services were fined for failing to have a care package available within two days of notification from a hospital that a client is to be discharged. With an ever-increasing elderly population the demand for nursing home placement has increased and this may affect patients waiting for discharge from hospital.

The Healthcare Commission published a report "the State of Healthcare 2005" showing the number of delayed discharges was falling due to the availability of services in the community. Other reports have shown that people have been admitted into care when they could have been supported in their own homes. Identifying manual handling needs as soon as possible means that the correct equipment and manpower is in place before the discharge from hospital.

2. Management, organisation, supervision and support

Discharge from hospital can be stressful for the person (patient/ service user) and their relatives/ carers. Equipment used to move a person in hospital may be different to that used at home. If person specific equipment is used in hospital and is compatible with equipment at home this may be sent home with the person rather than thrown away (such as slide sheets).

If the discharge is planned well the handing over of care from hospital to home/ nursing or care home should be seamless. A multidisciplinary and multi-agency approach (DoH, 2003[1]) will help to ensure all equipment and human resources are in place before the person arrives home.

In some cases a person may not be discharged to their own home. In these cases care workers must allow for possible disorientation and the increased chance of slips, trips or falls.

3. Staffing levels

Hospital staff should identify the number of caregivers required to help the person in all aspects of daily living. This will help with identifying the resources needed when the person is discharged from hospital.

Transport staff need information about whether the person uses a wheelchair, walking aids or will need to be transferred using a stretcher/ trolley so that adequate staffing levels are provided. Extra staff may be required if the person is being transferred to a property with steps, stairs or ramps.

Bariatric patients will have special needs see G15.

4. Staffing competencies (after Benner, as cited in Ruszala et al, 2010)

Novice- Possible groups

- Nursing students
- Therapy students
- New transport staff

Students and new staff should be given adequate training before escorting a patient home following a hospital stay. Ideally they should shadow an experienced person so that they can watch and ask questions to verify learning.

Advanced Beginner- Possible groups

- Trainee transport staff coached by a mentor who has experience of manual handling
- Conversion students who have rehabilitation experience.

Competent

- Minimum of 2-3 years' experience, aware of environmental/ financial/ social/ health issues which may affect discharge home. Able to assess and plan manual handling activities to reduce risk of injury. May lack experience in being able to see an overall picture. For example may recognise a person with mobility problems in their own environment such as a clinic or a hospital ward but not have experience in coping and finding solutions to more complex handling needs at home. Recognises that the family carer will also have needs that will require addressing.

Proficient

- Understands problems as a whole and takes a holistic approach. For example risk manager/ discharge co-ordinator.

Expert

- A member of staff with a wealth of experience who has intuition. Able to recognise a problem without going through process of analysis. For example Manual Handling Adviser.

5. Environment

Risks in persons' homes are unpredictable and therapy staff accompanying persons on home visits should be alert at all times to hidden dangers such as cats and dogs/ small rugs.

It may be necessary to enlist help from relatives and carers to make adaptations in the home environment in order to discharge a person home safely. Limited space may restrict manual handling activities and sometimes the family may be asked to remove large pieces of furniture from the room in order to enhance safety. Changes to the environment rest with the person and the family.

If the person does not have capacity, that person's best interests must be served whether by family or someone appointed by the Court of Protection, to enable the person to cope with the activities of daily living at home.

Equipment and support may be available from statutory services, e.g. occupational therapists, physiotherapists, district nurses. If the person is self-funding, advice should be given to assist the person/ family in purchasing suitable equipment/ adaptations for safety and to avoid costly mistakes.

6. Communication

The person and carer/s should be involved in the discharge planning as equal partners with the professional staff. All discharges should be discussed with the person including any recommendations such as height of the bed/ chair or toilet. If the admission was a planned one, the recommendations should have been discussed with the person prior to the admission.

For a person admitted as an emergency the discharge planning needs to start on admission.

Where relatives are willing to be involved in the person's care, they should be consulted about any decisions/ recommendations.

