Chapter 4

Individualised Care Options

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Chapter Overview

For a person with complex needs an individualised care package can only be designed following a thorough and timely assessment of the whole person which must involve their family and carers.

Appropriate choices can only be made when there is effective dialogue and empathy with the person. Even with excellent communication skills, choices will depend upon having sufficient knowledge of the variety of local services available.

The list of locally available options must contain a description of the services, together with the eligibility criteria and potential costs, for which the person may be liable. Although discharge planning is a process, it needs to be individualised to support people to make informed choices:

- Individuals, families and carers need to understand how and when discharge arrangements are going to take place so that they can be involved in planning
- Staff need to involve other professionals across the MDT so that they have sufficient time to assess the patient and make appropriate arrangements
- Information about creative care options needs to be comprehensive, accessible and up to date. This is easier to achieve if it is centrally coordinated
- Staff and patients need to have information about eligibility criteria, referral protocols and capacity in order to be able to access alternative care options

Creating Individual Solutions

The social model of health encourages people to take accountability for their own wellbeing. However to achieve this, individuals need good information about the choices that are available to them and support from professionals on how to access them.

"Not everyone wants to go out to Bingo, day-care, luncheon clubs or special interest groups."

This Chapter explores the need for discharge assessment and planning to take a much more creative approach to the development of care packages. The purpose is to tailor responses to individual needs in such a way that they are empowered to maintain their health and well-being for the longer term. This involves:

- Managing expectations
- A full range of choices
- Accessing care options
- Identifying other enablers

Care options can only be determined following a thorough assessment of need. It is important that specific care options are not discussed or considered too early in the process and that any discussions do not pre-judge the assessment process.

Managing Expectations

It is important to manage the expectations of all parties with regard to:

- The practical discharge process
- The outcomes that can be planned for
- The service options that may be available
- How and when information will be communicated
- Voicing concerns

The expectations need to be understood from the following three perspectives.

1. Individuals

Individuals must feel fully included in the discharge planning process, and to know that their pathway is planned around their specific needs.

The care plan should be shared with them and they should be encouraged to ask questions, especially if the expected care or timescales vary from the plan.

It is essential that health and social care Practitioners use the assessment process to help individuals to:

- Identify any personal risks to their health and well being
- Jointly formulate plans that minimise and manage those risks
- Have mutually transparent discussions about the realistic care options available

"Not having time is not an excuse. Five minutes spent asking the right questions now can save weeks of delay and distress for everyone."

Research has shown health and social care services can sometimes decrease independence both on admission to hospital and when providing community care. Increased dependency will have a negative impact on the individual's physical and emotional well-being.

It must be clearly communicated at an early stage that the aim of the care provided is to restore the individual to their maximum potential. This will help to manage expectations and is particularly important when the care plan includes transfer to a rehabilitation facility or intensive Reablement at home.

2. Family and Carers

As described in Chapter 3, it is essential that family members and carers are consulted with on admission and at the beginning of the assessment process. If the patient does not have mental capacity, then any further consultation will need to comply with the Mental Capacity Act, as described in Chapter 5.

Carers Groups often report that they feel frustrated that they are not listened to and that essential information such as medication administration is lost. This carries obvious risks both from a patient safety perspective and with regard to effective discharge planning.

The use of EDD as described earlier, also allows families and carers to plan ahead and be able to support the individual when they come home from hospital.

Practical examples include:

- Booking time off work to take their relative home in the morning, rather than relying on ambulance or voluntary transport later in the day
- Getting shopping in
- Making sure the home is warm

It is important not to make assumptions regarding what care and support will be provided by family members or neighbours.

"Simple checks can save distress and prevent possible readmission later."

It may be the case that a crisis in informal social support has led to the hospital admission. In which case, early identification of these issues will assist in managing the expectations of all those involved and facilitate timely discharge.

Practitioners need to explain that the service provided will be dependent on:

- Full assessment of need undertaken at an appropriate time in the individual's journey, for example following a period of rehabilitation
- Meeting appropriate eligibility criteria for service provision

"Don't forget that funding for social care is provided subject to eligibility criteria being met and is means-tested; individuals should be forewarned that this is the case."

This can be a stressful time for patients and carers that are unfamiliar with the care system:

"You may have to repeat information and check understanding.Written information sheets are helpful to supplement verbal dialogue but should not replace it."

3. Practitioners

It is important that appropriate members of the MDT are involved in discharge planning as early as possible.

Some patient needs will be predictable, while others will be dependent on the impact of treatment and the recovery that takes place during the hospitals stay. Practitioners should recognise these possible changes and avoid discussing specific services options in detail, too far in advance

Patients and carers are often provided with different answers to their queries depending on which professional they speak to. This in turn leads to confusion, anxiety and loss of confidence in the health and social care system, which is a significant contributory factor of delayed transfers of care.

As increasing numbers of individuals are admitted with existing community-based support for their long term conditions, it is vital that prompt and effective communication is established in accordance with local information sharing protocols.

Professionals who may already be involved in delivering care could include:

- GP
- Practice Nurse
- District Nurse
- Specialist Nurse eg for Chronic Conditions
- Social worker
- Community-based Therapist
- Domiciliary Care Agency
- Voluntary agencies
- Consultant

If the individual has an existing Care Coordinator, they may continue to manage liaison between the other agencies involved.

