

To: Chief Executives HSC Trusts



Department of
**Health, Social Services
and Public Safety**

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AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÄNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**

Copy:
Chief Executive HSC Board
Chief Executive PH Agency
Chief Executive PCC
Chief Executive RQIA
Board/Trust Lead Director for Carers'
Issues
HSC Trust Carer Co-ordinators

Circular HSS (ECCU) 3/2010

2 September 2010

Dear Colleague

**CIRCULAR HSS (ECCU) 3/2010: CARER AND DISCHARGE GUIDANCE –
GUIDES FOR CARERS, STAFF AND MANAGERS/POLICY MAKERS**

The carers' strategy, "*Caring for Carers – Recognising, Valuing and Supporting the Caring Role*", was published in January 2006. The strategy is inter-departmental and inter-agency, dealing with health and personal social services, employment, training, education, information and support services. It sets out what the Department has been doing, and what it still needs to do, to give carers the quality of life which they deserve.

The strategy identified the need for Trusts to have a clear policy for hospital discharge to ensure that carers are fully informed and involved in the discharge planning process of the person they care for. The *Guidance on Discharge of Hospital Patients*, issued by the then Department of Health and Social Services, to Boards and Trusts in November 1998, states that: "users and carers should be fully involved in assessments prior to discharge; that they should be aware of the implications of any decisions taken; that care plans should be agreed with them; that there should be opportunities for them to discuss any concerns; and that sufficient time is allowed for alternative acceptable arrangements to be made." The carers' strategy stated that in many cases these standards are not met, and recommended that the Department develop good practice guidance in relation to "Carers and Discharge."

The Carers Strategy Implementation Group (CSIG), comprising representatives from Boards, Trusts and organisations representing carers, was tasked with

overseeing the development of this guidance. A subgroup of the CSIG, led by Carers NI, drafted the guidance which was subsequently endorsed and signed off by the CSIG. The draft guidance was issued in October 2008 to all HSC Boards and Trusts for comment and was endorsed by related policy branches across DHSSPS.

The Carers and Discharge Guidance has been developed in 3 parts; the documents are attached to this circular as follows:

- A Carer's Guide (attached at **Appendix 1**)
A specially formatted version of this guide, allowing it to be printed in booklet form can be accessed on the department's website using the following link:
<http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-carers/ec-carers-guidance.htm>
- A Practical Guide for Staff (attached at **Appendix 2**)
- A Guide for Managers and Policy Makers (attached at **Appendix 3**)

This guidance does not introduce any new requirements or principles for Trusts to implement, rather it consolidates what has already been published on this issue. The purpose of the guidance is to remind Trusts of their obligations with respect to services for carers, and to draw together all of the published recommendations and requirements for delivery of the discharge process, for ease of reference.

Trusts are now required to:

- make all staff aware of the contents of this circular and the 3 attached documents;
- ensure that the Trust's engagement with carers throughout the discharge process is informed by the contents of this circular; and
- arrange to have "A Carer's Guide to Discharge" leaflet distributed to carers as appropriate.

Enquiries

If you have any queries about the contents of this circular please contact June Faccini on (028) 9052 2374 or by email at june.faccini@dhsspsni.gov.uk.

This circular is also available on the Department's website at: <http://www.dhsspsni.gov.uk/eccu3-2010.pdf>

Yours faithfully



CHRISTINE JENDOUBI
Director of Primary and Community Care



Department of
**Health, Social Services
 and Public Safety**

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CARERS AND DISCHARGE

A carer's guide to hospital discharge

August 2010

Am I a carer?

Your mother may just have had a stroke. Your husband or wife may have been disabled in a road traffic accident. Your son may have just gone through a distressing period of acute mental ill health. It doesn't matter what age you are, or what else you have going on in your life. If someone you care about has been in hospital, and you know that they are not going to be able to manage at home without your help, then you are a carer.

A carer is someone who, without payment, provides help and support to a family member or friend who may not be able to manage without help because of frailty, illness or disability. Carers can be adults caring for other adults, parents caring for ill or disabled children, or young people under the age of 18 who care for another family member.

What is discharge?

This is a catch-all term used to describe the process for getting a patient, who is in hospital or an intermediate care setting (for example, for a short period of rehabilitation), ready to leave. It involves talking to the patient and their family/friends about what kind of support and help they might need, helping them make informed choices and making sure that the support is available when they get home. It often involves moving first to some kind of 'step-down', rehabilitation unit or an intermediate care setting for a while, before finally moving home.

