



## **Discharge from Hospital**

*Elaine Dowell and Ava Easton, Encephalitis Society*

Planning for discharge should start from the moment of admission to hospital, and ideally, be managed by a named or key nurse. When it is time for discharge, government guidelines suggest a inter-disciplinary discharge planning meeting should be offered to make sure that proper plans, support and care can be provided to meet an individual's needs at home. The person affected and their key family members should be present. A list of Discharge standards taken from the Dept. of Health website [www.dh.gov.uk](http://www.dh.gov.uk) are listed below.

At first sight any difficulties may not appear to be significant, therefore it may simply be assumed that a return to normal life will not be problematic. However, as some cognitive deficits are subtle, their effect on any functioning within the home and work place may not initially be evident or may be underestimated.

If there are likely to be continuing health and social care needs, a care plan should be produced. This will identify who will provide the care and support at home. The person who will be the main carer should be happy with the plans that are put in place, and if they are not, they need to say so and explain why. Everyone should be convinced that all placements and plans are in place before a return home and access to any community services is begun – such as Care assistance, Respite facilities, Day Care, Speech and Language Therapy, Occupational Therapy, Physiotherapy.

The person's GP should be advised of their discharge from hospital by letter, which may be sent directly or given to the person to hand over. It usually gives information about hospital treatment, medication to be given at home, and any follow-up arrangements. A typed discharge summary will usually be provided to the GP and should be received within 10 days of discharge.

In a few cases, return home will not be possible and the facilities of a comprehensive residential rehabilitation programme may be required. The majority of people will be managed in local units although it may be appropriate for the person affected to be referred to a specialist centre for assessment and care planning, even if the implementation of the care plan is to be followed up by local professionals. Some people will need to be transferred to a specialist centre, with full neuroscience facilities and an interdisciplinary team with specialist skills in brain injury rehabilitation. Some centres have an outreach service available to staff from local rehabilitation units providing support to therapists asked to work with people affected by encephalitis who may have relatively little experience of encephalitis and its after effects.

This list is taken from a Department of Health document "Discharge from hospital: pathway, process and practice" which can be downloaded

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4003252](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003252)

## **Patient's and Carer's Discharge Standards**

Patients being discharged from hospital have the right:

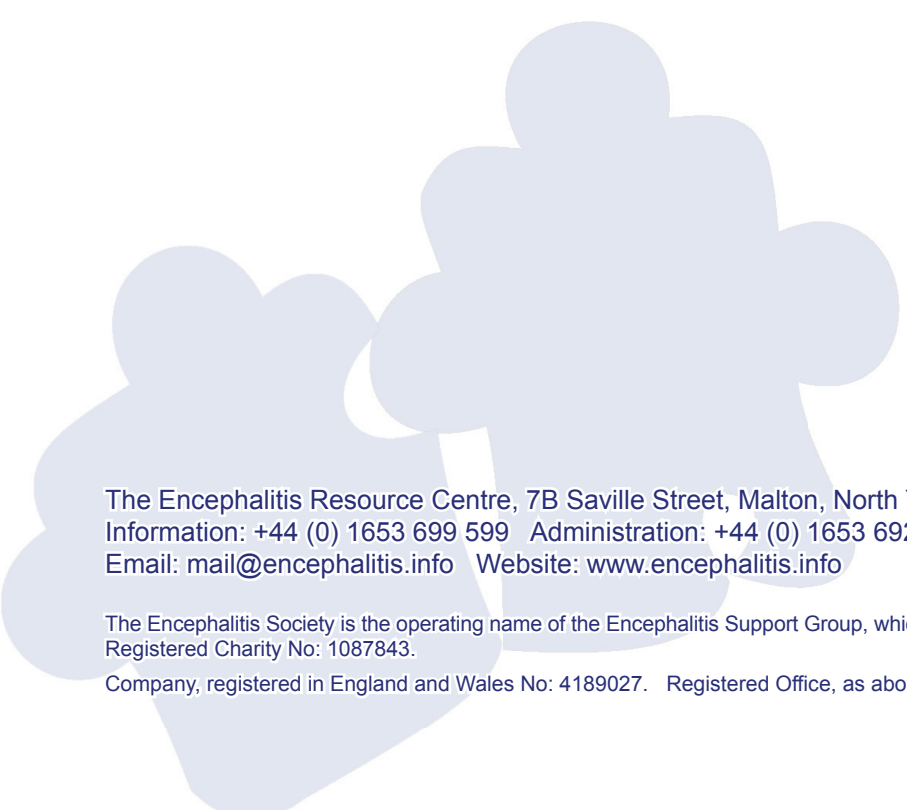
1. To full information on their diagnosis and the assessment of their health and social needs in preparation for discharge.
2. To be fully involved in planning their own discharge, together with a relative, carer or friend as appropriate.
3. For the discharge plan to start on or before admission where possible.
4. To full information on the services available in the community relevant to their care.

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5. To full information on short- or long-term nursing or residential care, including financial implications.
6. To be given an appropriate contact number where they can get help or advice on discharge.
7. To be given a clear, legible discharge letter detailing the support services provided for them (where appropriate).
8. To full information on health authority eligibility criteria for continuing care.
9. The discharge planning team to be available as a point of contact to offer support and advice to patients, carers, statutory and voluntary agencies.
10. Information on advocacy support.
11. To have access to the trust complaints procedure and any complaint regarding their discharge arrangements investigated and a full explanation given.
12. If still not satisfied, then be given access to the health service commissioner.

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*The views expressed in any quoted resources represent those of the authors and are not the views or official policy of the Encephalitis Society and its Professional Panel.*



The Encephalitis Resource Centre, 7B Saville Street, Malton, North Yorkshire YO17 7LL UK  
Information: +44 (0) 1653 699 599 Administration: +44 (0) 1653 692 583 Fax: +44 (0) 1653 604 369  
Email: [mail@encephalitis.info](mailto:mail@encephalitis.info) Website: [www.encephalitis.info](http://www.encephalitis.info)

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