Discharge Policy for Hospital Patients in Shetland

Approval date:	**7th December 2021**
Version number:	**1.0**
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Review date:	**7th Dec 2024**
Security classification:	**Official – Green: unclassified information**

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Document reference number: NAPOL012

NHS Shetland Document Development Coversheet*

Name of document	Discharge Policy for Hospital Patients in Shetland		
Document reference number	NAPOL012	**New or Review?**	Review
Author	Amanda McDermott, Acting Chief Nurse (Acute & Specialist Services)		
Executive lead	Kathleen Carolan, Director of Nursing and Acute Services		
Review date	7 December 2024		
Security classification	Official – Green: unclassified information		

Proposed groups to present document to:		
Multiagency Discharge Group	CCG	ANMAC

Date	Version	Group	Reason	Outcome
6/4/21	0.1	Multi Agency Discharge Group	PI	PRO
20/4/21	0.1	Falls MCN	PI	PRO
9/6/21	0.1	ANMAC	PI	PRO
15/11/21	0.2	Consultants Group	PI	PRO
7/12/21	0.2	CGC	FA	A

Examples of reasons for presenting to the group	**Examples of outcomes following meeting**
• Professional input required re: content (PI)	• Significant changes to content required – refer to Executive Lead for guidance (SC)
• Professional opinion on content (PO)	• To amend content & re-submit to group (AC&R)
• General comments/suggestions (C/S)	• For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)
• For information only (FIO)	• Recommend proceeding to next stage (PRO)
• For proofing/formatting (PF)	• For upload to Intranet (INT)
• Final Approval (FA)	• Approved (A) or Not Approved, revisions required (NARR)

***To be attached to the document under development/review and presented to the relevant group**

Please record details of any changes made to the document in the table below

Date	Record of changes made to document
6th Oct 2021	New text added to sections; Social worker / Care Coordinator / Duty social work, Discharge to residential care, care charges and discharging patients who lack capacity. These sections have been reviewed by Social work leads and approved by their legal team.
10th Nov 2021	Amendments to policy in line with the Scottish Government paper 'Transforming Urgent and Unscheduled Care - Optimising Flow-Discharge without Delay' Aug 2021. Context added to National context section and references to Estimated dates of discharge (EDD) changed to Planned date of discharge (PDD). Additions to roles and responsibilities that reflect teams supporting the 'home first' or 'home to assess' ethos. Link to the paper added.

Contents

1. Introduction

Shetland NHS Board (NHS Shetland) and the Health & Social Care Directorate recognise the importance of a jointly agreed policy for discharge from acute care.

The policy is to be followed when a patients needs indicate that they are medically fit for discharge and the pre planning involved.

The aim is to provide a consistent coordinated approach with multi-disciplinary, multi-agency input, while maintaining the individual's interests as central to the discharge planning process to ensure patients are discharged to community settings in a timely and appropriate manner – ensuring that their needs and wishes are communicated and their ongoing care and treatment needs are addressed prior to discharge.

We recognise that by working together, as a partnership, we will get better outcomes for us, as service providers, and for our clients.

As a result of significant legislative, policy, practice and other service developments this policy has been revised and updated.

2. Aim of this policy

The aim of the policy is to:

- Ensure a positive experience for the service uses
- Ensure the needs of the service user are met fully
- Reduce the delays associated with the unavailability of resources linked to assessed need at the point where service users are assessed as medically fit to leave hospital

It will also address reasons where a service user may be ready-for-discharge, but the discharge is delayed due to:

- Social care reasons
- Housing reasons
- Patient/carer/family-related reasons

3. Definition of delayed discharge

Following the integration of health and social care, a delayed discharge is a hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready-for-discharge date. Any distinction between health reasons and social care reasons for delay have ceased and therefore, from April 2017 delayed discharges are reported in three main categories:

- Health and social care reasons
- Patient and family related reasons
- Code 9 – where partnerships, for reasons beyond their control, are unable to safely secure a patients safe, timely and appropriate discharge from hospital

Delays reported under 'Health and Social Care' reasons are those awaiting the appropriate arrangement to be made by the health and social care partnership for safe discharge.