Making decisions about caring?

You may not have considered yourself to be a carer until now and you may be trying to adjust to a completely new situation. Perhaps you are bringing a relative home who used to live elsewhere or providing additional support for them in their own home. You may be wondering how you will cope with someone whose life has been considerably changed due to injury or illness impacting on their ability to manage independently. Or you may have been looking after someone at home until now, but are unsure whether you can continue to provide all the help they may need after their hospital stay.

No one wishes to remain in hospital for longer than is necessary and there will always be a need to bring about timely discharge. You should not, however, experience this as undue pressure to accept caring responsibilities beyond those which you are able or willing to undertake. The pressure for discharge might come from hospital staff who need the beds and it may come from the patient and other family members. Indeed, you may also want the person to be at home as soon as possible. However as a carer you need to consider other areas of your life:

- If you have a job will your caring responsibilities affect it?
- Do you have children or other people who depend on you?
- Is your own health at risk from stress or from tasks such as moving the patient?
- Are other family members or friends able/willing to contribute to the caring role?

As a carer you have a choice of whether or not to provide care, or about the amount of care that you feel you can safely provide. It is very important that you are realistic about what will happen when the patient comes home, that you have all the information you need to make a decision, and that all options are explored.

What can carers expect to happen

All Health and Social Care Trusts have policies about involving carers and you also have certain rights. This section explains what you can expect to happen.

1. When the patient is first admitted

Your involvement should begin as soon as the person is admitted to hospital. If the admission is planned and not as an emergency then your involvement should begin before they are admitted.

CHECKLIST

✓	Has someone asked you if you provide help or support to the patient?
✓	Have you been given details of a named person within the hospital you can talk to about all aspects of the hospital stay and the eventual discharge? This might be a nurse or a social worker.
✓	Have your communication needs been addressed, e.g. interpreter, signer, written information in accessible format etc?

2. Throughout the in-patient stay

All the staff that you deal with during the patient's stay in hospital or an intermediate care setting (Doctors, Nurses, Physiotherapists, Occupational Therapists, Social Workers and others) should apply the following principles in their dealings with you, the carer:

CHECKLIST

✓	Your knowledge of the patient and your expertise in caring for them should be recognised by staff.
✓	With the patient's permission you should be fully involved as an equal partner at all stages of their treatment including decisions about what needs to happen for a timely and positive discharge.
✓	You have a choice about caring. No assumptions should be made about your or other family members' willingness to provide care. A distinction should be made between a person caring about someone and a person providing care for someone.
✓	Everyone is different. Consideration should be given by staff to carers who face additional barriers to services including people with communication difficulties, people from minority ethnic communities, carers of people with mental health needs, carers of people with learning disabilities, older carers who may have health issues themselves and young people under the age of 18 (young carers) ¹ .
✓	Staff foster good and effective communication with you and maintain records of discussion with you.

¹Note: it is important to ensure that children and young people do not assume caring roles that will disrupt their education or adversely impact on their development, health or wellbeing. Where younger carers are identified, consultation with the Trust's Children's Services is advised.

3. Planning for discharge

Planning for someone coming home after a period in hospital can have a huge impact on people's lives. Your employment, health and relationships can all be affected. Carers need to be able to make **informed** choices.

CHECKLIST

✓	Have you been given clear and concise written information about your involvement in the discharge process and told about local sources of help and support, including independent sources of advocacy?
✓	Have you been told of your right to, and encouraged to participate in, a carer's assessment under the Carers and Direct Payments Act (NI) 2002? This is an assessment of your needs and is an opportunity to discuss the implications of caring so you can make informed decisions.
✓	Have you been told about the diagnosis and treatment of the patient and the long term implications of their condition? This should include medication, possible side effects and the practical realities of the extent of caring and should include the opportunity to talk to a pharmacist, if necessary.
✓	Has someone asked you about your ability and willingness to care, during the assessment of the patient in preparation for their return home?
✓	Have you been involved in: <ul style="list-style-type: none"> • Discussion about future care options? • Assistance with convalescence and rehabilitation, including occupational

	therapy home visits and physiotherapy? <ul style="list-style-type: none"> visits to residential or intermediate care/rehabilitation settings where possible?
✓	Have you received the training you believe that you need, for example moving and handling, safe use of equipment, providing medical care, administering medication, and caring safely?

