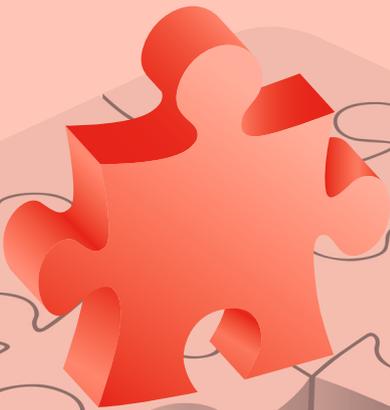


# JBDS-IP

Joint British  
Diabetes Societies  
for inpatient care

## Discharge planning for adult inpatients with diabetes

October 2017



## **This document is coded JBDS 10 in the series of JBDS documents:**

### **Other JBDS documents:**

The use of variable rate intravenous insulin infusion (VRIII) in medical inpatients; October 2014, JBDS 09

Management of Hyperglycaemia and Steroid (Glucocorticoid) Therapy; October 2014, JBDS 08

Admissions avoidance and diabetes: guidance for clinical commissioning groups and clinical teams; December 2013, JBDS 07

The management of the hyperosmolar hyperglycaemic state (HHS) in adults with diabetes; August 2012, JBDS 06

Glycaemic management during the inpatient enteral feeding of stroke patients with diabetes; June 2012, JBDS 05

Self-management of diabetes in hospital; March 2012, JBDS 04

Management of adults with diabetes undergoing surgery and elective procedures: improving standard; revised October 2015, JBDS 03

The management of diabetic ketoacidosis in adults; revised September 2013, JBDS 02

The hospital management of hypoglycaemia in adults with diabetes mellitus; revised September 2013, JBDS 01

### **These documents are available to download from:**

**ABCD website:** [www.diabetologists-abcd.org.uk/JBDS/JBDS.htm](http://www.diabetologists-abcd.org.uk/JBDS/JBDS.htm)

**Diabetes UK website:** [www.diabetes.org.uk](http://www.diabetes.org.uk)

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# The writing process

During the writing of this guideline available literature was reviewed and general areas for consideration were discussed within the JBDS-IP care group including conflicts of interest of which there were none. A draft version was written and initially sent to the writing and review group, changes were discussed and incorporated as appropriate. This process was repeated several times until there was good consensus within the writing group. The guideline was subsequently sent to the full JBDS group and the process was repeated. Finally all the multi-professional endorsing groups received the document and their comments were considered and incorporated.

This guideline will be freely and widely available to all trusts with no copyright restrictions. It is hoped that it will be a useful resource for all healthcare professional that are involved in discharge planning. However, as with all the JBDS guidelines, the authors welcome any comments, criticisms or suggestions for future reviews. If you have any comments please email either [esther.walden@nnuh.nhs.uk](mailto:esther.walden@nnuh.nhs.uk) or [carol.jairam@imperial.nhs.uk](mailto:carol.jairam@imperial.nhs.uk).

**Due for review October 2018**

# Foreword

This guideline continues the series of Joint British Diabetes Societies for Inpatient Care (JBDS-IP) guidelines which have been developed to improve the standards of care for people with diabetes when they are admitted to hospital. It focuses on ensuring a safe and timely discharge or transfer from hospital by means of effective discharge planning with particular reference to the specific needs of people with diabetes. It should be used within the wider context of general discharge planning. All recommendations have been based on evidence, where possible, and consensus opinion drawn from accumulated professional knowledge. It attempts to align the unique and sometimes complex needs of patients with diabetes with other national guidance for discharge planning. Readers should also be aware that other excellent suites of guidance for diabetes management exist, e.g. NICE (The National Institute for Health and Care Excellence). See Further Reading.

During the writing process, comments have been incorporated from a wide range of organisations with an interest in diabetes.

As with all of the JBDS-IP documents, this guideline is dynamic and will be reviewed in response to feedback via JBDS organisations with a view to incorporating emerging evidence.