In person-centred care a single assessment process (SAP) is used (DoH, 2003[2]). Where necessary a multidisciplinary/ multi-agency team meeting is set up before discharge to discuss the best interests of the person who is going home. Occupational therapists may wish to discuss a home visit and/ or what equipment has been identified as needed at home and when it will be available. Social Service personnel may be involved to identify a care package and the allocation of a care manager. In some areas a re-ablement team may bridge the gap between hospital admission and home and the patient may have had support from a crisis team before hospital admission. In some cases hospital admission could have been avoided altogether but this would have depended on how well care workers, relatives and the patient were able to cope or were supported, for example by the provision of manual handling equipment such as standing hoists, turn-safe discs or slide sheets. These could have enabled a person to continue to be cared for in her/ his own home.

Communication as to whether the person is at risk of falls, deterioration in health and other factors such as manual handling issues should be discussed with all relevant professionals. Information technology is becoming more sophisticated and now information can be shared between GP surgeries, community services and local hospitals on line.

7. Treatment planning

N/A

8. Moving & handling tasks

The patient may have a home assessment before full discharge from hospital. Occupational therapists/ physiotherapists/ nurses involved may be asked to transport pieces of equipment such as walking frames and aids to daily living in their own vehicles. This requires careful planning. If possible, heavy items should be delivered to the person's home prior to the visit to reduce the risk of the professional having to struggle with this equipment. This will also reduce the risk of an accident with unsecured heavy equipment in the car.

If a home assessment has not been carried out then the person may require advice on manual handling issues such as how to get into/ out of a car. Similarly, family/ care workers may require advice on how to assist the person with this procedure.

Relatives/ care workers may require training in lifting a wheelchair into/ out of the boot of a car, and how to avoid lifting heavy loads.

Hospital transport services will need full details of the person's capabilities and what help is required for the person travelling home. Transport workers will require training which includes assisting from sit to stand, walking a person, using ramps, steps and stairs. Training should include how to secure a wheelchair into the correct position with restraining straps. Relatives should be asked to take belongings home in advance to minimise the number of bags that need to be carried by the person and the transport staff.

9. Moving and handling assessment

Transporting to home/ care home a handling assessment (MHOR 2004) must be undertaken to establish how the person is able to travel/ be transported home on her/ his discharge. The assessment would include whether relatives can collect the person, if the person is able to get in/ out of a car, or if alternative transport is required.

When somebody with mobility difficulties is discharged, a moving and handling assessment should be carried out in the person's own home/ place where they will be transferred, to ensure that any equipment is compatible with the environment and furniture. Where possible the first assessment should be undertaken during a home visit prior to discharge (see section 6). The

assessment should be repeated once the person is at home, as often people can manage activities of daily living in their own environment better than in hospital.

The TILE(E) assessment (MHOR 2004) must consider the number of handlers and what handling aids are needed, or any environmental changes required. In some cases a person may need to have a bed downstairs for safety, or loose rugs/ mats may need to be removed to reduce the risk of falls.

Neither relatives of the person, nor the person should be expected to use a hoist and sling without appropriate training and support because of the potential risk of incorrect sling application or hoist failure whilst in use. Once deemed competent, relatives and the person may use the hoist independently. In some counties there are M&H advisors for carers and their on-going support should be sought. It is strongly recommended that all family carers have access to such a person.

The expectations of the patient and the family must be taken into consideration and sometimes a compromise has to be made, for example over what the person can safely do, or what equipment might assist in using a shower or a bath.

10. Methods, techniques and approaches

This will be down to individual risk assessment in the person's own home.

11. Handling equipment

Handling equipment (e.g. hoist, turn cushion, small lateral transfer board) needed by the patient in their own home should be delivered in advance, particularly large pieces of equipment. It should not be the responsibility of the therapist to try to get large pieces of equipment in a domestic car.

Liaison with a community equipment supplier is important.

Consideration must also be given to equipment needed to facilitate discharge home via a vehicle, such as the use of a hoist, turn cushion, small lateral transfer board or a Handybar.

