

## Choice of Accommodation Protocol for In-Patients Requiring Placement in Residential or Nursing Home

Cardiff Local Authority – Vale of Glamorgan Local Authority and Cardiff & Vale  
University Health Board

November 2017

### 1. Scope

This local protocol concerns all individuals who, following an assessment of need, require ongoing support in a care home – either residential or nursing. It does not apply to people whose care needs can be met within their own home.

This protocol recognises the rights set out in national guidance for people to receive care in the setting most appropriate to meet their assessed needs. In arranging discharge from hospital, it is essential that the primary aim is to ensure the person returns home if at all possible. Only if this is not possible should other options such as residential care be considered.

### 2. Introduction

This protocol sets out the process to be followed by Cardiff Local Authority, Vale of Glamorgan Local Authority and Cardiff & Vale University Health Board when it is identified following multi-disciplinary assessment that an individual's needs are best met within a care home, either as a residential or nursing resident.

The local process supporting the implementation of this protocol will be compliant with the Care and Support (Choice of Accommodation) (Wales) Regulations 2015 and the All Wales Framework for Continuing NHS Funding

### 3. Fundamental Principles

The following fundamental principles are applied to ensure a fair and consistent approach to supporting hospital discharge is made available to all eligible patients

#### **Early Information, Assistance and Advice.**

The principle of making suitable Information, Assistance and Advice available to patients, and their carers/families at the earliest opportunity is central to the discharge planning process. This should include information in relation to financial assessments and charging for services.

All patients should receive a leaflet with necessary information, detailing the discharge planning processes. This is attached as **Appendix 1**.

#### **Discharge Home.**

As a general rule, people will not be discharged directly from an acute episode of hospital care to a permanent placement in a care home. The potential for reablement and/or recovery will be considered and excluded before any decisions are made on longer term care needs. The aim should always be to return home if possible and appropriate.

#### 4. Discharge to a Care Home

In circumstances where a person does require discharge directly to a care home following an acute episode of care, this decision must be taken following a full multi-disciplinary assessment of the person's potential for reablement and/or recovery. It is noted that the ward staff are not in a position to assess for care home admissions, so must refer to the Integrated Discharge Service at the earliest opportunity.

Both the NHS and the local authorities have responsibilities in this process to work together to ensure that care needs are met in the most appropriate and timely way. A permanent move to a care home is a major decision and should be treated as such. The process is much less likely to be successful where it is rushed or poorly planned, resulting in potentially adverse consequences for the person involved and their family, and also possibly result in the inappropriate use of health and social service resources.

The application of the choice guidance at local level should be embedded firmly in the discharge and transfer of care procedures operating locally between partners. The provision of information at the earliest appropriate opportunity, and consistent and effective communication with both the individual and their family/carers will help to address many of the difficulties and misunderstandings that can occur. Appropriate and timely communication with the individual and their relatives/carers is essential in ensuring the process of a move to a care home takes place in an efficient and effective manner, avoiding delays within appropriate settings.

This Choice of Accommodation Guidance aims to support professionals to help patients and their families through this major decision making process. The multi-disciplinary team will work with patients and their families to help them identify suitable care homes that will be able to meet the person's ongoing health and care needs.

A patient's lack of cooperation with the discharge process and/or to make a choice of accommodation will not prevent the discharge process from proceeding. This may mean exploring alternative solutions.

Where a place in the home of choice is not currently available, or is unlikely to become available in the near future, it will be necessary to identify an interim choice, until a place becomes available in the initial home of choice. People waiting for a place to become available in their home of choice will not be able to remain in hospital in the interim period.

Consideration of capacity and the principles and requirements of the Mental Capacity Act 2005, the Mental Health Measure 2010 and the Protection of Vulnerable Adult Procedures must underpin the application of this protocol.

Health and social care staff must take a proactive approach to managing choice of care home on discharge from hospital. The decision to discharge an individual must not be influenced by lack of availability of a person's choice of care home or the outstanding resolution of financial issues.