The guideline has been produced by JBDS-IP on behalf of Diabetes UK, the Association of British Clinical Diabetologists (ABCD), the Diabetes Inpatient Specialist Nurse (DISN) UK Group and Training, Research and Education for Nurses in Diabetes (TREND-UK).

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## Rationale for this guideline

This guideline has been developed to help healthcare professionals in secondary care plan the safe and effective discharge of adult inpatients with diabetes. The guideline complements the 2010 Department of Health (DH) guidelines on the safe and timely discharge or transfer of patients from hospital into the community by emphasizing the specific steps and assessments required for patients with diabetes.

This document focuses specifically on aspects of diabetes care that should be considered at discharge and includes a range of summary checklists for staff. However, it is important to recognise that discharge or transfer planning is not condition specific, and that all aspects of a patient's health and social needs should be taken into consideration.

It is intended this guideline will supplement current hospital Trusts' discharge policies already in place.

## Who should read this guideline?

- All members of the hospital multidisciplinary Diabetes Specialist Team (DST)
- All medical and nursing staff and allied healthcare professionals looking after adult inpatients in a hospital setting
- All members of the community diabetes care provider team
- Hospital and ward managers
- Local clinical commissioning groups
- Social services team

# Executive Summary: Recommendations for effective and appropriate discharge planning

- Effective discharge planning for inpatients with diabetes improves patient experience, reduces length of stay and readmission rates.
- Discharge planning for inpatients with diabetes should begin at the time of admission to ensure a smooth, safe and documented transition from hospital to discharge destination (Table 1).
- Clear guidelines for all wards need to be in place for early referral to the diabetes specialist team.
- All inpatients with diabetes, and/or their carers, should be involved in their diabetes care pathway and discharge planning (Table 2).
- A patient's ability to self-manage and their social support should be taken into account when choosing a glycaemic management plan on discharge.
- Community support for glycaemic monitoring for patients unable to self-care, for whatever reason, should be arranged prior to discharge.
- All medication, insulin passports, equipment and devices for glycaemic management and monitoring, as appropriate to individual needs and wishes, must be available for the patient or carer at the time of discharge (Tables 3–5).
- All patients and their carers must be aware of their diabetes care provider following discharge as well as contact details to access emergency support for diabetes care if required.
- On discharge all community services pertinent to the patient, including the GP, must be informed of changes made to the diabetes treatment and follow up plans in the care pathway.
- Patients should be given a copy of their continuing diabetes care plan and discharge summary which should include the name of the medication, dosage, frequency of dosing, device for injections (GLP-1 and/or insulin), if appropriate, and follow-up arrangements post-discharge.
- The discharge planning process should include all of the patient's needs, of which diabetes should be a part, not the sole focus.
- Ensure the discharge planning for patients admitted primarily for another condition but also have active foot disease does not overlook their specific foot care needs.

# Introduction

Since 2010, the National Diabetes Inpatient Audit (NaDIA) has provided an annual snapshot of diabetes inpatient care in England and Wales, and has shown consistently that the prevalence of diabetes in acute hospital inpatients is about 15–20%, with most diabetes inpatients being elderly with significant co-morbidities, and most admitted as emergencies. The 2013 NaDIA data reported in 2014 (NaDIA 2014) shows that only two thirds of inpatients with diabetes needing a referral to the diabetes team actually received one.

It should be emphasized that discharge planning for people with diabetes should take place within the wider context of effective discharge planning, and a Department of Health (DH) general summary of outcomes for effective discharge planning is shown below (Tables 1 and 2). The DH recognises that good discharge planning from hospital improves patient experience, reduces length of stay and readmission rates, and suggests 10 key steps and general principles that need to be followed to ensure safe and timely discharge (Tables 1 and 2).