4. The discharge

When patients leave hospital without appropriate plans being put in place there is a real risk that this could result in readmission to hospital. It is important that you feel prepared for the patient returning home and that plans include information about how you will be supported once the patient leaves hospital or intermediate care. The following checklist will help you to ensure that all appropriate arrangements are in place for a safe and timely discharge and to support you in the caring role.

CHECKLIST

✓	Have you been given reasonable notice that the person is coming home? Targets have been set to avoid any unnecessary delays in discharge; hospital staff will discuss these with you.
✓	Have you been given a copy of the discharge plan? This should have, in writing, everything that has been agreed about what will happen to support you and the patient. It should include details of medication and what to do in an emergency.
✓	Are all the agreed services to support you and the patient in place or do you know when they will be

	in place? Has essential equipment been delivered?
✓	Have arrangements as to how the patient will be transported home been agreed with you?
✓	Have you been given written information about local sources of help and how to access them?
✓	Have you been given the contact details for the Trust's Carers' Co-ordinator?
✓	Has the patient's GP been told they are coming home and informed that you are the patient's carer?
✓	Has the patient got enough medication to last until they can see their GP?
✓	Do you have a phone number to call if you have any worries or concerns, both during the normal working day and also out of hours or in emergencies?
✓	Have you had sufficient time and support to get everything ready at the patient's home? Is it warm enough; is there food in the house etc?
✓	Have you been told when the care plan will be reviewed and who will be responsible for arranging the review?

If you have any other issues or concerns not covered in the above checklist please do not hesitate to raise them with your named person, your key worker, nurse or social worker.

Produced by:

Elderly & Community Care Unit, DHSSPS, ☎ 028 9052 2374

This document is also available at: www.dhsspsni.gov.uk



Carers and Discharge

A Practical Guide for Staff

August 2010

About this guide

This guide is designed to help staff responsible for the discharge of patients (whether to home or to intermediate care settings) to ensure that the patients' carers are involved in all stages of the planning process. It provides an outline on how to identify carers; sets out the key principles of involving and supporting carers; and describes the five stages to carer involvement in discharge, which are:

1. Identification of carers;
2. Information for carers;
3. Planning for discharge;
4. The discharge; and
5. Review.

If discharge is direct from hospital or an intermediate care setting to home, all five stages will need to be covered. If the patient is being transferred from hospital to an intermediate care setting, only the first three stages will require attention in the hospital environment. Good discharge planning, while making the experience a better one for the patient, offers Health and Social Care Trusts a valuable opportunity to identify carers, and to help put in place the contacts and services that will support and sustain them in their caring role.

Who are carers?

Carers may not ever have thought of themselves as 'carers' before. In fact many will still not identify themselves as carers. They may think of themselves simply as the daughter whose mum has just had a stroke, the husband whose wife has been left seriously disabled by a traffic accident, the young person¹ who worries what will happen when dad comes home after an episode of severe mental illness.

But if someone they care about has been in hospital, and that person will not be able to manage at home without their help, then they are a carer. It is important to note that where patients themselves have a caring role, their discharge planning should take into account the impact of their caring responsibilities on their own health and social care needs following discharge.

Each Trust has a Carer Co-ordinator whose role includes offering advice and support on dealing with issues affecting carers. You can find their details on the Trust's website.

¹ Note: it is important to ensure that children and young people do not assume caring roles that will disrupt their education or adversely impact on their development, health or wellbeing. Where younger carers are identified, consultation with the Trust's Children's Services is advised.

Key Principles of Involving and Supporting Carers

'Caring for Carers: Recognising, Valuing and Supporting the Carers Role'² states that 'carers should be fully involved in the timing of discharge from hospital and that carers should be given all the information they require about the future care of the patient. Trusts' discharge policies should reflect this objective.