If the individual has been admitted from a care home, the Registered Manager will be a key link in the assessment and care planning process. Early liaison will also help identify any issues that may impact on discharge from hospital, for example:

- Increased frailty requiring assessment for NHS-funded nursing care
- NHS Continuing Health Care funding
- Transfer to a different category of care home

"As a professional working in hospital, your ultimate aim is to get your patients well and back to their optimum level of health and independence as quickly as possible."

A Full Range of Choices

To promote independence and support individuals at home in their community, NHS Trusts, Local Authorities and Local Health Boards have developed a range of intermediate and long-term care solutions.

The table below provides some examples of the types of services that may be available in your area to support individuals to minimise and manage risks to their health and social well-being.

"It's better to ask advice about these sorts of services than miss an opportunity. Speak to your local teams."

This is not an exhaustive compendium and each locality will have a unique range of choices, some of which may be subject to means testing.

Examples of Care Options

Need	Providers	Type of support offered
Benefits and allowances	Social services, voluntary sector e.g. Citizen's Advice or Age Concern	Advice on eligibility and how to apply. Support with form filling
Direct payments	Local authorities	Receipt of direct payment of funds so that the individual can employ there own carers/create their own care package
Housing issues	Local authorities Housing associations	Advice and support on dealing with accommodation issues, including housing benefit and larger adaptations
Extra care housing schemes	Local authorities Housing associations Private sector	Provision of supported living accommodation/ sheltered housing, that can be an alternative to care home placement with a comprehensive care package
Small household repairs/ adaptations	Voluntary sector and local authorities	'Care and Repair'-type services. 'Man in a Van' to fit equipment essential for discharge e.g. handrails

Need	Providers	Type of support offered
Remote support at home using telecare	Social services Private sector	'Assistive technology' e.g. personal alarm systems, fall detection, dementia care packages
Homelessness	As above plus voluntary sector and LHBs Trusts	Advice and support on specific issues facing those who are homeless or at risk of becoming so Counselling, practical help. Outreach clinics/direct support
Short-term low level support checking service on discharge	Voluntary Sector	Hospital Discharge Schemes. Usually maximum of 5 days e.g. checking house is warm, shopping, organising prescriptions, help with meal preparation or light personal care
Supported Recovery and Reablement	Social Services LHBs	Intensive time-limited support (usually 6 weeks) from multi-disciplinary team

Need	Providers	Type of support offered
Intensive clinical intervention	NHS Trusts/LHBs	Rapid Response Teams to access rapid diagnostics and/or to provide specific clinical intervention e.g. IV antibiotic administration, DVT treatment Community mental health/crisis intervention teams
Clinical monitoring	NHS Trusts LHBs GPs	Telemedicine: remote supervision of vital signs etc District nurse or specialist nurse visits/ community mental health teams GP/practice nurse clinics
Practical social & emotional support for living with a chronic condition	Voluntary agencies LHBs GPs	Support groups, practical advice, and internet Expert Patient programmes Specialist nurse input Counselling
Coping with bereavement	Voluntary sector	Practical advice and emotional support

Need	Providers	Type of support offered
Nutrition and Diet	Social services Voluntary sector Domiciliary care agencies	'Meals on Wheels', Frozen meals delivery, luncheon clubs, day centres Support with shopping/ food preparation
Medication compliance	Community pharmacies Social services Domiciliary care providers	Collection/ordering and delivery of repeat prescriptions Medication reviews Advice on administration, including use of Dosette boxes etc Supervision of medication compliance as part of a care package
Help with domestic chores low level social support	Voluntary and private sector	Cleaning, "washing the nets", ironing, shopping, and gardening
Care of pets	Voluntary and private sector	Pet-sitting or fostering, dog walking etc

Access to Care Options

Across Wales, it is evident that different types of services are provided in different localities. This can cause difficulties for staff working in hospitals that receive patients from many different areas, if information about these services is not easy to access or constantly kept up to date.

Details of intermediate care services are published on most Local Health Board websites and in local directories of services. In some areas, details are also available on NHS Direct and work is in progress to create a single national database.

In the meantime, it is recommended therefore that the most useful local information is collated centrally, perhaps by the Discharge Liaison Nurses or Hospital Social Work Team. These groups of staff usually act as the key point of contact for up to date local information, including details of eligibility criteria and contact points.

Clinical Follow Up

If the patient requires ongoing clinical review following discharge from hospital, clear information must be given verbally and in writing to confirm the arrangements for this.

Clinical reviews can be undertaken in a variety of settings including:

- Outpatient clinics
- GP clinics
- Day hospitals

Information on discharge will need to include:

- Date, time and location of appointment
- Reason for appointment
- What the patient needs to bring with them for example letters, specimens, medication
- Specific instructions for any investigations
- Transport arrangements if required

The patient may need to modify their normal routine or behaviours following their stay in hospital for example:

- New diet or nutritional supplements
- Restrictions on alcohol intake
- Giving up smoking
- Undertaking an exercise plan
- Change to medication and possible effects

Furthermore, some follow up services will be arranged on discharge to be provided at the person’s place of residence, such as district nursing.

Patients, their family and carers must be provided with clear, easy to read information to take home with them, plus contact details of support services, in case of further query.