**Table 1. 10 key steps to ensure safe and timely discharge (Ready to go, DH 2010)**

1	Start planning for discharge or transfer before or on admission
2	Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision
3	Develop a clinical management plan for every patient within 24 hours of admission
4	Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level
5	Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer
6	Review the clinical management plan with the patient each day, or as appropriate, take any necessary action and update progress towards the discharge or transfer date
7	Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence
8	Plan discharges and transfers to take place over all seven days of the week to deliver continuity of care for the patient
9	Use a discharge checklist 24–48 hours prior to transfer
10	Make decisions to discharge and transfer patients each day

**Table 2. Recommendations and Outcomes of Effective Discharge Planning**

Recommendations	Outcomes
1. Discharge and transfer planning starts early to anticipate problems, put appropriate support in place and agree an expected discharge date	<ul style="list-style-type: none"> <li>• Potential reduced length of stay</li> <li>• Reduced risk of readmission</li> <li>• Reduced risk of delayed discharge</li> </ul>
2. A person-centered approach treats individuals with dignity and respect, and meets their diverse or unique needs to secure the best outcomes possible	<ul style="list-style-type: none"> <li>• Patients and carers should feel their expertise is recognised and used appropriately in care planning and goal-setting</li> </ul>
3. The care planning process is coordinated effectively	<ul style="list-style-type: none"> <li>• Potential reduced length of stay</li> <li>• Reduced risk of readmission</li> <li>• Reduced risk of delayed discharge</li> </ul>
4. Communication creates strong and productive relationships between practitioners, patients and carers	<ul style="list-style-type: none"> <li>• The service is valued by the local community through clear lines of communication</li> </ul>
5. The MDT works collaboratively to plan care, agree who is responsible for specific actions and make decisions on the process and timing of discharges and transfers	<ul style="list-style-type: none"> <li>• Resources are used to best effect enabling targets to be met and therefore improve service delivery</li> </ul>
6. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date	<ul style="list-style-type: none"> <li>• Optimises patient and others involvement, staff input, patient safety and experience</li> </ul>
7. Social care are involved, where appropriate, and the requirements for the assessment and discharge notification are met	<ul style="list-style-type: none"> <li>• Positive relationships with other local providers of health, social care and housing services</li> </ul>
8. Patients and carers are involved at all stages of discharge planning, given good information and helped to make care planning decisions and choices	<ul style="list-style-type: none"> <li>• Patients and carers can feel confident of continued support with the right information and advice to help them in decision-making, continued support on discharge and an identified point of contact</li> </ul>
9. Patients who do not have capacity to make decisions are given their rights and obligations under the Mental Capacity Act	<ul style="list-style-type: none"> <li>• Avoidance of blame, disputes over responsibility for delays and fewer complaints</li> <li>• Safer transition and communication between primary and secondary care when multi-agency support is required</li> </ul>
10. A person's eligibility for NHS continuing healthcare is assessed where appropriate	<ul style="list-style-type: none"> <li>• Resources are used to best effect enabling targets to be met and therefore improve service delivery</li> </ul>

# Principles of discharge planning in diabetes care

Diabetes care, and discharge planning for people with diabetes, should recognise the complex interplay between educational, physical, social, external systems and psychological factors in diabetes management (Simmons, 2001), within the wider context of effective discharge planning (Tables 1 and 2). In general:

- The discharge needs of patients with diabetes should be assessed within 24 hours of admission. Assessment involves information gathering about knowledge of diabetes, self-management skills, education and social circumstances, expected change in functionality as a consequence of ill-health and the potential barriers to self-care that may affect a safe discharge.
- To aid planning, discharges should be categorised as 'simple', 'complex' or 'rapid'.
- Prompt referral to the diabetes specialist team (DST) should be made following assessment of all patients in line with the Trusts referral criteria, and for anyone with an expected complex discharge.
- Care-planning and goal-setting should involve the patient and, if appropriate, their carer to improve concordance and maximise independence as appropriate.
- Key information should be provided in a timely manner, throughout the inpatient stay and again on discharge.
- The discharge plans should be reviewed as the clinical and social situation dictates with an estimated date of discharge stated. The inpatient stay is often dynamic metabolically, physiologically and functionally necessitating open, frequent communication amongst members of the multi-disciplinary team.
- Staff should ensure that patients are ready for discharge once the acute phase of care is complete, and the patient is medically stable and functionally optimised as appropriate for the final destination. This includes ensuring all equipment relating to diabetes care is available as appropriate.
- Changes made to diabetes care should be communicated to the relevant care provider in the community setting to ensure continuity. As far as possible, patients and carers should be made aware of the expected treatment pathway post discharge, the diabetes care provider and contact details.
- Patients and other health care professionals involved should be aware of any investigation results pending, with actions to be taken post discharge clearly documented to the GP/other care provider.
- **Outlined below is a diabetes discharge checklist (Table 3), an insulin use discharge checklist, (Table 4), and a more general educational needs checklist of topics to be considered (Table 5), all of which can be adapted for local use.**

### Table 3. Diabetes Discharge Checklist

Ward nurse to complete prior to discharge. Completed form to be filed in medical notes.

Surname \_\_\_\_\_ First Name \_\_\_\_\_ Hospital No. \_\_\_\_\_ NHS No. \_\_\_\_\_

#### Insulin or sulphonylurea – treated patients

Hypoglycaemia avoidance

- Confirm that patient and/or carer are aware of the risk of hypoglycaemia
- Confirm that patient and/or carer know about the signs and symptoms and treatment of hypoglycaemia
- Confirm that patient and /or carer have access to treatment of hypoglycaemia at home e.g. Options of quick-acting carbohydrate and glucagon if indicated

#### Insulin administration and treatment supplies. Delete if not applicable

- Self-caring  Residential home
- Carer  Nursing home
- District nurse  Other care facility (please specify) \_\_\_\_\_
- Glucose meter \_\_\_\_\_
- Ketone meter (for people with type 1 or ketosis-prone type 2 diabetes)
- Insulin device \_\_\_\_\_ Vial/syringes \_\_\_\_\_  
Pre-filled pen \_\_\_\_\_  
Durable pen \_\_\_\_\_  
Insulin pump \_\_\_\_\_
- Needles \_\_\_\_\_ Sharps box \_\_\_\_\_
- Safety needles for District Nurse or carer input if indicated \_\_\_\_\_
- Insulin passport & Patient information booklet

#### Diabetic Foot Disease

- Confirm that Diabetes Specialist Team are aware of discharge
- Check antibiotics
- Confirm \_\_\_\_\_ days worth of dressings provided
- District Nurse for dressings
- Podiatry appointment
- Diabetic Foot Clinic

#### All patients with diabetes

- Electronic Discharge Summary (EDS) to GP (to include medication changes and review expectations)
- Ensure patients receive detailed discharge counselling especially on altered doses to ensure no errors are introduced on discharge
- EDS to Diabetes Care Provider and District Nurse if appropriate
- Care plan
- Follow-up plans
- All discharge medication including return of patients own drugs and insulin from fridge

Completed by: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Table 4. Insulin-treated patients discharge checklist: subcutaneous injections, insulin pumps and GLP-1 injectables**

**The ward nurse should ensure all patients have the following:**

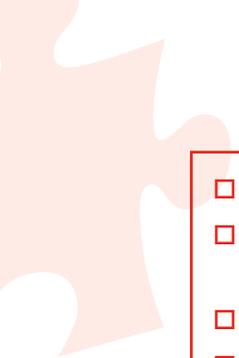
- Appropriate formulation of insulin supplied in line with patient's needs and discharge plan must be provided
- Provision of a 7 day supply of insulin syringes/pen devices/cartridges (this may vary with different Trusts from 7–14 days)
- 10ml vial of insulin (if required)
- Disposable pen with safety needle (if required)
- Blood glucose meter and/or ketone meter, strips and lancets
- Sharps bin if in line with Trust policy and continued in primary care
- Insulin passport/insulin safety card
- Patient information leaflets
- Contact number of DISN involved in patient's care during the inpatient stay or community DSN if transferring to intermediate care