Medically fit for discharge decision lies with the consultant, and the ready for discharge date is the date in which the hospital patient is clinically ready to be discharge from inpatient hospital care and this is based on MDT and is multi-factorial.

- Medically fit – medical opinion of responsible consultant
- Ready for discharge date – multi-disciplinary date set where all parties agree the patient is ready for discharge.

The ready for discharge date (RDD) is the date on which the hospital patient is ready to be discharge from inpatient hospital care. This is determined by the consultant responsible for the inpatient medical care, and in consultation with all agencies involved, agree that the individuals care needs can be further assessed or properly met outside a hospital setting.

A small number of patients will have an agreed Planned Date of Discharge (PDD), involving trial periods of assessment and rehabilitation at home. These patients are not yet fully ready for discharge from hospital and should not be classified as a delayed discharge.

The above is taken from the Delayed Discharges Definitions Manual where more details information can be found – https://beta.isdscotland.org/media/6769/dd-data-definitions-manual.pdf

4. National policy context

4.1. National guidance

In August 2021 the Scottish Government released its paper 'Transforming Urgent and Unscheduled Care, Optimising Flow; Discharge without Delay'. The paper aims to define best practice, centred around preventing delay in all patient journeys and ensuring patients stay in hospital only as long as is clinically and functionally necessary. https://www.nhsgoldenjubilee.co.uk/application/files/6216/3489/4272/Discharge_without_Delay_Discussion_Paper_Final.pdf

In 2015 the Scottish Government launched 'Improving unscheduled care; 6 essential actions'. The programme aim is 'safe person centred effective care delivered to every patient, every time, without unnecessary waits, delays or duplication'. Essential action 3 relates to patient rather than bed management. This essential action focuses attention on the operation management of patient flow, as opposed to 'bed management'. Placing emphasis on the co-ordinated creation of a multi-disciplinary, patient-centred discharge plan as soon as possible after admission, and then on the timely, synchronised execution of the plan each day, prevents delay and ensures that patients are treated and discharged without delay. This will require engagement with all supporting departments and services such as laboratory, pharmacy, allied health professionals, discharge lounges and patient transport services.

The work stream promotes effective patient tracking throughout the journey and support operational management of the plan at an individual level, and across all patients, the effective balancing of capacity and demand at a system level.

A key part of action 3 is The Daily Dynamic Discharge Approach – Improving the timeliness and quality of patient care by planning and synchronising the day's activities. This document aims to help readers and potential implementers understand some of the 'man-made' causes of delayed

discharge, and sees to provide a framework to support sites to improve performance, by increasing throughout and better aligning demand with capacity early in the day.

https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2016/06/daily-dynamic-discharge-approach-guidance-document/documents/00503010-pdf/00503010-pdf/govscot%3Adocument/00503010.pdf

5. Local policy context – joint working

Joint working is essential for the effective management of discharge from hospital. In some cases, decisions on the best care for an individual following discharge from hospital are based on a professional assessment of his/her health, social care and housing needs. It is important therefore, that the input from these professionals is co-ordinated effectively and promptly.

Admission to hospital (secondary care) will normally either be elective at the request of the patient's General Practitioner, for planned investigations or surgery, by transfer from another NHS facility or as an emergency. The discharge planning process will begin as soon as practical after admission and in the case of planned admissions, may begin prior to admission to hospital.

The multi-disciplinary team (MDT) meet on a weekly basis to discuss discharge plans, this includes the duty social worker and other social care representatives. This is a useful process to ensure information is shared with all involved. However, hospital staff should contact relevant professionals at the earliest opportunity to avoid delays in discharge planning.

For some patients the information required for effective discharge will be collated using the With You For You (WYFY) process. Requests for background information and access to existing assessments, Care Managers or Care Coordinators can be made through the duty social worker. If the patient or family have identified an existing care manager or social worker, they should be contacted directly. This allows for effective information sharing and early identification of potential discharge problems – it also ensure that any existing services can be informed.