The key principles underpinning this guidance are –

- Carers should be identified and involved in discharge planning as early as possible.
- Every effort should be made to support and prepare carers. This should be balanced against the views of the patient with regard to their choices and their consent to what information is shared with others about them. When patients refuse permission to allow the carer to be involved in decisions about their future, carers should be informed of this and their right to a separate assessment reinforced.
- Carers' knowledge of, and expertise in, caring for the patient should be recognised.
- Carers should have choices about caring, choosing not to undertake the caring role or the degree to which they wish to commit to the caring role. Assumptions should not be made about a person's willingness to provide care. A distinction should be made between a person caring **about** someone and a person providing care **for** someone.
- Carers should have a named person within the hospital who is responsible for the co-ordination of all stages of discharge planning and ensuring the carer's involvement.
- Carers should be involved as equal partners at all stages, including the timing of discharge from hospital or intermediate care setting.
- Good and effective communication between staff and the carer is vital for the carer to be adequately informed to make choices and to feel that they have been properly listened to. All contact and discussions with carers should be documented.
- Carers should be provided with information and advice to help them in their caring role, including their right to a separate carer's assessment³ under the Carers and Direct Payments Act (Northern Ireland) 2002.
- Carers have individual needs and consideration should be given to diversity and equality issues. Groups of carers who face additional barriers to services include people from minority ethnic communities, carers of people with mental health needs, carers of people with learning disabilities, older carers who may have health concerns themselves and young people under the age of 18 (young carers).
- Carers should be sign posted, where appropriate, to independent sources of advocacy or support.

² Caring for Carers can be accessed at:

<http://www.dhsspsni.gov.uk/ec-dhssps-caring-for-carers.pdf>

³ Information about carers' issues, including Carer's Assessment can be accessed through:

<http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-carers.htm>

Five Stages to carer involvement in discharge

1. Identification of carers

Carers are first and foremost family and friends and do not always recognise themselves as being a “carer”. Carers should be involved in planning discharge as early as possible and such involvement will add considerable value to the process.

CHECKLIST

✓	Do the referral notes clearly identify a carer? This may be a family member or friend.
✓	<p>If there is no note of a carer, it is still likely that there is a carer who may not yet have been identified:</p> <ul style="list-style-type: none"> • Have you asked the patient if they have family or friends who may be acting as their carer? • Have you asked family and friends if there is anyone providing any form of care or support to the patient? • Have you considered that a child or young person may be involved in providing care and support? If so, consultation with the Trust’s Children’s Services is advised. • Have you checked with professional colleagues in the community regarding information on carers?

2. Information for carers

Assuming caring responsibilities, particularly after a patient’s stay in hospital, can have a huge impact on carers’ lives. Their employment, health and relationships can be affected. Carers need to be able to make **informed** choices about their contribution to the caring role.

CHECKLIST

✓	Has permission to share information with the carer been actively sought from the patient?
✓	Has the carer been told about the diagnosis and treatment of the patient and the long term implications of their condition? This should include medication, possible side effects, and the practical realities of caring (e.g. time commitment, liaison role with GPs, care workers etc and potential effects of caring role on other family, social and work commitments.)
✓	If the patient refuses permission to allow the carer to be involved in decisions about their future, has the carer been informed of this and their right to a separate assessment reinforced?
✓	Has the carer been given written information and signposted to local sources of help and support?
✓	Has the importance and purpose of a separate carer’s assessment been explained to the carer? Has the carer either participated in a carer’s assessment or have arrangements been made to undertake this once the carer is actively caring?
✓	Have the carer’s communication needs been addressed e.g. interpreter, signer, written information in accessible format etc.?

CARER'S ASSESSMENT

Who can have a carer's assessment?

Any person who is providing, or is intending to provide, care where the impact of caring is substantial has a legal right to an assessment. The range of common factors which substantially impact on the caring role are covered in the '*Carers' Assessment and Information Guidance*' (see resource list) and include:

- the carer's own health e.g. an older person with a heart condition may be at considerable risk if the caring role involves moving, lifting and handling;
- the person may be working and caring commitments could put their job at risk e.g. without reliable help getting a patient out of bed in the morning, the carer may be unable to get into work on time; and
- family commitments e.g. a woman looking after her mother whilst parenting two small children.

What can a carer's assessment achieve?

- It allows carers time to think through what caring entails, identify their needs and assess the likely impact on them (and their own family) when the patient returns home.
- It determines a carer's eligibility for support services, including services directly to the carer.
- It provides the carer with advice and information e.g. benefits, housing.
- It identifies other support which might be beneficial e.g. training, carers support group.

3. Preparing for Discharge

Planning for discharge should be a multi-disciplinary process but should be co-ordinated by the named contact. The discharge process should acknowledge carers as partners in the decision making process. The carer has 'expert' knowledge of how to care for the patient. Members of the multi-disciplinary team will have expertise that could benefit the carer in helping them to care for the patient effectively and safely.