## 5. The Process

### **Stage 1: An Assessment indicates that the person's needs are met most appropriately within a care home.**

The discharge process will have commenced on admission, with goal setting via an estimated/predicted date of discharge discussed with the patient and relatives/carers, and information leaflets relevant to the discharge process provided, that contain advice on expectations and timescales.

As part of their ongoing care and discharge planning, each individual identified as having complex discharge needs will have received ongoing multi-disciplinary assessment, co-ordinated by a named person. The outcome of this assessment process will identify the level of assessed need and indicate the care needs requiring intervention on discharge.

As part of this assessment process, it is essential that the multi-disciplinary team have considered and documented that:

- All other possible options have been explored including the potential to support assessed needs with an ongoing package of social care at home.
- The patient/carer/family or advocate has been fully involved throughout the process.
- The potential for reablement and/or rehabilitation have been considered and discounted.
- It is not possible to support the continued independence of the person in the community, even if this would be the preference of the person.
- Eligibility for Continuing NHS Health Care has been considered.
- The patient's status under the Deprivation of Liberty Safeguards
- The patient's mental capacity to consent to the transfer in care.
  - Is there a responsible Lasting Power of Attorney?
  - Is there a Court appointed Deputy?
  - Has the patient made an Advanced Decision?

The outcome of the assessment will also indicate whether the person's needs are most appropriately met with a residential or nursing placement within a care home.

At this stage a member of the MDT will be identified as the Care Co-ordinator, this could be a social worker, nurse, or therapist and will be determined by the prevailing need of the patient. This will include those who are likely to be "self funding".

The social worker will make arrangements for the financial assessment to be discussed with the patient and their family/carer/advocate. It is noted that the Financial Assessment process can take up to four weeks,

## Stage 2: Choice Protocol requirement triggered

### WEEK ONE

#### 2a. Meet with patient/carer/family

Once a person's needs have been assessed and the outcome is that care home support is required, the care co-ordinator will meet with the patient/carer/family or advocate and explain the outcome of the assessment, and discuss the options that are now available that are able to meet on-going care needs. The Care Co-ordinator will explain the choice protocol, and provide the patient/carer/family or advocate with an information leaflet and a care directory to support and supplement this discussion. The financial assessment will commence.

Restrictions on choice, for example related to specialist needs, will be explained to the patient/family or carer. If there is no vacancy in any of the homes of choice then the person will be expected to move to a suitable care home that can meet their needs with a vacancy as an interim arrangement. This could be a care home located outside of the patient's own Local Authority boundary.

The outcome of this meeting **must** be documented, and a summary provided, within 3 working days, to the patient/family/carer to support early identification of appropriate care home. (**Letter 1 / 1a**) Patients, families or carers who require support in choosing an appropriate care home will be referred to the Age Concern Discharge Support Officer. The Discharge Support Officer will be able to provide information regarding current capacity within each of the homes.

If patient is currently subject to a DoLS Authorisation on the hospital ward, consultation with the Relevant Person's Representative (RPR) must take place and be recorded. If the person subject to a DoLS does not have a RPR appointed then an Independent Mental Capacity Advocate must be appointed and consulted with.

For Vale residents: The Vale of Glamorgan council ask patients to choose up to three care homes – their first, second and third choices – these should be care homes that have either current available capacity, or are expected to have available capacity within the near future – i.e. within in the next two weeks.

For Cardiff residents: Cardiff Council finds permanent and short stay residential and nursing home placements through an online tendering system which covers all registered care homes in the area. The allocated social worker will search the system for suitable and available care home placements for the patient / family to choose from. Homes which feel that they can meet the patient's identified care needs will have two working days to respond to offer a bed at a specified price. This is subject to the home agreeing the placement following their assessment and discussion with the patient / family. From the results, the patient / family will then be able to make a choice of the home they would prefer and which they can afford.