It is important that active welfare power of attorneys or guardians are identified, documented, and made party to all discussions/decisions.

Communication between members of the multi-disciplinary team must be robust if the policy is to be effective. The Responsible Nurse, Health Service Liaison Social Worker, and Care Manager will work closely to ensure that the appropriate staff/agencies are involved as part of the multi-disciplinary team, depending on the circumstances of each service user.

The multi-disciplinary team may include:

- Primary Care Team
- Care Manager, Care Co-Ordinator or Social Worker
- Senior Team Lead Community Care Resources
- Mental Health Officers
- Allied Health Professionals
- Ward Nurses
- Senior Charge Nurses

- Dementia Services
- Community Nursing
- Immediate Care Team
- Specialist Nursing
- Pharmacists (hospital and community)
- SIC Housing
- Ambulance Service
- Voluntary Services e.g. Independent Advocacy

If an appropriate referral is not made to the right team/person within an appropriate time frame, this can become a barrier to appropriate care management which can:

- Cause great anxiety to the patient
- Result in conflict between the patient and the health and care team, which can have a negative impact on establishing a partnership approach to care.

Further details on the co-ordination of the assessment and care planning process are provided within the With You For You documentation.

6. Information sharing

The sharing of relevant, up-to-date information between professionals helps to ensure that adults and children receive the care, services, protection and support needed. It is an established part of good practice that is supported by experience, research and legislation. Sharing personal information between partner agencies is vital for a coordinate and seamless service for people.

Personal information is shared in accordance with the Shetland Data Sharing Policy developed by NHS Shetland, Shetland Islands Council, Northern Constabulary, Shetland Area Command and Shetland Council of Social Services. https://www.shetland.gov.uk/downloads/file/2128/data-sharing-policy

It provides a framework for the secure and confidential sharing of information between partner organisations, enabling them to meet the needs of individuals and groups for their care, protection, support and delivery of services in accordance with Government expectations and legislative requirements.

Information is shared on a case-by-case basis, subject to the agreement of the service user.

7. Process of discharge

7.1. The consultant

The consultant is responsible for agreeing the medically fit discharge date and then will remit other multi-disciplinary planning decisions and ready-for-discharge date to the multi-disciplinary team.

The consultant is responsible for delegating completion of an immediate discharge letter (IDL) to allow for prompt ordering of medication, in complex cases this may happen 1-2 days prior to

the Planned Date of Discharge (PDD), only if medical conditions are stable and medications unlikely to change before PDD. For simple discharges IDLs should be written soon after the ward round to allow for pre noon discharges.

Wherever possible, the patient (and with their consent) their carer(s) will be involved and any decisions should be discussed at a multi-disciplinary level.

The consultant (in discussion with the multi-disciplinary team, family and care manager) ensures that the patient has capacity to understand the decisions that are being made and the information he/she is being given. If this is in doubt, the principles of the Adults with Incapacity (Scotland) Act 2000 should be followed with advice from a social worker, unless the person does not have capacity.

Whilst being **medically** fit may be considered the **minimum** criteria for discharge, other factors such as availability of accommodation and social circumstances need to be considered. Discharge should not therefore be carried out until all planned, and agreed arrangements are completed and in place. This allows for same day, rapid discharge of patients, who require little support services, as well as for more complex discharges that require a larger degree of support and co-ordination. A discharge-planning (or case conference) meeting would be considered an integral part of more complex discharges.

Any concerns regarding abuse or exploitation of a vulnerable person, or a person considered to be at risk, should be shared and the Adult Support and Protection Procedures followed.

7.2. Nursing staff

Many of the tasks on discharge will be undertake by nursing staff in the hospital, and the service user's responsible nurse should be closely involved in the discharge planning process.

The Nurse in Charge or Deputy would be responsible for the following:

- Promoting a culture that embraces a Discharge without delay approach;
    - Prioritising planning and reducing the risk of inadvertently causing delays to morning/daylight discharge.
    - Whole-system planning and preparation for discharge
    - Adopting 'home first' as an ethos, 'discharging to assess' as a default.
- Identifying the need for a case conference/discharge planning meeting for complex discharges, especially where the health/social care needs have changed significantly. Where a care co-ordinator is involved, the responsible nurse will liaise with the coordinator to agree on the need and timing of any conference.

