Discharge from hospital
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Practical issues
Planning for discharge should start from the moment the patient is admitted to hospital, and ideally, be managed by the professional who is in charge of their care (the nurse in charge is usually the main point of contact).

Patients shouldn’t be discharged if their condition is not stable, they are not safe to be discharged and there are no plans to manage their care after leaving the hospital. If the patient/their carers do not agree about the discharge date, they need to speak to the nurse in charge or their current doctor. However, a patient has the right to discharge themselves from hospital anytime (if they have capacity to do that).

The patient/their carer needs to arrange for their own transport from hospital, but staff can make transport arrangements at request. If patients are advised to stay off work, they need a sick note to take to their employer.

Informing the GP
The GP should be advised of the discharge by letter, which may be sent directly to them or given to the patient to hand over. The letter usually gives information about hospital treatment, medication to be given at home and any follow-up arrangements. If medication is given to take at home, a repeat prescription from GP is needed before this medication runs out. If there is a lot of medication it may be useful (cheaper) to purchase a prescription prepayment certificate (PPC) which covers you for all NHS prescriptions, including dental prescriptions, no matter how many items you need. More information about it can be found on the NHS website (www.nhs.co.uk), by phone on 0300 330 1341 or from local GP surgery.
**Considerations regarding encephalitis**

Before discharge, patients should be assessed according to their needs such as assessments by a neurologist, neuropsychologist, physiotherapist, occupational therapist, speech and language therapist, dietician, social worker, etc. Following those assessments, plans and referrals for after discharge should be in place to meet the patient’s needs.

Full information and explanation about the illness and after-effects should be given to the patients, their families and carers.

Most people affected by encephalitis are left with some form of acquired brain injury (ABI). Sometimes, the difficulties may not appear to be significant and it may simply be assumed that the return to former life will not be problematic. However, problems can become more apparent when people are trying to return to work, education and home life. It is therefore important to secure some method of follow up after discharge and/or have the contact details of someone (e.g. neurologist) who can help in case they are problems.

**Continuing health and social care needs**

If the patient is likely to have continuing health and social care needs, a discharge plan will be produced. This will identify who will provide the care and support after discharge. It could be residential/nursing care, intermediate care or care at home. The patient and/or their carer need to be involved in planning and decide what is realistic so that any discharge plan is as achievable as possible. If the patient is discharged at home, a relative may decide to be in charge of the care. They don’t need to do that, but if they do, they need to think carefully of all the implications. All plans need to be in place before returning home and beginning to access any health-care services.

In some cases, 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.
The patient should be asked for consent, informed about any referrals to other agencies and be given a clear plan of what happens next and any likely financial implications. If the patient doesn’t have capacity to do this, their carers should be consulted.

* Each hospital has its own policies and arrangements. Any concerns regarding the discharge can be raised with the person in charge of the care and/or the Patient Advice and Liaison Service (PALS).

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Thank you!

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