Particular sensitivity will need to be shown where there is conflict between the carer and patient about timing of discharge. The carer should be offered an opportunity to talk in private so that they may be candid.

If discharge is straight to home, then all elements of this checklist will need to be covered. If discharge is to an intermediate care facility, then the carer's named contact should ensure that the carer has a chance to discuss what will be covered at this stage, and what will be covered on eventual discharge to home.

CHECKLIST

✓	Has the carer been given contact details for a named person they can talk to about all aspects of the discharge?
✓	Has there been an assessment of the patient in preparation for a return to the community and/ or intermediate care? Was the carer's willingness and ability to care taken into account?
✓	Has the carer been fully involved in deciding the timing of the discharge of the patient, taking into account the carer's circumstances?
✓	Has the carer been offered a separate carer's assessment and encouraged to

	take this up?
✓	Has the carer been involved in <ul style="list-style-type: none"> • occupational therapist, dietician and physiotherapy home visits and assessments as appropriate? • visits to residential or intermediate care settings, where possible? • discussion about future care options?
✓	Has the carer been provided with necessary training e.g. safe use of equipment, moving and handling, administration of medication, etc? Has the carer been offered an assessment of their training need?
✓	Has the carer met with the pharmacist to talk over medication and any possible side effects, if appropriate?

4. The Discharge

When patients leave hospital without appropriate plans being put in place there is a real risk that this could result in readmission to hospital. It is important that plans include how the carer will be supported once the person in hospital leaves. The following checklist will help you prepare the patient and the carer for discharge.

CHECKLIST

✓	Are adequate support services in place for both the patient and the carer?
✓	With the carer's consent, have community based health and social care services been notified that there is a carer and has the carer been told whom to contact?
✓	Has the carer been given a copy of the discharge plan?
✓	Does the discharge letter for the GP state that the patient has a carer?
✓	Have the family and carer been fully involved, at the earliest possible opportunity, in the timing of discharge (having regard to relevant discharge targets) and asked/supported to make practical arrangements, e.g. put on heating?
✓	Have suitable arrangements on how the patient will be transported home been agreed?
✓	Does the carer know whom to contact in an emergency?
✓	Does the carer know whom to contact if they have questions about the patient's care or health?

5. Review

The review of the case is important to find out how the carer is managing and whether services in place are adequate and/or appropriate.

✓	Have the necessary referrals been made to community services?
✓	Is the carer clear about when the case will be reviewed and who will be responsible for setting up the review?

Useful Resources

- *Caring for Carers: A Strategy for Carers, Recognising, Valuing and Supporting the Caring Role* (DHSSPS 2006), which can be accessed at:
<http://www.dhsspsni.gov.uk/ec-dhssps-caring-for-carers.pdf>
- *Good practice in consent: Implementation guide for health care professionals* (DHSSPS 2003), which can be accessed at:
<http://www.dhsspsni.gov.uk/hssmd07-03.pdf>
- *Consent – what you have a right to expect: A guide for relatives and carers* (DHSSPS 2003) which can be accessed at:
http://www.dhsspsni.gov.uk/consent_relatives.pdf
- *Carers Assessment and Information Guidance* (DHSSPS 2005), which can be accessed at:
<http://www.dhsspsni.gov.uk/ec-carers-assessment-information-guidance.pdf>
- *Good Practice Guidance - Training for Carers*, Circular HSS (ECCU) 3/2008 (Appendix C) which can be accessed at:
http://www.dhsspsni.gov.uk/microsoft_word_-_circular_hss__eccu__3_2008_-_implementation_of_carers__strategy.pdf
- *Promoting Partnerships In Care- Inspection of Social Care Support Services for Carers of Older People* (DHSSPS 2007), which can be accessed at:
http://www.dhsspsni.gov.uk/promoting_partnerships_in_care.pdf
- *Standards for Adult Social Care Support Services for Carers*, (DHSSPS 2008), which can be accessed at:
http://www.dhsspsni.gov.uk/standards_for_adult_social_carer_support_services_for_carers.pdf
- Trust information leaflet(s) for carers, which can be accessed on the Trust's website.
- *The Complete A-Z for Carers*, which can be accessed from:
<http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-carers/ec-carers-guidance.htm>
- *Where to Find Help* (a guide for carers) Carers Northern Ireland, which can be accessed at:
<http://www.carersni.org/Information/Findinghelp>
- *Carers and Discharge: A carer's guide* (DHSSPS 2010), which can be accessed at:
<http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-carers/ec-carers-guidance.htm>
- *Carers and Discharge: A guide for managers and policy makers* (DHSSPS 2010), which can be accessed at:
<http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-carers/ec-carers-guidance.htm>