The role of the responsible nurse is to:

- Chair any case conference and liaise with the relevant health and care professionals as necessary and agree appropriate attendees. The format of the meeting should be focused around the service user needs.
- Ensure that Planned Date of Discharge (PDD) are recorded in patient's notes and Trak Care updated as necessary following decision points.
- Discuss the discharge with the patients and family/carer and reports any concerns to the named consultant and multi-disciplinary team prior to discharge.

- Ensure that where patients have previously accessed social care services, the nursing staff have contacted the existing care manager/care co-ordinator or liaise with the duty social work to restart any existing services.
- Will jointly contribute to keeping patients as active and stimulated as possible to avoid deconditioning.
- A minimum of 24 hours and up to 3 days may be required to restart services – it is therefore essential to inform service providers of the PDD indicated by the consultant as soon as this is known, so that arrangements can be made for services to be resumed immediately once the patient is fit for discharge.
- Ensure that the service user receives their medication with verbal and written explanation of usage and any follow up instructions.
- Ensure that an appropriate nursing discharge letter /email is sent to social care staff i.e. care at home staff or unit managers, to allow for prompt start-up of appropriate services
- Ensure that a nursing decision is made as to whether or not an ambulance is required (where possible, the Ambulance Service should be given 24 hours' notice for the Mainland, and 48 hours' notice of the outlying Islands). Where an ambulance is not required, the patient should be advised that it is their responsibility to arrange transport, whether this is to their home or to a care centre

Unless prior discussion has taken place, patients who need community health and care services on discharge should not be discharged at weekend or late in the day to ensure that there are no gaps in provision that would put a patient at risk.

The responsible nurse must liaise with duty social work or allocated worker to ensure effective communication and co-ordination throughout the process.

The Adult inpatient discharge checklist is used to ensure that the following tasks are completed through comprehensive and robust discharge planning;

- An Interim Discharge letter is available for the patient including details of follow up.
- Essential equipment is delivered installed prior to discharge
- Where appropriate the following professionals are communicated with regarding discharge; GP, Care coordinator, Care home, OT, Physio, Community nursing team, Intermediate Care team, Specialist nurses, Dietician.
- Supply of nutritional supplements available on discharge.
- Transport needs considered, necessary bookings made.
- Surgical site Surveillance form for Hip Fractures follows patient to community if discharge prior to 30 days post op. Communicated with Community Nursing team who take over responsibility.
- Clear and Precise Handover given and receiving staff, both verbally and written.
- ALL medications explained to patient and/or relatives/carers as appropriate.
- Own medications returned, including controlled drugs.

- DNACPR reviewed prior to discharge and accompanies patient on discharge, relevant people informed
- Catheter passport is completed and accompanies patient
- 2 weeks supplies of wound dressings or continence products provided.
- Cannulas/Electrodes removed
- Valuables returned from safe
- Care home/care team/receiving family phoned upon patient leaving ward to provide access.

7.3. Allied Health Professions

Allied Health Professions may be required to carry out assessment and intervention as part of the multi-disciplinary team. Advice and information will be given to the patient and where appropriate their family/carers/representative. AHPs will jointly contribute to keeping patients who have been referred to them as active and stimulated as possible to avoid deconditioning.

AHPs would be responsible for the following:

- Promoting a culture that embraces a Discharge without delay approach;
    - Prioritising planning and reducing the risk of inadvertently causing delays to morning/daylight discharge.
    - Whole-system planning and preparation for discharge
    - Adopting ‘home first’ as an ethos, ‘discharging to assess’ as a default.

Where ongoing reablement is required within an interim placement on discharge, the relevant AHP's involved will provide a reablement plan to care staff with clear advice in relation to care staff input.

Where Intermediate Care Team support is required at the point of discharge, the relevant AHP will submit a written referral.

As part of the Occupational Therapy assessment, any equipment or home adaptation needs will be identified and relevant referrals to third party providers (i.e. SIC, Hjaltland) will be made prior to discharge.