## 2b. ONE WEEK follow up

One week after the initial meeting with the patient/carer/family/IMCA, the Care Co-ordinator will make further contact and enquire about progress in identifying appropriate vacancies, and also to discuss any problems that have been identified. This follow up can be achieved via a telephone call or via a meeting, whichever is deemed most appropriate in the individual circumstances. At this follow up, the care co-ordinator will:

- Assess if there have been any changes in the patient's health status that may require reassessment.
- Support and advise the patient/carer/family to enable them to resolve any difficulties encountered in identifying an appropriate vacancy.

Following this, the care co-ordinator will ensure that any changes or updates are shared with the multi-disciplinary team, and the outcome of the follow up **must** be documented. (**Letter 2**)

## WEEK THREE

If there is any delay in progressing the identification of a vacancy consideration will be given to a further letter being sent in which a final offer will be made to arrange to meet within a clear time frame to help resolve any problems. (**Letter 3**)

## 2c. Completing the Discharge Arrangements

During the two week period allowed to identify a vacancy, the Care Co-ordinator will liaise with appropriate members of the multi-disciplinary team and the patient/carer/family/IMCA to ensure that any additional assessments are completed in response to changing needs. They will inform the discharge planning process. The care co-ordinator will also monitor and confirm the necessary financial assessments have been completed to ensure that funding arrangements can be put in place.

## 2d. Care Home Confirmation

As soon as a vacancy is identified in the home of choice the discharge process can be completed. If there is no vacancy in the first home of choice, then the care co-ordinator will ask for a place to be taken up in the second or third choice. The need to proceed with discharge even though the first choice of care home is not available needs to be reinforced during this process. The patient/carer/family need to be reassured that arrangements will be made to transfer to the first choice as soon as a place becomes available.

Once a named care home has been identified, the Statement of Need/Aims can be shared to ensure the care home meets identified needs which should include the person's status under the Deprivation of Liberty Safeguards and an assessment of their mental capacity to consent to the care transfer. This process will include a representative from the care home visiting the patient to confirm their needs can be met. It is essential that the care home make a fresh request for a DoLS Authorisation up to 28 days prior to any transfer if the care home has reason to believe that the patient is not able to consent to the transfer and will be deprived of their liberty at the care home.

If it is apparent that no vacancy will be available in any of the patient's preferred care homes within two weeks, the Care Manager will examine the suitability of any appropriate care home that has a place available.

A meeting will also need to be arranged between the Social Worker and the family to complete the necessary documentation and finalising agreements. This process **must** be documented.

## 2e. Discharge

It is expected that discharge will be undertaken within 2 days of completion of the above stages.

## 3. Dispute Procedure

If there is disagreement related to the proposed discharge to interim or permanent accommodation then the patient, their representative, the UHB and Local Authority will jointly decide on discharge arrangements.

In the event of the disagreement being between the UHB and the Local Authority there will be a meeting prior to the discharge date to resolve the matter. The meeting will be between the Divisional Nurse and the Operational Manager, Adult Services. Others may be invited to be present for example the Care Co-ordinator, the Social Worker or the Discharge Liaison Nurse. If the staff fail to reach agreement the matter will be escalated within 24 hours to the Director of Nursing UHB and the Director of Social Services, LA with a view to the dispute being resolved prior to the discharge date. Consideration will be given to involving the patient and/or his family, carer, advocate as appropriate.

In the event that agreement cannot be reached between the patient/family/carer/IMCA and the UHB and Local Authority the following procedure must be followed:

If the patient is assessed as having the mental capacity to decide on their discharge destination, the UHB and Local Authority must ensure:

- The patient has been provided with all the information required to make a discharge decision, including:
  - An assessment of their ongoing health and social care needs and relevant care plan.
  - A risk assessment highlighting the potential consequences of not moving into a care home.
  - A description of alternative care options and an analysis of the pros and cons of these options.
  - A discharge date

If the patient is assessed as not having the mental capacity to decide on their discharge destination and is objecting, the UHB and local authority must ensure:

- The patient and their representative has been provided with all the information required to make a discharge decision, including:
  - An assessment of their ongoing health and social care needs and relevant care plan.