If the patient and/or carer are not able to self-manage insulin injections and requires District Nursing input, the ward nurse is responsible for ensuring the following:

- Referral to District Nursing team with clearly defined and specified level of support required documented
- Copy of discharge summary to be faxed to the District Nursing team sent 48 hours before discharge wherever possible to reduce risk of post-discharge discrepancies
- Ensure early referral to the diabetes specialist team to resolve any equipment issues in a timely manner

**Table 5. Educational Review Checklist - individualised to patient's circumstances**

- What is diabetes – type, pathophysiology, treatment
- Oral glucose lowering drugs – mode of action, dosing, frequency, side-effects, timing
- Glucagon-like peptide 1 (GLP 1) injectable – mode of action, dosing, frequency, injection technique, injection sites, side-effects, timing
- Food and nutrition – nutritional goals, outline of nutritional care plan i.e. principles of a healthy diet, adequate carbohydrate at the right times during admission, carbohydrate counting, weight management, nutrition support such as enteral feeding and nutritional supplementation
- Monitoring – indication and frequency, target range and reason for individual parameters, choice of glucose meter, practical aspects of testing and care of meter, sites for testing, alternative site testing, sharps disposal
- Blood ketone testing – indications, practical aspects of testing, frequency and interpretation of results
- HbA1c – what is it, relevance to care, target
- Insulin action – endogenous and exogenous effects on blood glucose, injection technique, storage of insulin, getting supplies of insulin, carbohydrate counting in relation to dose adjustments, glycaemic index and portion sizes
- Injection sites – rationale for rotation, lipodystrophy
- Choice of device – syringe and vial, disposable pens, re-useable pens with cartridges, pump
- Needle length – rationale for choice, injection technique, sharps disposal
- Hypoglycaemia – causes, types of hypoglycaemia, signs and symptoms, treatment, options of simple and complex carbohydrates with regard to the glycaemic index of foods, prevention strategies, use of glucagon if appropriate
- Hyperglycaemia – causes, signs and symptoms, acute effects, long-term effects, medication adjustments, when to escalate for admission avoidance
- Pregnancy – women of child-bearing age, pre-conceptual care, planned pregnancy, care during pregnancy, contraception
- Sick day rules – safe management of diabetes during intercurrent illness, insulin dose adjustment, monitoring
- Exercise – effect on glycaemic control, effects on cardiovascular outcomes, principles of dose adjustment, national recommendations
- Acute complications and avoidance of same – DKA, HHS, hypoglycaemia
- Chronic complications – microvascular, macrovascular
- Alcohol – effect on glycaemic control, national recommendations
- Smoking – effect on glycaemic control, national recommendations, smoking cessation
- Shift work – food intake, monitoring and adjustment of medications such as insulin
- Driving – legalities of DVLA reporting, hypoglycaemia management, restrictions, insurance
- Special occasions & cultural issues – managing diabetes safely for celebrations, religious occasions such as Ramadan
- Eye Care – impact of diabetes on eyes, need for retinal screening, expected care provision
- Foot care – daily foot care, access to podiatry, emergency care
- Written instructions – literature to supplement discussions, education and care plan
- Sex – erectile dysfunction, treatments, counselling

- 
- ❑ Psychology support or psychiatric support – community psychiatric nurse (CPN) if needed
  - ❑ Travel – preparation, vaccination, travel letter, adjusting insulin when crossing time zones, impact of extremes of temperature on blood glucose monitoring, storage of insulin during travel
  - ❑ Identification – ID card, medical alert jewellery, insulin passport
  - ❑ On-going follow up – clear understanding of diabetes care provider, appointments, prescriptions and assistance as required
  - ❑ Prescriptions
  - ❑ Contact details for diabetes care provider and emergency occasions

Amalgamated from: Fox & Mackinnon, 2002, Diabetes UK 2011

## Specific challenges for inpatients with diabetes

The inpatient setting by its very nature provides a host of 'obstacles' to support sound clinical management of diabetes and appropriate and safe glycaemic control therefore creating a potential barrier to early discharge. Some of these issues are summarised below.

