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Burdett Trust for Nursing

Manual

Burdett discharge planner for adults with a learning disability

Contents

‘How to’ guide

This discharge tool has been developed following a review of the evidence base, gaining expert consensus, and working with people with a learning disability who have experience of being in secure inpatient settings.

The ‘how to’ guide prompts the reader to think about key areas of support and practice and to work in partnership with the person with a learning disability, their family and carers and the wider multidisciplinary team around the person. In this way the tool is not didactic but enables the Registered Nurse and person with a learning disability to develop a person-centred discharge plan that reflects the person's circumstances and support needs prior to and following discharge.

This discharge tool should be used in conjunction with relevant statute, the Nursing and Midwifery Council Code of Conduct, relevant national policy and local clinical policies and guidelines. It has been designed for Nurses to use within a multidisciplinary team to facilitate successful discharge and to support people with a learning disability to lead more independent and fulfilling lives in the community, close to family and friends.

Key

Symbol	Meaning
☹	Signs of relapse or deteriorating health or risk factors
☺	Signs of well-being or strengths or protective factors
+	Add more information according to individual need, local or service specific circumstances or other pertinent information

NHS England 12-point discharge plan checklist

The 12-point discharge plan should be used in conjunction with this discharge tool in line with policy led practice. (www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/learning-disability-and-autism/).

A ‘patient detail’ front sheet can be added to this section with key information, demographic data and NHS identification numbers taken from your organisation’s electronic patient record system.

Legal status under the Mental Health Act, 1983 as amended and Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards, 2008 can be added as part of the front sheet.

This tool has been designed to enable the merging of existing clinical documents such as Health Action Plans, Risk Assessments, Placement Profiles into this discharge tool. We do not expect clinical teams to duplicate information where it already exists and documents can be inserted, linked, dragged and dropped or copied and pasted into this tool as required. When choosing this option, please take care to ensure that you meet your statutory obligations under Data Protection and GDPR and your local policies. This could include the removal of third-party information for example.

Section 1: All about me

This section is all about the person being discharged and should be completed with the service user. It is not about diagnosis, offending, behaviours that challenge, needs or care plans. It should tell the reader about who the person is – their personality, their likes, hobbies and interests, hopes and dreams. Within this section it is also important to support the person to describe their cultural and ethnic heritage as well as reli-gious, spiritual or philosophical outlooks.

A 'pen portrait' can be used to do this. Pen portraits are a 'sketch of a person's character' so that you can form an impression of that person in your mind and what is important to them for example their social supports, culture, religion or ethnicity.

The remainder of section 1 requires the input of personal data and also contains a checklist in line with the NHS England 12-point discharge plan.

Section 2: Pre-admission

In this section, the reason(s) for admission should be set out followed by goals and aims of the admission. Contact with the criminal justice system, court disposal and sentencing, Home Office restrictions and/or license (probation) conditions should be documented in this section.

The goals and aims should be linked to those shared with local Commissioners as part of the Commissioner reporting.

A separate section has been included to give the views and opinions of the patient about their admission.

Section 3: Pre-discharge

In this section, the person's progress is measured against the goals and aims of prescribed assessment or treatment interventions within their current care plans. This is to show the journey and story of the person's admission.

Section 4: Transition

This section should be used to hand over essential information about the person's health and well-being. This includes physical and mental illnesses and treatment plans, upcoming appointments or scheduled reviews. Information should also be provided about any reasonable adjustments required to ensure the best health experiences and outcomes. Information about the person's current Annual Health Check (www.nhs.uk/conditions/learning-disabilities/annual-health-checks/) and Health Action Plans should also be included. These can be uploaded from existing documents.

This section also details specific social care needs including access to independent or statutory advocacy services, finances and benefits and how to maintain friend-ships made during the person's stay on the ward. People with a learning disability in inpatient settings would like to be supported to maintain relationships with other patients once they have been discharged, including visiting or using digital technology to keep in touch. If the person would like this to happen then a plan to support it should be developed together.