Any requirement for ongoing physiotherapy on discharge will be communicated to the Community Physiotherapist.

7.4. Pharmacist

The Pharmacy Department dispenses discharge medications and provides advice on the use of medicines for the patient. Where appropriate advice should also be given to the carer or patient representative. The pharmacist responsible for the ward should receive the discharge prescription at least 3 hours in advance of discharge for short stay patients and 24 hours before discharge for long stay patients if the patient is stable and medication are unlikely to change before PDD. All of the patients’ own medicines (PODs) should be sent to pharmacy for checking along with the discharge prescription. The Pharmacy Department is not open on a Saturday and Sunday so patients likely to be discharged on these days should have their prescriptions dispensed on a Friday where possible. If medicines must be supplied from ward stocks at the

weekend pre-labelled stock should be used as far as possible using the policy supplied by pharmacy. A record of all medicines supplied must be made in the register on the ward.

Where there are specific requirements for administration arrangements at home e.g. as part of a care at home package, the pharmacist will make arrangements for the supply of a compliance sheet or Medicines Administration (MAR) sheet as appropriate. If an assessment of a patient's ability to manage their medicines at home is required the pharmacist will make an arrangement for the Community Care Pharmacy technician to visit. If for any reason the discharge should be delayed or cancelled, it is important to inform the pharmacy. The pharmacist must re-assess the appropriateness of the medicines as close as possible to the time of discharge to ensure accuracy and prevent error.

7.5. Social Worker / Care Coordinator / Duty Social work

The allocated Social Worker or Care Coordinator is responsible for discharge planning in collaboration with the multi-disciplinary team. This includes completing the Understanding You assessment in order to determine the care needs of the patient as well as their eligibility for support, in order to facilitate a safe and successful discharge.

Where a patient does not already have an allocated Social Worker or Care Coordinator this role will be undertaken by Duty Social Work.

The social workers would be responsible for the following:

- Promoting a culture that embraces a Discharge without delay approach;
    - Prioritising planning and reducing the risk of inadvertently causing delays to morning/daylight discharge.
    - Whole-system planning and preparation for discharge
    - Adopting 'home first' as an ethos, 'discharging to assess' as a default.

8. Patient Involvement

Patient and carers will be involved in decisions at each stage of the assessment and discharge from hospital process. The patient and, where appropriate, their carers will be invited to multi-disciplinary meetings, discharge planning and case conferences.

9. Carers

Each ward will have access to a carers link Monday – Friday, they will ensure that a carer is referred to Social work for a carers assessment if requested.

Under section 28 of the Carers Act 2016, the hospital has a duty to involve carers, including young carers, in discharge from the hospital. Carers should be encouraged and advised to;

- Speak to hospital staff and let them know you are the carer and how they can contact you
- Speak to the person you care for to get consent to discuss their care with staff
- Ask questions at discussions about hospital discharge and let staff know what caring you are able and willing to do when your relative comes home
- Think about how you will cope with any changes in your caring role, and if you need an adult carer support plan or a young carer statement

10. Provision of equipment

Community nursing have the following equipment:

- Beds (not for long term use)
- Mattresses (not for long term use)
- Static commodes
- Pressure cushions

To request the above items the responsible AHP or Nurse should use appendix 2 and email the form to shet.cnequipmentrequest@nhs.scot

All other equipment would need to be sourced from OT, including long term beds and mattresses.

11. Discharge to residential care

When a patient is returning to residential care, staff and the care centre will ensure that this is achieved in the shortest possible timescale, and staff will ensure that all necessary support is in place prior to discharge.

Home first is the default position when planning for discharge, however it is recognised that there are situations whereby a patient is unable to return home and therefore requires an interim placement in a residential setting. Interim placements should only be considered once all other options have been fully explored with access to placements being via an Understanding You assessment completed by the allocated Social Worker, Care Coordinator or Duty Social Work in collaboration with the multi-disciplinary team.

