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Interim Executive Director of Communities & Wellbeing

Date 4th December 2018
Please ask for [redacted]
Direct Line [redacted]

Department for
Communities & Wellbeing

[redacted] –
Interim Assistant Director
of Adult Operation

PRIVATE & CONFIDENTIAL

Ms. L J Hashmi

HM Area Coroner
Greater Manchester North

Dear Ms. Hashmi,

I am writing in response to your letter dated 9th August 2018. In my response I have included an overview of the discharge process from Killelea, what we are changing going forwards and also the rationale for the decision to discharge the late Dr Donald Clegg to a short stay placement.

Choices for Living Well bed based (Killelea) discharge process

Planning for discharge

Planning for discharge commences upon a customer's admission to Killelea.

The MDT works closely with customers to facilitate safe and timely discharges from the Choices for Living Well bed based service.

The decision to discharge

The decision to discharge a customer is made as an MDT, and involving the customer / family.

Where a customer has been assessed as lacking the mental capacity to make a decision about discharge, the decision to discharge and discharge destination are made as a Best Interests decision.

For customers who have completed their period of rehabilitation or who are not able / unwilling to participate in rehabilitation a decision to discharge to an alternative setting will be made if they are not ready to return home.

For customers show are awaiting a package of home care, they may require a transfer to a short stay setting in the interim, as there is often is a high demand for beds at Killelea e.g. customers awaiting discharge form hospital. This decision is made as an MDT and professional rationale for not transferring to an interim bed are considered on a case by case basis by the management team e.g. customers with dementia, who may find an additional move unsettling.

The following actions are completed prior to discharge:

Therapy staff confirm that equipment and adaptations that are essential for discharge are in place

Transport arrangements are made – these may be with family/ friends, or depending on moving and handling needs, a wheel chair taxi or hospital transport may be required.

Date and time of discharge agreed with the customer and family

If the customer is to have a formal package of care at home or is transferring to a short stay setting or residential care, the date and time of discharge is agreed with all parties

Arrangements are made for discharge of medications, and ensuring the appropriate documentation is taken with the customer e.g DNAR/ District Nurse file.

Handover of information / transfer of care:

GP, Chemist, District Nursing team, Continence Team, other involved services are informed of the discharge time and date

Onward referrals are made e.g. to the District nursing team to order pressure relieving equipment. Contact is made to ensure that the appropriate pressure

relieving equipment is in place e.g. air flow mattress prior to discharging the customer home/ alternative setting to help ensure a safe discharge.

<u>For customers having local authority commissioned support at home</u>:

Relevant information form the support plan is shared by the Brokerage team with care providers prior to discharge

For complex cases – care providers are encouraged to attend a moving and handling handover discussion with the therapy staff at Killelea

The care agency/ setting is provided with contact telephone numbers for the Connect and Direct (CAD) Hub and the Out of Hours service.

For customers having local author commissioned placement in a short stay setting, residential care or nursing care:

For complex cases – care providers are encouraged to attend a moving and handling handover discussion with the therapy staff at Killelea

Arrangements are made for the provider to visit to complete their own assessment, as part of their admissions process

For providers who accept referrals over the telephone, a copy of the social care assessment and support plan will be provided prior to admission

The care agency/ setting is provided with contact telephone numbers for the Connect and Direct (CAD) Hub and the Out of Hours service.

For customers with complex health needs:

Continuing Health Care screening is completed by the MDT at Killelea and assessments/ reports are requested from the District Nursing Team / Consultant Geriatrician to provide evidence for funding appropriate support for such customers , for example 'Fast Track' funding for a nursing placement.

For customers having a privately arranged package of support / placement:

Arrangements are made with the provider to visit and complete their own assessment

A copy of the social care assessment completed at Killelea is made available

The customer/ family is made aware of their right to a review from the local authority as required by the Care Act 2014

The care agency/ setting is provided with contact numbers for Bury Council should circumstances change/ additional input is required

The care agency/ setting is provided with contact telephone numbers for the Connect and Direct (CAD) Hub and the Out of Hours service.

Following discharge

Within 24 – 72* hours post discharge (*if discharged prior to the weekend)

A safe and telephone call is made to check that the customer is settling in well back at home / care setting

If any issues have arisen these will be addressed initially by Killelea staff and further action taken. This may be a follow up from Killelea staff e.g. a visit , or signposting to another service

Contact telephone number are shared with customers and with care providers, The customer/ care provider will be notified that their caser will be reassigned to an alternative team for review and the contact telephone number for that team will be shared (as well as the number for CAD// Out of Hours)

Self –discharge

Occasionally, a customer will decide to self-discharge from Killelea

A discussion takes place with the customer by a member of staff, to ensure that the customer is making an informed decision and to check that they are aware of any risks

Prior to discharge the customer will be asked to sign a disclaimer form

The customer is provided with contact telephone numbers for the Connect and Direct (CAD) Hub and the Out of Hours service.

If the customer is assessed as lacking the mental capacity to make this decision, consideration is given to where a DOLs application needs to be made. The decision to discharge and discharge destination would be made in the customer's best interest, following the Best Interests process.

Within 24 – 72* hours post discharge (*if discharged prior to the weekend)

A safe and telephone call is made to check that the customer is settling in well back at home / care setting

If issues have arisen, Killelea staff will make a professional judgement as to next actions, depending on the level of need/ risk e.g. signposting to another service or contacting the locality duty team.

Change to the discharge process

Following a review of the discharge process from Killelea we have made the following change:

For customers who are being discharged to a short stay placement at either Elmhurst or Spurr House we will arrange to invite Elmhurst or Spurr House staff to attend the discharge planning meeting at Killelea, so that they can meet the customer and assess if they are suitable for the service.

Rationale for discharging Dr Clegg to a short stay placement

The allocated social worker for Dr Clegg, [redacted], arranged a discharge planning meeting with Dr Clegg and his son [redacted] on the 10 January 2018. The Agreed actions included arranging for a home care provider to assess Dr Clegg's needs for a private package of care

Ms. Barnes contacted a number of home care providers between 10th January and 24th January, however none had capacity to arrange to assess at that time, nor to provide a package of home care.

There was a very high demand for beds at this time, from both the hospital and the community. When a customer is ready for discharge but there is no support available to enable discharge to destination of choice, a move to a short stay placement may be required.

We have used Elmhurst on many occasions and have considered this to be a safe and appropriate placement setting to meet the residential care needs of customers, where a nursing placement is not required.

The proposed move to a short stay placement was discussed with Dr Clegg and his son on 24th January 2018 and this discharge arrangement was agreed.

Ms. Barnes followed the admission process for Elmhurst when booking the placement, and liaised with the relevant Occupational Therapist to refer for appropriate pressure equipment and ensured that this was in place before the discharge took place. [redacted] also provided a copy of the social care assessment which detailed Dr Clegg's needs.

Yours sincerely,

[redacted]

Head of Service

Adult Operations Senior Management Team