- A risk assessment highlighting the potential consequences of not moving into a care home.
- A description of alternative care options and an analysis of the pros and cons of these options.
- An application to the Court of Protection must be made as soon as possible to determine discharge destination.
  - In addition to this, an application to the Court of Protection for a Conveying Order must be sought in order to transfer the patient to an interim placement.
  - Once Conveying Order in place, the patient can be moved to interim placement but NOT before.

The UHB has responsibility for implementing the discharge and will advise as appropriate on the procedures to be followed in the event of a dispute.

## Template Letter 1 – Vale of Glamorgan and Neighbouring Authorities

Dear (insert name)

### Re: Supporting Discharge from Hospital to Care Home

Thank you for attending the meeting today to discuss your safe discharge from hospital.

You have recently been assessed by the multi-disciplinary team (which may include for example doctor, nurse, physiotherapist, occupational therapist) in order to establish your current care needs. You were involved in this assessment process and you have agreed that you do not have a primary need for healthcare and therefore you do not meet the eligibility criteria for continuing NHS Healthcare. You do meet the Local Authority eligibility criteria for care. This assessment has indicated that those needs would be best met in a (insert relevant type) Care Home.

In order to assist you in your search you have been provided with a list of local registered care homes and an indication of where there are current vacancies. You need to make a choice about which care home you would like to move to. It has been explained to you that you are medically fit for transfer from hospital and that you cannot stay in hospital longer than is necessary. This means that you need to choose three care homes that can meet your needs, one of these care homes must have a vacancy.

We would ask you to choose up to three care homes nominating your first, second and third choices and we would ask you to make these choices based on the care homes that have current available capacity or are expected to have available capacity within the near future i.e. within the next two weeks.

We expect the process for you to find a suitable care home; discharge and transfer to it will take no longer than **4 weeks** in total. Whilst this process is in progress you may be transferred to an interim care bed if this is deemed to be appropriate.

If there is no vacancy in any of the homes of choice then you will be expected to move to a home with a vacancy as an interim arrangement.

As soon as you are able to identify a suitable care home with a vacancy we can invite the home manager to come and meet you on the ward and assess and agree whether the home can meet your needs.

We will contact you in two weeks to check if you have identified a suitable care home with a vacancy.

If at any stage you experience a particular problem, please contact your care co-ordinator (insert name and contact no) so that they may provide you with any additional support/advice that you may need to ensure that you are able to progress towards your safe and timely discharge.

Yours sincerely

Ward Sister/Consultant (**This letter is to be written within 3 days of the meeting**)

## Template Letter 1a – Cardiff Residents

Dear (insert name)

### Re: Supporting Discharge from Hospital to Care Home

Thank you for attending the meeting today to discuss your safe discharge from hospital.

You have recently been assessed by the multi-disciplinary team (which may include for example doctor, nurse, physiotherapist, occupational therapist) in order to establish your current care needs. You were involved in this assessment process and you have agreed that you do not have a primary need for healthcare and therefore you do not meet the eligibility criteria for continuing NHS Healthcare. You do meet the Local Authority eligibility criteria for care. This assessment has indicated that those needs would be best met in a (insert relevant type) Care Home.

Cardiff Council finds permanent and short stay residential and nursing home placements through an online tendering system which covers all registered care homes in the area. Your allocated social worker will search the system for suitable and available care home placements for you to choose from. Homes which feel that they can meet your care needs have two working days to respond to offer a bed. This is subject to the home agreeing the placement following their assessment and discussion with you. From these results, you will then be able to make a choice of the home you would prefer and which you can afford.

We expect the process for you to find a suitable care home; discharge and transfer to it will take no longer than **4 weeks** in total. Whilst this process is in progress you may be transferred to an interim care bed if this is deemed to be appropriate.

If there is no vacancy in any of the homes of choice then you will be expected to move to a home with a vacancy as an interim arrangement.

As soon as you are able to identify a suitable care home with a vacancy we can invite the home manager to come and meet you on the ward and assess and agree whether the home can meet your needs. We will contact you in two weeks to check if you have identified a suitable care home with a vacancy.