### Potential obstacles to achieving optimal glycaemic control in hospital

Hospital related issues	Patient issues
'Nil by mouth' status	Infection
Procedures	Physiological stress/illness/trauma
Lack of activity	Fear of hypoglycemia
Changes in mealtimes	Fear of injections
Feeding regimes	Weight change
Steroid therapy	
Mismatch between meals and medications	
Diabetes is often a secondary diagnosis	
Lack of ownership for diabetes care	

## Assessment

Discharge planning should be built into the initial assessment process and should look beyond the inpatient episode of care. This proactive approach is aimed at ensuring safety for the patient at home or community facilities and reducing risk of readmission (Dunning, 2003). Assessment provides the opportunity for information gathering, and anticipation of potential problems which allows for early resolution of potential barriers to discharge. Clear, sensitive communication with the patient and family is essential especially for the patients who experience a considerable new loss of function (Katicreddi & Cloud, 2009).

### Initial Discharge Assessment by the Ward Nurse

The initial discharge assessment will be undertaken by the ward staff using the 10 key steps outlined in Table 1 and any other assessment tools in use in individual hospitals. This assessment will help to determine which members of the multidisciplinary team will need to be involved during the inpatient stay and in the discharge planning process. Early referral is paramount to avoid delays in discharge. Ward pharmacists should be involved in this initial discharge assessment in order to determine issues with concomitant medications that may affect blood glucose levels and highlight potential difficulties with medication administration and adherence. Prompt referral to the Diabetes Specialist Team for involvement in the in-patient care pathway and discharge planning process should include the criteria outlined in the 2011 'The Think Glucose' assessment tool, (Table 6). These are evidence based criteria and when used can facilitate discharge planning and reduce length of stay.

**Table 6. Think Glucose – Patient assessment tool and referral criteria to Diabetes Specialist Team (DST)**

Always refer	Sometimes refer	Rarely refer
<ul style="list-style-type: none"> <li>• Admission for urgent or major elective surgical procedure</li> <li>• Acute coronary syndrome</li> <li>• Diabetic ketoacidosis/ hyperosmolar hyperglycaemic state</li> <li>• Severe hypoglycaemia</li> <li>• Newly diagnosed Type 1 diabetes</li> <li>• Newly diagnosed Type 2 diabetes</li> <li>• Intravenous insulin infusion with glucose outside limits</li> <li>• Previous problems with diabetes as inpatient</li> <li>• Intravenous insulin infusion for over 48 hours</li> <li>• Impaired consciousness</li> <li>• Unable to self-manage</li> <li>• Parenteral or enteral nutrition</li> <li>• Foot ulceration</li> <li>• Sepsis</li> <li>• Vomiting</li> <li>• Patient request</li> </ul>	<ul style="list-style-type: none"> <li>• Significant educational need</li> <li>• Intravenous insulin infusion with good glucose control</li> <li>• Nil by mouth more than 24 hours post surgery</li> <li>• Persistent hyperglycaemia</li> <li>• Possible Type 2 diabetes</li> <li>• Stress hyperglycaemia</li> <li>• Poor wound healing</li> <li>• Steroid therapy</li> </ul>	<ul style="list-style-type: none"> <li>• Minor, self treated hypoglycaemia</li> <li>• Transient hyperglycaemia</li> <li>• Simple educational need</li> <li>• Routine dietetic advice</li> <li>• Well controlled diabetes</li> <li>• Good self-management skills</li> <li>• Routine diabetes care</li> </ul>