Carers and Discharge

A Guide for Managers and Policy Makers

August 2010

About this guide

This guide is designed to help Trusts develop effective policy and practice in identifying and involving carers in planning for a patient's discharge from hospital and intermediate care settings. It should be used in conjunction with the *Carers and Discharge: A practical guide for staff*¹ and *Carers and Discharge: A carer's guide*.²

The guide provides an outline of how to identify carers; provides information on carers' experiences of discharge in Northern Ireland; briefly describes the legislative and policy context; sets out the key principles which underpin involving and supporting carers; and highlights the standards that carers should expect with regard to their involvement in planning a patient's discharge, all of which should be reflected in the Trust's discharge policy.

The three standards are:

1. Identification of the Carer;
2. Information for the Carer; and
3. Support for the Carer at transition to home

Good discharge planning, while making the experience a better one for the patient, offers Health and Social Care Trusts a valuable opportunity to identify carers, and to help put in place the contacts and services that will support and sustain them in their caring role.

Who are carers?

Carers may not ever have thought of themselves as 'carers' before. In fact many will still not identify themselves as carers. They may think of themselves simply as the daughter whose mum has just had a stroke, the husband whose wife has been left seriously disabled by a traffic accident, the young person³ who worries what will happen when dad comes home after an episode of severe mental illness.

But if someone they care about has been in hospital, and that person will not be able to manage at home without their help, then they are a carer. It is important to note that where patients themselves have a caring role, their discharge planning should take into account the impact of their caring responsibilities on their own health and social care needs following discharge.

¹ *Carers and Discharge: A practical guide for staff* can be accessed at:

<http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-carers/ec-carers-guidance.htm>

² *Carers and Discharge: A carer's guide* can be accessed at:

<http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-carers/ec-carers-guidance.htm>

³ Note: it is important to ensure that children and young people do not assume caring roles that will disrupt their education or adversely impact on their development, health or wellbeing. Where younger carers are identified timely and effective procedures should be in place for referral to or consultation with the relevant Trust's child care team.

Carers' experiences of discharge in Northern Ireland

Many patients will be looked after by carers. It is vital that carers are provided with support to care safely and effectively. Without this, patients' health and wellbeing may be at risk, leading to an increased likelihood of readmission. In addition, the carer's health and well being may also deteriorate.

"I felt we were completely on our own, left to sort the situation out as best we could with someone so very ill, after a massive stroke and serious operation."

- Only one in four carers in Northern Ireland were given a choice about whether or not to undertake the caring role.
- 17% of patients had to go back into hospital within two months of being discharged. All of their carers felt it was because they left hospital too early.
- 33% of carers said they were not consulted about the discharge plan.⁴

Why Trusts must support and engage with carers through discharge.

- Trusts have a legal duty under the Carers and Direct Payments Act 2002 to inform carers of their right to an assessment and if requested, to carry out an assessment.⁵
- *Community Care: First Report*⁶ called for regular review and update of hospital discharge policies and procedures.
- *Guidance on Strengthening Personal and Public Involvement in Health and Social Care (Circular HSC (SQSD 29/07))*⁷ highlights the centrality of effective user and public involvement as a key element of clinical and social care governance.
- *Caring for Carers: A Strategy for Carers, Recognising, Valuing and Supporting the Caring Role*⁸ indicates that Trusts must have a clear policy on carers and discharge.
- *Circular HSS (ECCU) 4/2006 Implementation of the Carers' Strategy*⁹ states that Trusts' discharge protocols must "include the identification of carers and their full engagement in the planning of arrangements for discharge".

This guidance is issued to assist in making sure that the needs of carers are adequately addressed in Trusts' discharge policies.

"No doctor or any staff asked me if I would cope with the discharge and whether any help was needed. They may have spoken to my husband who is more than capable of speaking for himself, but even he forgets to ask if I am coping. I feel strongly the carer should have input."