If at any stage you experience a particular problem, please contact your care co-ordinator (insert name and contact no) so that they may provide you with any additional support/advice that you may need to ensure that you are able to progress towards your safe and timely discharge.

Yours sincerely

Ward Sister/Consultant

**(This letter is to be written within 3 days of the meeting)**

## Template Letter 2

Dear

### Re: Supporting Discharge from Hospital

Following your meeting/discussion with (**insert care co-ordinator's name**), the Care Co-ordinator on (**insert date**). I am writing to confirm our telephone conversation/meeting of when you indicated that you have made the following progress in identifying appropriate vacancies/not made any progress. (**If appropriate put in an additional meeting to discuss any problems**).

It is important that these arrangements are made as soon as possible so that you can move to a placement where your care needs can be met more appropriately. As you may be aware long stays in hospital can increase the risk of people losing confidence and independence. In addition, in order for the Health Board to meet the care needs of everyone, the hospital needs people who have finished their medical treatment to be discharged to make way for others who are just starting theirs. Therefore we are keen to work with you to progress your discharge without undue delay.

Please arrange with the ward staff to make an appointment to meet your Care Co-ordinator within the next three days so that you can inform him/her of your choice of care homes. If there are any extenuating circumstances that you have not been able to make us aware of please ask the ward staff to arrange for me to come and see you on the ward or telephone me on the contact number above.

At this meeting we will wish to discuss with you your up-to-date health position and to support and advise you/carer/family to enable you to resolve any difficulties encountered in identifying an appropriate vacancy.

Yours sincerely,

**Senior Nurse**

## Template Letter Three

Dear

### **Re: -- Patient Name – Supporting Discharge from Hospital**

Following the letter to you dated (**insert date**) I understand that you have not progressed arrangements for your (or your relative/friend) discharge to a care home.

It is very important that you contact the Care Co-ordinator who will meet with you within the next 48 hours. I regret that if you do not make progress with your discharge arrangements, working with the Care Co-ordinator, the Health Board and Local Authority will make the discharge arrangements/appropriate safe alternative arrangements.

I would like to stress that transfer from hospital needs to be progressed to ensure that patients' needs are met in the most appropriate care setting.

Yours sincerely,

**Lead or Clinical Board Director of Nursing.**

## Choice of Accommodation Protocol for Inpatients

### Proposed Timeline and Performance Indicators

	Day	Required Action	Performance Measure	Lead	Dispute process
Stage 1	0	Integrated Assessment indicates that person's needs are met most appropriately within a care home.	Letter 1 /1a sent at Day 0.	Ward Staff	
		Care Co-ordinator identified.			
		Financial Assessment initiated.			
Stage 2	1-7	Meeting held with patient / carer / family with request to choose up to 3 care homes.	.		
	14	Follow-up contact made by care co-ordinator as follow-up and ongoing support provided as required.	Letter 2 sent by day 17.	Senior Nurse	UHB and Local Authority meet to review dispute and decide discharge date with referral to relevant Directors as necessary.
	21	Completion of Discharge arrangements (to home of choice or temporary accommodation)	Discharge enacted OR Letter 3 sent by day 21.	Clinical Board	
	23	Discharge takes place.			

Performance monitored and recorded via weekly DTOC Thursday Meetings.

## Appendix 1

### [Intranet Link to PDF](#)

#### THE DAY OF YOUR DISCHARGE

A final check will take place to ensure that everything is in place for your discharge/transfer of care. If you do not need to stay in a bed for medical reasons, you will need to be ready to leave the ward by 10 am. If necessary, the ward staff can arrange for you to wait in the comfort of the Discharge Lounge for your relatives to collect you.

A week's supply of your current medication and/or dressings will be provided for you with instructions about how and when it needs to be taken/used. Ongoing supplies will be the responsibility of your GP. If you have any concerns about your medication, please speak to the nurse in charge or your ward pharmacist. At home, please speak to your GP or community pharmacist.

