Discharge Policy

Revised March 2013

Discharge Policy

Care Home Name: Wellbeing Residential Group

Policy Statement

Wellbeing Residential believes that every service user who leaves or is discharged from the home should do so as part of a planned process of care and should be supported through the process wherever possible so that the move to a new home or environment can be made as easy and as safe as possible. This policy is designed to ensure continuity of care between hospital and community services, in line with the Community Care Act 1993. Wellbeing Residential Group complies fully with the Mental Health (Patients in the Community) Act 1995: aftercare under supervision; the *Supervised Discharge Order* and guardianship under the Mental Health Act 1983 (as amended under the Mental Health Act 2007).

Aim of the Policy

This policy is intended to set out the values, principles and policies underpinning this homeôs approach to the discharge of service including planned discharges and self-discharge. The key aims of discharge should be that it meets the service usersôneeds and that their safety and care is ensured during the process.

Discharge Policy

Wherever possible the Wellbeing Residential will work to ensure that discharges from the home are planned well in advance so that proper continuity of care can be established, and so that individual service users can have the maximum independence, autonomy and control over their lives. Wellbeing Residential believes that planned discharge can be defined as an agreement between the service user, their care team, their relatives/carers and the home, which considers and addresses the rights and responsibilities of all those concerned in the discharge process. Essential to this agreement are adequate information and discussion with the service user, flexibility to meet individual needs, effective referral to future care providers, and the availability of ongoing support services.

When discharge is planned the home will follow the procedure below.

1. Wellbeing Residential will agree to a discharge plan which will be drawn up with the service user, their relatives, the care team responsible for the service user, their key worker and, where possible, staff from the home where they will be discharged to. This will include a care programme approach meeting if appropriate. The plan must:
    a. specify the resources available to the client upon discharge
    b. state the reason for the transfer or discharge
    c. summarise the services that were provided by the home
    d. evaluate the achievement of the goals and objectives of the service user
    e. contain the signature and title of the person who prepared the summary.

2. The plan for the transfer and discharge of a client must be explained to the service user in a language or manner that he or she understands.
3. Enter all details into the service user's plan.
4. Set a discharge date with the client.
5. Request each service user to fill in an evaluation/satisfaction questionnaire before they leave.
6. Complete discharge documentation with the keyworker upon discharge.
7. Send a copy of the discharge plan to the service user's key worker, GP and all agencies involved with the client.

Where a service user is being discharged to relatives or carers then the above procedure should still be followed as far as is reasonably practical and the relevant relative or carer should sign a form taking full responsibility for the discharge.

Self Discharge at Short Notice

In the event of a service user demanding to be discharged at short notice the home will do the following.

1. The service user's legal right to take their own discharge will be respected.
2. The home will do all that it can to advise and encourage the service user to remain in the home while they plan their discharge in collaboration with their key worker, relatives, advocates or friends.
3. In the event of the service user demanding to be discharged despite this advice, the service user will be asked to sign a form stating that they are taking their discharge against the advice of the home.
4. The service user's key worker, case manager or CPN will be informed.

In the case of a service user who takes their discharge and is, in the opinion of care staff at the time of discharge, a cause for concern as to their own safety or to the safety of others, then the member of staff in charge of the home should phone the police immediately. They should then inform the GP or duty GP service and the key worker, case manager or CPN.

Training

Relevant staff are trained on resident discharge as part of their training.

Signed: _____

Date: _____

Policy review date: _____