Reasonable adjustments

Any reasonable adjustments that have been helpful for the person to access ser-vices should be documented here too.

Relationships with others

Within this section, please give details about important relationships with oth-ers. This can be both personal and professional and extend to friendships and romance. Consideration should be given to how these relationships might be safely maintained or if this is not possible how this will be explained and man-aged. Plans for making new friendships and relationships on discharge should also be addressed.

Advocacy

This section should detail whether advocacy services are involved and if they will continue upon discharge. This may be independent advocacy of statutory advocacy services such as independent mental health advocates and independent mental capacity advocates.

Communication

This section should detail the person's preferred communication methods. This can include formal communication systems such as Makaton or PECS and/or informal, idiosyncratic or personalised communication and tools. This section should be used to detail verbal and non-verbal communication styles and preferences and how these might link to physical and mental health and well-being and any risk factors for the person.

Health and well-being

Mental health

This section should be used to provide information about any mental health issues and/or diagnoses along with treatment plans. This will include signs and symptoms of illness, relapse, early warning signs and crisis plans. A psychological formulation should also be included where available.

Physical health

This section should be used to provide information about any medical issues and/or diagnoses. It should include any ongoing or upcomng assessments and treatment plans. Details of the person's Annual Health Check and Health Action plan should be included. A hospital passport can also be added here or as an appendix.

See think link for more information about annual health checks: www.england.nhs.uk/learning-disabilities/improving-health/stomp/how-to-support-stomp.

In line with good practice prescribing guidelines (see www.rcpsych.ac.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-095701b41885

e84150b11ccc989330357c.pdf?sfvrsn=55b66f2c_4) the following information should be provided:

- indication and rationale for prescribing (including if off license);
- consent to treatment procedures used for example capacitous consent, capacitous refusal, Best Interests under the Mental Capacity Act or equivalents under the Mental Health Act, ie form T2 or T3 decisions;
- evidence of regular monitoring for side effects and treatment effects;
- reviews and evaluations for the need to continue or withdraw treatment (optimisation).

Finances and benefits

This section should detail pertinent financial elements such as benefit entitlement; Power of Attorney or appointed deputies etc. Any plans for financial support on discharge can be added here.

Behaviours of concern and risk

This section should summarise findings from any completed Functional Analysis and Behaviour Support plans.

The functional analysis and accompanying behaviour support plan(s) can be added to this section.

Risk management

In this section details of risk to self and others and from self and others should be summarised. This will include known risks, proactive strategies to manage this risk and protective factors, to not stop people progressing but to help them work towards doing more things safely and give more opportunities and better quality of life. It will also include reactive strategies and crisis plans.

Your organisation's risk management tools can be added here.

Living skills

Activities of daily living

This section provides information about activities of daily living and instrumental activities of daily living. It is based on the Roper-Logan-Tierney Model for Nursing.

Nurses should use the model to assess the person's relative independence and potential for independence in the activities of daily living. This should be viewed on a continuum that ranges from complete dependence to complete independence. To provide holistic care, nurses should also take account of five variables that impact upon individuals and their levels of dependence /independence.

- **Biological:** the impact of the overall health, of current injury and illness, and the scope of the person's anatomy and physiology.
- **Psychological:** the impact of emotion, cognition, spiritual beliefs and the ability to understand. According to Roper, this is about '*knowing, thinking, hoping, feeling and believing*'.
- **Socio-cultural:** the impact of society and culture as experienced by the individual, including expectations and values of class and status, gender and culture and perception of self and others within this context.
- **Environmental:** The model recommends consideration of not only the impact of the environment on the activities of daily living, but also the impact of the individual's ADLs on the environment (think about capable environments).
- **Politico-economic:** this is the impact of government, politics and the economy on ADLs.