When a person is discharged it is important that used equipment, when no longer required, is decontaminated and returned to storage ready for the next person.

Wheelchairs should be maintained and cleaned. Training should be given to the family and care workers in how to position the person safely in the chair, the correct way to push the chair, and in getting the wheelchair in/ out of a car, if required. Pulling the wheelchair backwards along corridors should be avoided.

12. Other equipment and furniture

Gas cylinders should be safely handled and placed in an appropriate carrier if accompanying the patient.

An electric profiling bed may be required for the safety of both carers and the person if the person needs assistance with bed moves.

A person with mobility problems should also have an appropriate height chair with arms extending to the front of the seat. Grab rails in the home as identified during the home visit should be installed prior to discharge. Care workers/ relatives should be advised how to assist a person safely to reduce the risk of falls and injury to either person or family/ care workers.

Difficulties may arise if the person shares a bed with a partner who wishes to continue to sleep with the person – negotiation may be required.

If a double bed is used by one person then handlers must use slide sheets with extension straps/ an in bed system to position the person near the edge of the bed for care, to avoid poor working postures.

There may be a need for a commode, particularly if the person is expected to stay downstairs and there is no toilet access.

13. Levels of risk

To carry out a 'suitable and sufficient' assessment, each task should be evaluated as part of the assessment process, so that the level of risk is quantified. Such assessments should be used, wherever possible, in the design of a safe system of work, and in highlighting any residual risks.

Various systems exist, but it is suggested that the NHS risk management 5x5 matrix, with 0-25 scale, is used for an overall evaluation of risk (NPSA, 2008) (see CD1, appendix 9 in folder 5). It is in common use, simple to use with 5 levels of risk, determined by a calculation of the likelihood or probability of an adverse event occurring multiplied by the severity of consequences or impact should it occur.

Likelihood/Probability (0-5) x Severity of Consequences or Impact (0-5) = 0-25

The values below are based on this system. Calculations lead to the following possible scores or ratings: -

1– 6 = Low; 8 – 12 = Medium; 15 – 16 = High; 20 = Very High; 25 = Extreme

These ratings can then be used to alert staff, to prioritise action and justify any necessary expenditure to make the situation safer, on the basis of reasonable practicability. Options can be evaluated by considering risks, costs, and actions planned or taken, to reduce the level of risk to the lowest level that is reasonably practicable, which can thus be demonstrated.

Risk analysis should be carried out on each individual and should start as early as possible during the hospital stay.

14. Alerting the manual handling team

The manual handling team should be alerted immediately if there has been a M&H problem with patient admission and transportation which may have implications for discharge. The team may also be contacted for advice regarding equipment needed on discharge.

15. Referral to and involvement of other specialists

The ambulance service should be contacted for advice if the person requires medical support during the journey or if the patient's weight is more than the SWL of a normal ambulance. This should be included in the local discharge policy.

16. Transport

All transport staff will need adequate training in handling techniques to ensure their own safety and the safety of their passengers. Training should also be given in making the person secure in the vehicle.

Assessment should take place to ascertain whether the person requires an escort and what qualification the escort should have. The type of vehicle needed should be suitable for the person being transported and their mobility needs.

18. References

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Further Reading

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Summary/ Key Messages

- **The intention of the entire strategy and standards document is to contribute to the improvement of: -**
  - The quality of care - 'patient experience' (dignity, privacy and choice)
    - clinical outcomes
  - Patient/ person safety
  - Staff health, safety and wellbeing
  - Organisational performance – cost effectiveness and reputation, etc.

- **The standard for G32 is:**

Systems are in place to facilitate transfers and plan successful hospital discharges.

- **Skilful M&H is key**

- **Special points for G32 are: -**
  - **Planning is vital and should start as early as possible**
  - **Care pathways should be formulated to deal with common 'flows' across organisational boundaries**
  - **Documentation that is common or compatible should be used**
  - **The individual needs of the person should be catered for**
  - **In the case of discharges home, equipment should be ordered in good time and be in situ <u>prior to discharge</u>**
  - **Home visits may be necessary**