Interim placements may be provided for further assessment (when it is not appropriate or possible for assessment to be undertaken at home), convalescence, reablement or palliative care. In Shetland we do not assess for long-term residential care in hospital. Therefore this happens post discharge if required therefore premature discussion of long-term care should be avoided as this can create unnecessary stress to the individual as well as families.

Where it is assessed that an interim placement is required, the Social Worker or Care Coordinator should submit their completed Understanding You assessment to Duty Social Work in order to request a bed. Duty Social Work will then screen the request in order to ensure that all options have been explored, in line with the home first agenda, and to approve the request. Once satisfied, Duty Social Work will allocate an appropriate residential bed in line with the SIC Bed Allocation Procedure. Decisions regarding bed allocation are based on priorities within the hospital as well as in the community. Patients accessing interim placements will not always be offered their preferred care centre, therefore all of those involved in discharge planning must be clear that this is the case in order to avoid building unrealistic expectations. Should a patient decline a bed Duty Social Work will work to source an appropriate alternative.

12. Care charges

Patients may be charged for some elements of their care following discharge from hospital therefore it is crucial that conversations are held regarding charging at the earliest opportunity.

Patients returning home from hospital may be charged for some elements of their care. Personal care is now free for all adults in Scotland however domestic support, social support, day care and meals on wheels are chargeable services. Patients assessed as requiring reablement will receive free support for new care at home services up to the initial six consecutive weeks post discharge, however this excludes any pre-existing services and meals on wheels.

As stated above, interim placements may be provided for a range of purposes including convalescence, reablement, palliative care, further assessment or to await care. Interim placements are chargeable although in some cases charges may be waived for a period of time dependent on the reason for the placement.

Patients accessing fast track palliative care will receive this free of charge up to a maximum of the initial eight consecutive weeks. The Social Worker or Care Coordinator will ask for confirmation of fast track palliative diagnosis from medical staff in order to confirm that charges will be waived.

Interim placements provided for the purpose of reablement are provided free of charge up to a maximum of the initial six consecutive weeks. It must be clearly assessed in the Understanding You, in collaboration with the multi-disciplinary team, that a patient requires reablement in order for charges to be waived.

Therefore it is essential that the reason for an interim placement is clearly identified and recorded in the UY and that this is agreed/signed by the patient/their representative due to the potential financial implications for the patient.

Requests for waiving of charges must be approved by the Executive Manager, Adult Social Work.

Please see charging policy below for further details: Paying for care – Shetland Islands Council

13. Discharging patients who lack capacity

13.1. Capacity

It should be clear in a patients' UY assessment if they have the capacity to consent to the services that they are assessed as needing. Only an Initial UY assessment is required for interim placements. Where a patient appears to lack the capacity to make decisions every effort must be made to maximise their capacity by providing the necessary support and appropriate communication tools to help them make decisions. The Scottish Government publication 'Communication and Assessing Capacity' provides guidance for Health and Social Care staff:

https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2008/02/adults-incapacity-scotland-act-2000-communication-assessing-capacity-guide-social-work-health-care-staff/documents/0055759-pdf/0055759-pdf/govscot%3Adocument/0055759.pdf

13.2. Discharge from hospital to residential placements

The Mental Welfare Commission's report 'Authority to Discharge' (May 2021) confirms when a patient lacks the capacity to make a decision about discharge from hospital to a care home there must be a legal framework in place to authorise the move and safeguard the individual's rights. The report can be found at the following link:

https://www.mwcscot.org.uk/sites/default/files/2021-05/AuthorityToDischarge-Report_May2021.pdf

Where it is confirmed that a patient lacks capacity to make decisions about the support they will need following hospital discharge it should be clarified if they have a proxy. For example, a Welfare Attorney or Welfare Guardian, who has the legal authority to act on their behalf and who holds the powers relevant to the decisions that need to be made. A Power of Attorney (PoA) is not valid until it is registered with the Office of the Public Guardian for Scotland (OPG). The Welfare part of a Power of Attorney only comes into effect when the patient loses capacity to make decisions about their welfare and where the Attorney has carried out the instructions to activate the welfare PoA, as stated in the PoA document.