The 12 ADLs are as follows:

1. breathing;
2. maintaining a safe environment;
3. communication;
4. eating and drinking;
5. elimination;
6. washing and dressing;

7. controlling temperature;
8. mobilisation;
9. working and playing;
10. expressing sexuality;
11. sleeping;
12. death and dying.

Instrumental activities of daily living

IADLs look at how we function and live in our community rather than the fundamental aspects of what we need to do to stay alive covered by ADLs.

The seven IADLs are as follows:

1. Companionship and mental support – this reflects the need for the person to have valued positive relationships to support their emotional and mental well-being and is an important aspect to ensuring that community placements are successful.
2. Transportation and shopping – focusing on the person's independent travel skills and ability to get essential items such as groceries and medication.
3. Preparing meals – this is about planning and preparing meals and storing groceries safely/hygienically.
4. Managing a person's household – the ability to clean, tidy up, take out the rubbish, remove clutter, do laundry and 'keep house'.
5. Managing medications – how much help may be needed in getting prescriptions filled, keeping medications up to date, and taking medications on time and in the right dosages – also preferred preparations, ie liquid, capsule, depot.
6. Communicating with others – managing the household's phones and mail (including Smart phones and email) safely (phishing, hacking, cyber bullying) and making the home hospitable and welcoming for visitors.
7. Managing finances – how much assistance a person may need in managing bank balances, benefits and money and paying bills on time.

My daily routine

Use this section to co-write about the person's typical day. This can include key points or preferences such as time the person likes to wake up, eat meals, or any scheduled activities or hobbies etc.

Moving on into the community (transition)

This section should include information about the person's wishes for moving on and where they would like to live given the options available. This can include where they would like to live, type of accommodation, who they would like to live with and the support they will need. The section should include the person's hopes and dreams for community living and any worries that they may have about moving on. A plan to address any worries or concerns about moving on should be developed.

If there are any disagreements about placements then this should be documented along with any adaptions, resolutions or 'agree to disagree' situations.

A placement profile can be uploaded into this section.

Moving on – ward or hospital transfer

Some service users may be moving wards in a hospital or transferring to another hospi-tal. This may be as part of a stepped rehabilitation plan. In this situation, moving on plans should be adapted to the type of transfer. This discharge tool is a living document and therefore should transfer with the person. The receiving clinical team can continue to use the document with the person to plan for the next stages of their care and treatment.

Section 5: Community living: after discharge planning and community team

This section concerns itself with what happens after discharge to ensure that the person and their care team know about their responsibilities and how to access support as and when required. Additionally, it should provide details of emergency contacts within the first 72 hours, how to get help and support in the short, medium and longer term; what to do in emergency situations and sched-uled appointments and reviews. This can be tailored to local service availability and design.

A handover plan with the person and their inpatient and community teams should be agreed and communicated within this section of the discharge tool. This can include: transition plans; how to meet and get to know new staff; becoming familiar with new residence and the local area; and leave arrangements.

In line with Assuring Transformation guidance, the NHS England/Improvement Discharge Checklist can be used by the multi-professional team to ensure that all required steps have been taken.

Many of the people with a learning disability that we spoke to and indeed the literature reviewed demonstrated that there was a need to maintain relationships and make transitions. A leaving party or similar event is a good way to mark the occasion and is a tangible point of change for the person and their team.

What to do if I am worried about my discharge. Being heard

People with a learning disability also wanted to know who they should speak to if they were unhappy about their care or their new home. Details of local complaints procedures, patient advice and liaison services (PALS) office or advocacy services should be shared with the person as part of their discharge preparations.

Easy read discharge planner

A copy of the discharge tool should be shared with the person whose discharge is being planned. Alongside this an Easy Read version of the discharge plan can be summarised and shared with the person. The person should be offered the choice of either or both versions for their records.

A suggested Easy Read formatted discharge planner has been developed to accompany the discharge tool. This Easy Read Discharge Planner should be tailored to the needs of the person that it is about. The person whose discharge is being planned should have a copy of the Easy Read Discharge Planner to keep with them.

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