Sometimes the medical team will request that you attend an outpatient appointment. This is arranged by the receptionist on the ward and you will receive a written confirmation of your appointment following your discharge.

#### MORE HELP AND ADVOCACY

More Help and Advocacy (someone who will speak up for you) is available for patients, families and carers from:

Age Connects Home First Support Service  
02920 663693  
Care and Repair Cardiff - 02920 473337  
Care and Repair Vale - 01446 704308

#### USEFUL CONTACTS

Occupational Therapist

Physiotherapist

Pharmacist

District Nurse

#### Community Resource Team

North and West Cardiff - 029 21824101

South and East Cardiff - 029 2063 9988

Vale of Glamorgan - 01446 704138

#### Integrated Discharge Service

University Hospital Llandough  
029 2071 5322

University Hospital of Wales  
029 2074 2760/2098

## CARING FOR PEOPLE KEEPING PEOPLE WELL



## PLANNING YOUR DISCHARGE

<input type="text"/> Patient Name
<input type="text"/> Hospital Number
<input type="text"/> Admission Date
<input type="text"/> Planned Discharge Date
<input type="text"/> Ward Telephone Number

#### OUR COMMITMENT TO YOU

Welcome to Cardiff and Vale University Health Board. We appreciate that a hospital stay can be a stressful and worrying time, but we will offer support and advice to you and your family/carers throughout your hospital stay. For some patients, this may involve a discussion about the continuing support you need when you return home so that your discharge is as straightforward as possible.

If you have any questions about the information in this leaflet, please ask any of the staff looking after you. They will be happy to help. Thank you for working with us as this helps us to improve services for you and other patients.

#### PLANNING FOR YOUR DISCHARGE OR TRANSFER FROM HOSPITAL

Hospital is the right place to be when you have specific treatment and care needs. Once your treatment is complete, it is important that you leave hospital as soon as possible to make way for other patients who need to be admitted. We will start

planning for your discharge as soon as you are admitted to hospital by:

- Agreeing with you a planned date for your discharge which will be noted on the front of this leaflet
- Assessing what your care needs are likely to be when you are ready to go home.
- Involving any relevant staff who can help in meeting those care needs, such as an Occupational Therapist, Physiotherapist, GP, Speech Therapist, Community Nurse, Social Worker, etc;
- Making arrangements for equipment or services that you may need when you leave hospital.
- Discussing arrangements with your family/ carers if appropriate

#### INVOLVING YOU, YOUR FAMILY AND CARERS

All staff will work with you and your family/carers to plan your safe transfer or discharge.

You or your family/carer may have concerns, for example, about your future safety at home, your ability to move

around, or manage your personal care, medication or domestic arrangements. Please raise any concerns with a member of staff as soon as possible.

If you have a carer, we will involve them and make sure they are consulted about your discharge arrangements.

We will also tell your carer where they can find information and organizations which will help them care for you.

#### HOW YOU CAN HELP US TO HELP YOU

When we know what date your hospital treatment is likely to be complete, we will tell you you're expected discharge or transfer date. It is important that you are aware of this so that necessary arrangements can be made in advance. These may include:

- Transport home - patients are expected to arrange their own transport (before 10 am);
- Suitable clothing and footwear (if you are not already using them in hospital);
- Access to a key to your property or someone to let you in;

- Adequate basic food supplies;
- Adequate heating in your home;
- Delivery of any equipment needed to provide care in your home.
- Where appropriate you may be transferred to the discharge lounge, whilst you wait for your transport

#### FURTHER SUPPORT

If it is difficult for you to return to your own home, a number of options can be considered and will be discussed with you. These may include:

- Home First Services;
- An emergency call system or adaptations to your own home;
- Temporary support to enable your recovery at home;
- Transfer to a community hospital;
- Moving to sheltered housing or to extra care housing where there is 24 hour support and care;
- Short stays or longer term in a Residential or Nursing Home.

While we wish to support your choice of placement, if there is no availability then we will ask you to transfer to a temporary placement.