As highlighted in 1.2 the status of the placement, for example, interim or convalescence, and the financial implications must be clearly explained to the patient, their proxy or carer. Where a patient lacks capacity to sign their UY assessment this should be stated on the signature page, and it should be signed by their proxy or carer to confirm they agree with the support plan and that the financial implications have been explained.

13.3. Power of attorney / welfare guardianship

It is the Attorneys' responsibility to carry out the required steps to activate a welfare PoA. For example, where the PoA document states that a doctor must assess the patient of being incapable of making decisions about their welfare, then the Attorney must ask a doctor to do so. During hospital admissions, however, it may be appropriate for the Social Worker / Care Coordinator to assist with activating a Welfare PoA to expedite discharge planning.

There is no specific form for doctors to complete when they assess that a patient lacks the capacity to make welfare decisions, but it is important for it to be confirmed in writing to enable the Attorney to verify their legal authority to act on the patient's behalf. S47 Certificates are completed by medical practitioners, under the Adults with Incapacity (Scotland) Act 2000 where a patient lacks the capacity to make decisions about medical treatment. S47 certificates should not be used to record a lack of capacity in other areas. Further guidance is available in the Code of Practice (Part 5)

https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-third-edition-practitioners-authorised-carry-out-medical-treatment-research-under-part-5-act/documents/

When a welfare PoA is activated it does not have to be registered with the OPG, but Social Workers / Care Coordinators should record on the Hazard tab on Swift to confirm that the Attorney has legal authority to make welfare decisions on behalf of the patient. It also highlights to staff that there is a proxy involved who must be consulted.

The Attorney should provide a copy of the PoA document to services involved, in order to confirm that they have the legal authority to act on behalf of the patient in relation to the decisions that need to be made.

A Continuing [financial] PoA can start immediately as soon as a patient grants it, and it is registered with the OPG. Alternatively, it may only become effective when the patient becomes incapable, dependent on what the patient has stated in their PoA.

If there is any uncertainty about an Attorneys' authority, or a PoA which has been made in another country, it can be discussed with the first contactable Mental Health Officer (01595 744 400). SIC staff can also consult with Governance and Law.

Where a Welfare Guardianship order is in place staff should check if it contains the powers relevant to the decision to be made, and must consult the guardian.

Where it is unclear if a patient has capacity, and they do not have a proxy who can act on their behalf, an informal assessment of his/her capacity should be requested from a Doctor, in relation to the area of decision making in question. Where capacity issues only relate to a severe communication difficulty it may be more appropriate for the assessment to be undertaken by a Speech and Language Therapist or a Clinical Psychologist.

13.4. Adults with Incapacity Discharge Meeting

An Adults with Incapacity (AWI) Discharge Meeting will need to be held, prior to a patient being discharged from hospital, if:

- The patient is assessed as lacking capacity.
- There is no proxy who can make decisions on his/her behalf.
- The patient needs an interim placement in a residential setting, on their discharge from hospital.

Where a patient who lacks capacity does not have a proxy is returning to a residential placement and an AWI meeting has not previously been held, to agree the legal status of the placement, then Care Coordinators should contact Duty Social Work (01595 744 468) to discuss if an AWI Discharge meeting needs to be held. If the Care Coordinator is not based in the Adult Social Work Team the Duty Senior will chair the meeting, and discharge planning will be supported by the Duty Social Worker

An AWI Discharge Meeting should be chaired by a Senior Social Worker, and where possible attended by:

- The patient
- Carers / family
- Ward staff
- Doctor responsible for their care
- Social worker / Care Coordinator
- Any other relevant professionals involved, if required
- A minute taker

A Mental Health Officer (MHO) should be invited to the meeting if it is complex, there is disagreement, or if MHO advice is needed to ensure that the decisions made are compliant with legislation, rights and good practice.

The AWI Discharge Meeting should cover the following:

- If the patient is unable to attend the reason for this and their views about the proposed care arrangement.