⁴ *You Can Take Him Home Now* Carers National Association (now Carers UK) 2001

⁵ Information about carers' issues, including Carer's Assessment can be accessed at:

<http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-carers.htm>

⁶ *Community Care: First Report* can be accessed at:

http://www.dhsspsni.gov.uk/review_of_community_care.pdf

⁷ *Circular HSC (SQSD) 29/07* can be accessed at

http://www.dhsspsni.gov.uk/hsc_sqsd_29-07.pdf

⁸ *Caring for Carers* can be accessed at:

<http://www.dhsspsni.gov.uk/ec-dhssps-caring-for-carers.pdf>

⁹ *Circular HSS (ECCU) 4/2006* can be accessed at:

http://www.dhsspsni.gov.uk/hss_eccu_4-2006_carers_circular_-_signed.doc.pdf

Key Principles of Involving and Supporting Carers

Discharge policies should be based on key principles about how carers will be fully involved and supported. They should also set out how these principles will be delivered and monitored. The key principles underpinning this guidance are –

- Carers should be identified and involved in discharge planning as early as possible.
- Every effort should be made to support and prepare carers. This should be balanced against the views of the patient with regard to their choices and their consent to what information about them is shared with others. When patients refuse permission to allow the carer to be involved in decisions about their future, carers should be informed of this and their right to a separate assessment reinforced.
- Carers' knowledge of, and expertise in, caring for the patient should be recognised.
- Carers should have choices about caring, choosing not to undertake the caring role or the degree to which they wish to commit to the caring role. Assumptions should not be made about a person's willingness to provide care. A distinction should be made between a person caring **about** someone and a person providing care **for** someone.
- Carers should have a named person within the hospital who is responsible for the co-ordination of all stages of discharge planning and ensuring the carer's involvement.
- Carers should be involved as equal partners at all stages, including the timing of discharge from hospital or intermediate care setting.
- Good and effective communication between staff and the carer is vital for the carer to be adequately informed to make choices and to feel they have been properly listened to. All contact and discussions with carers should be documented.
- Carers should be provided with information and advice to help them in their caring role, including their right to a separate carer's assessment under the Carers and Direct Payments Act (Northern Ireland) 2002.
- Carers have individual needs and consideration should be given to diversity and equality issues. Groups of carers who face additional barriers to services include people from minority ethnic communities, carers of people with mental health needs, carers of people with learning disabilities, older carers who may have health concerns themselves, and young people under the age of 18 (young carers).
- Carers should be sign posted, where appropriate, to independent sources of advocacy or support.

Discharge from Hospital to Intermediate Care Settings

If discharge is to an intermediate care facility rather than directly to the patient's home, careful consideration must be given to which elements of discharge planning are carried out in hospital, and which are carried out in the intermediate care setting.

Regardless of whether discharge is direct from hospital or an intermediate care setting to home or from hospital to intermediate care, Standards 1 and 2 (Identification of the Carer and Information for the Carer) will need to be put in place. Standard 3 (Support for the Carer at transition to home) will apply on transition to home.

Putting Principles into Action

The Trust's discharge policy should clearly set out and reflect the standards which will inform carers of what they should expect. It should provide a framework for implementation by staff. Involving patients and carers in the development of the policy will make sure that services are developed which people really need and are targeted most effectively. The discharge policy should also be developed in consultation with community and primary care personnel and ensure that it is integrated within existing arrangements for assessment and care management.

Discharge policies should be regularly reviewed. This will present a good opportunity to ensure that certain standards of supporting carers are embedded within existing Trust policies and practices. You should ensure that the standards are applied across the following six areas of activity:

- (i) staff training programmes;
- (ii) written information in appropriate formats e.g. Braille, tape, different languages etc
- (iii) discharge policies;
- (iv) multi-agency working e.g. referral protocols with GPs and community teams procuring and providing services;
- (v) performance indicators; and
- (vi) carer satisfaction surveys

The following standards checklist will help your Trust audit policy and practice.

Standard 1: Identification of Carers

<i>Many people with caring responsibilities will not see themselves as 'carers', nor will patients necessarily recognise that friends/ family members are carers. Ward staff will need to be proactive in identifying carers.</i>	(i) Staff training	(ii) Information	(iii) Discharge policy	(iv) Multi-agency	(v) Performance Indicators	(vi) Carer survey
All staff should have a basic understanding of carers and be able to implement Trust policy of identifying carers.						
Carers should be identified as soon as possible after admission. Particular attention is required with regard to identifying younger carers; older carers; and patients who themselves have a caring role .						
Processes are in place to identify the "main carer" and to engage with families as necessary.						
There should be a single point of contact for the carer whether using the named nurse system or other local arrangement such as discharge co-ordinators.						

