Discharge Process

We aim to ensure co-ordinated, safe and timely discharge of patients from the Hospice, ensuring that the appropriate arrangements are in place for ongoing care that continues to meet the needs of our patients and their families.

We are likely to commence discharge conversations early into your admission.

Some people will require very little support from other services after discharge, whereas others may need a full care package.

When is discharge considered?

The inpatient unit at East Cheshire Hospice is a specialist facility, designed to provide personalised symptom management and restore patient independence as far as their condition will allow.

The discharge process is triggered either:

- When a person requests discharge from Hospice services OR
- When it is deemed that the patient no longer requires the specialist level of care provided by the inpatient unit at East Cheshire Hospice.

We work together with patients and families to provide personalised care which respects personal wishes – including where a patient wants to be cared for. For example, if someone is being cared for at the Hospice but would like to be at home at the end of life, we will work hard to achieve this.

We appreciate that sometimes people would, ideally, prefer to stay in the Hospice, or continue to be seen by the Hospice team indefinitely. Unfortunately, due to limited resources and high demand for our services, we are unable to provide ongoing care if a patient's condition is stable.

This means that if a person's condition improves enough for care to be safely provided and monitored elsewhere, or if an individual no longer requires our specialist palliative care input, then discharge will be planned – allowing other people with specialised palliative care needs to access our services.

What happens during discharge planning?

During discharge planning, the personal circumstances, needs and wishes of each individual are carefully considered, including any recent changes in condition that may influence the level of care and type of follow-up required.

We use information gained from our assessments to advise on how to best manage the patient's condition in their preferred place of ongoing care. We might suggest, for example, that our Hospice @Home team or district nurses visit regularly after discharge, that certain equipment might be needed, or that a residential or nursing home may be able to more appropriately meet a person's specific needs.

If extra care is needed at home, or if residential or nursing home care is required, the Hospice team can advise on how this might be funded.

For day therapy patients who have enjoyed and benefitted from the social aspect of day therapy, sometimes alternative activities or services can be identified.

In more complex situations, community or hospital teams may be invited to a planning meeting to discuss options and agree discharge plans with the patient, their family/carer and Hospice staff.

If a person's situation changes during discharge planning, then the decision to discharge may be discussed again and deferred if appropriate.

Who is involved in discharge planning?

The Hospice team provide support and information to enable the patient – and where appropriate their family or carer – to be closely involved with any decision-making about care throughout their time at East Cheshire Hospice and at the time of discharge. We work together to provide care packages that are suitable for each individual.

Several members of the Hospice team may be involved in supporting discharge planning, such as the nurse, doctor, physiotherapist, occupational therapist, social work care assessor, and the family support team.

The Hospice team also works closely with other teams in the community and in local hospitals. They often need to be involved in the discharge planning process and can become further involved with a patient after discharge. For example, Hospice @Home, district nurses, and/or specialist palliative care team may continue to monitor a person's condition alongside the GP, or may continue to offer specific interventions for problems such as lymphoedema, catheter care or wound care.

What happens at the time of discharge?

Any person discharged from Hospice services is given information about who to contact if there are any problems, including the 24 hour Hospice advice line on 01625 666999

Information is also provided about follow-up arrangements and a discharge letter is sent to update other professionals involved in the patient's care, such as the hospital consultant or specialist nurse, GP, district nurses and out of hours services, such as Hospice @Home.

Everyone discharged from the inpatient unit is given an appropriate supply of medication – to allow enough time to order a repeat prescription from their GP – as well as an information sheet about the medication.

Patients discharged from lymphoedema services are given a supply of hosiery, and the GP is given information about ordering further supplies when needed.

What can be done if a person's condition changes after discharge?

By working together, we hope to meet the needs of each individual, whilst ensuring our services are open to as many people as possible.

However, we also know that sometimes people need us again at a future date. If the need arises, a professional (such as the GP, district nursing sister/Macmillan Nurse or consultant) can refer a patient back to Hospice services.