- The views of anyone relevant, such as family or care staff who are unable to attend, about the proposed care arrangement.
- A summary of the patients' current medical condition and functioning.
- A summary of the patients assessed outcomes and the proposed care arrangement to meet these outcomes.
- A summary of any other relevant assessments e.g. OT, Physiotherapy, SALT.
- Views from attendees as to whether the principles of the Adults with Incapacity (Scotland) Act 2000 are met. The principles are:
    1. Benefit
    2. Least restrictive
    3. Take account of the wishes of the patient
    4. Consultation with relevant others
    5. Encourage the patient to exercise his/her skills and develop new skills.

S13ZA of the Social Work (Scotland) Act 1968 allows a local authority to provide services to a person who is assessed as needing a service but who lacks the capacity to consent to receiving that service. If a move to an interim placement is agreed under S13ZA the following conditions must apply:

- There is no proxy (e.g. Welfare Power of Attorney or Welfare Guardian) with relevant authority, and there is no application for an order under the 2000 Act with relevant powers in the process of being determined; and
- The UY assessment indicates that there are no issues which would warrant an order under the 2000 Act; and
- There would be no other benefit to the patient in applying for an order under the Adults with Incapacity (Scotland) Act 2000.
- In providing services the patient will not be deprived of his or her liberty (i.e. subject to constant control and supervision and not free to leave) under Article 5 of the European Convention of Human Rights; and
- The person agrees with the proposed action; and it appears that he/she is likely to remain in the care arrangement for the required time.
- All interested parties agree with the intervention proposed.

The following points should be covered at the meeting:

- If the patient becomes resistant to the care arrangement agreed under S13ZA then their Social Worker / Care Coordinator or Duty Social Work (01595 744 468) should be informed.
- S13ZA does not prevent anyone from applying for guardianship, if it is needed and anyone wishes to make an application.
- A review will be held around 6 weeks after the start of the new care arrangement and then 6 monthly afterwards, however, reviews can be held earlier if required.

The minutes of the AWI Discharge Meeting should clearly state:

- If the Principles of the 2000 Act have been met
- The package of care or outcomes that were agreed
- If any outcomes were agreed under S13ZA of the Social Work (Scotland) Act 1968 and the reasons for this.
- If the patient becomes unhappy or unsettled with the care arrangement, agreed under S13ZA that their Social Worker / Coordinator or the Duty Social Work [01595 744 468] should be informed. This is especially important if the care arrangement could be considered to be depriving the patient of his/her liberty.

Where an interim placement has been agreed under S13ZA the allocated Social Worker should send out the proforma letter as found in section 13, Appendix 6 of the AWI Procedures 2016, following the meeting. Social Work Assistants will be supported to send the letter by their line manager. Where the coordinator is not based in the Adult Social Work team the Chair of the AWI Discharge Meeting will send the letter.

13.5. Patients with Incapacity Case Conference

A full AWI Case Conference will need to be held if:

- The patient lacks capacity and there is no proxy in place and
- The patient is resisting a move to an interim placement on discharge from hospital, or other proposed care arrangement, or
- There is conflict amongst those involved about what is in the patients' best interests, or
- The patient will be at risk by refusing or resisting the care arrangement.

Social Workers / Social Work Assistants should follow the steps in the Shetland Islands Council Adults with Incapacity Procedures section 3 'Providing Services and Deprivation of Liberty'. Staff out with the Adult Social Work Team who are coordinating discharge should contact the Duty Social Worker to discuss the need for an AWI Case Conference (tel. 01595 744 468).

An AWI Case Conference involves all relevant parties, including the patient where possible. It should be chaired by a Senior Social Worker, and attended by a Mental Health Officer. An SIC Solicitor should be invited, especially if it is complex or it is likely that the local authority will have to apply for an order, however, their attendance will not always be required and written advice can be obtained in advance of the meeting. An AWI Case Conference will consider the legal authority that is needed to move a patient who is assessed as lacking capacity out of hospital, or to provide them with the support they require. This may include circumstances where the patient is opposed to a care arrangement and will be at risk as a result, or there is conflict about what is in their best interests or restriction of liberty issues. In such circumstances an order may have to be sought under the 2000 Act to facilitate their discharge from hospital.