Standard 2: Information

<i>Carers need information to make decisions about taking on a new caring responsibility or changes to their caring role. The choices carers make at the time of discharge can affect their relationships, their health and their employment.</i>	(i) Staff training	(ii) Information	(iii) Discharge policy	(iv) Multi-agency	(v) Performance Indicators	(vi) Carer survey
Carers should be given information which is comprehensive, accurate and appropriate, accessible and responsive to individual needs (see Information Checklist below).						
Staff are competent at communicating key information and have resources to enable them to signpost carers to appropriate sources of support.						
The carer's communication needs have been addressed e.g. interpreter, signer, written information in accessible format etc.						
A file should be set up to record all contacts and discussions with carer.						
Staff actively seek permission from the patient to share information with the carer in line with DHSSPS practice guidelines. ¹⁰						
When patients refuse permission to allow the carer to be involved in decisions about their future, carers should be informed of this and their right to a separate assessment reinforced.						
If discharge is to an intermediate care setting, staff must explain what the carer can expect to happen next.						
Carers are given contact details for the Trust's Carers' Co-ordinator.						

INFORMATION CHECKLIST

Carers should receive information about:

- how they will be involved in the hospital discharge process;
- how to care safely and effectively;
- the condition of the person they will be caring for;
- medication and its side effects, if appropriate;
- their right to a carer's assessment;
- local services and support groups, including access to independent advocacy; and
- how they can comment on their involvement, challenge decisions and make complaints.

¹⁰ Guidance in relation to Good practice in consent can be accessed at: <http://www.dhsspsni.gov.uk/hssmd07-03.pdf>

Standard 3: Support for the Carer at transition to home

<i>Unless carers have proper support in place, the transfer from hospital to home can have significant consequences for both the carers' and the patients' health, well-being and quality of life.</i>	(i) Staff training	(ii) Information	(iii) Discharge policy	(iv) Multi-agency	(v) Performance Indicators	(vi) Carer survey
Carers are involved in: <ul style="list-style-type: none"> occupational therapist, dietician and physiotherapy home visits and assessments, as appropriate; visits to residential or intermediate care settings, where possible; and discussion about future care options. 						
Carers are fully involved in drawing up the patient's care plan and receive a copy in writing or appropriate format.						
Where carers choose to have a carer's assessment, it is carried out in accordance with DHSSPS guidance. ¹¹						
Carers are fully involved in deciding the timing of the discharge of the patient, which has regard to their circumstances						
In line with relevant targets, the care package and relevant equipment must be in place prior to discharge and carers trained in its use, if necessary.						
Carers should be provided with support and training to care safely and effectively.						
Community based health and social care services are notified that there is a carer and the carer been told who to contact.						
Discharge letters, including those for the GP state that the patient has a carer						
The family and carer are fully involved, at the earliest possible opportunity, in the timing of discharge (having regard to relevant discharge targets) and asked/supported to make practical arrangements, e.g. put on heating.						
Suitable arrangements on how the						

¹¹ The Regional Carers Support and Needs Assessment Tool can be accessed at: <http://www.dhsspsni.gov.uk/eccu2-09.pdf>

patient will be transported home are agreed.						
The carer knows who to contact in an emergency						
The carer knows who to contact if they have questions about the patient's care or health.						
Carers should be offered a date after discharge to review whether support is adequate and whether a reassessment is required.						
Readmission rates due to a lack of carer support are monitored.						

Useful Resources

- Circular HSS (ECCU) 2/2009 *The Regional Carers Support and Needs Assessment Tool* DHSSPS 2009
- *Carer's and Discharge – A carer's guide* DHSSPS 2010
- *Promoting Partnerships In Care – Inspection of Social Care Support Services for Carers of Older People* DHSSPS 2007
- *Guidance on Strengthening Personal and Public Involvement in Health and Social Care (Circular HSC (SQSD 29/07)* DHSSPS 2007
- *Involving and Consulting Carers* Carers Northern Ireland 2007
- *Caring for Carers: A Strategy for Carers, Recognising, Valuing and Supporting the Caring Role* DHSSPS 2006
- *Carers Assessment and Information Guidance* DHSSPS 2005
- *Good practice in consent: Implementation guide for health care professionals* DHSSPS 2003
- *'You Can Take Him Home Now'* Carers National Association (now Carers UK) 2001