**Table 7. Areas for consideration during discharge assessment**

<b>Diabetes</b>	<b>Social</b>	<b>Physical</b>
Degree of glycaemic control prior to admission	Socioeconomic Factors – family support, employment status	Normal functional level prior to admission
Current diabetes control – treatment, biochemistry	Learning barriers – language, cognition, dexterity, competence related to diabetes self management	Physical/ self-care limitations – e.g. blindness, stroke, amputation
Diabetes management – who administers insulin/tests blood glucose if applicable	Mental capacity – dementia, mental illness	Functional level, ability to self-care and consideration of age
Diabetes equipment required – pens, needles, insulin pump, monitoring equipment, specialist adaptations to support independence	Educational potential – sight, hearing, manual dexterity, cognitive ability	Presence of any symptoms
Diabetes complications – kidney function, liver disease, retinopathy, neuropathy	Social support – carers and family circumstances, social services, community support	Presence of co-morbidities
Ability to continue/start insulin self-administration	Dependence on multi-agency support for continued care	Life expectancy, prognosis, End of Life Care
Nutritional status – parenteral or enteral feeding, supplements, change in meal timing, religious and cultural preferences	Resupply of medications post discharge	Physical capacity to comply with treatment
Educational need – has their diabetes treatment changed, did diabetes lead to the admission	Homelessness	Mobility

## Patient Education

- The ultimate goal of discharge planning is to provide the patient with the 'survival skills' needed to manage and take responsibility for their own health, with self-management education being deemed a key component of the transition plan (Rothman & Wagner:2003).
- There is some evidence which supports the idea that inpatient education influences earlier discharge and improved outcomes following discharge back to the community (Nettles, 2005). As early as 1966, Etzwiler described 3 phases of patient education: 'acute or survival education,' 'in depth education,' and "continuing education.' 'Survival skills' describes education provided whilst the patient is in hospital so that issues are contained to topics essential for safe patient discharge.
- More recently the American Diabetes Association suggested hospitalisation provides an opportunity for patient education (ADA, 2013). They suggest key areas such as nutrition, foot care, activity, concordance with medication, monitoring and risk reduction be addressed.
- The Diabetes Inpatient Specialist Nurse with the support of generalist nurses, pharmacists, dietitians, if indicated, and medical staff can provide tailored education for specific educational gaps during an inpatient stay which is an essential part of discharge planning.
- The basis of education involves basic pathophysiology, medicines management, avoidance of diabetes crises, maintenance of glycaemia and day to day impact of diabetes management on social activities.
- If the ward nurse has the knowledge and skills to complement the DISN input, the blending of specialist and generalist nurse input can further strengthen patient support. Each individual nurse should work within his/her level of competence in accordance with the Trust guidance.

## Classification of discharge

Following initial assessment, the type of discharge needs to be documented to ensure that time and resources are used to the best effect. Discharges should be categorised as 'simple', 'complex' or 'rapid'.

Simple discharge	Complex discharge	Rapid discharge
<ul style="list-style-type: none"> <li>• Involve minimal disturbance to the patient's daily routines.</li> <li>• Does not prevent or hamper the patient being discharged to their usual place of residence.</li> <li>• Will not require a significant change in support offered to the patient or their carer.</li> <li>• Self-caring patient with no decline in functional ability as a result of illness.</li> </ul>	<ul style="list-style-type: none"> <li>• Deviates from the normal discharge pathway and requires complex coordination of services to enable safe discharge.</li> <li>• This may include social work referrals, multidisciplinary meetings, continuing care checklists and a possible change between admission and discharge destination.</li> </ul>	<ul style="list-style-type: none"> <li>• May be simple or complex and is usually as a result of the end of life pathway or palliative discharge.</li> </ul>
<p><b>E.g.</b></p> <ul style="list-style-type: none"> <li>• Pregnant woman with newly diagnosed diabetes</li> <li>• Post-operative surgery</li> </ul>	<p><b>E.g.</b></p> <ul style="list-style-type: none"> <li>• Frail elderly patient</li> <li>• Patient with a mental illness</li> <li>• Patient with learning difficulties</li> <li>• Homeless person</li> <li>• Person post-limb amputation</li> <li>• Person requiring multi-agency support</li> <li>• 'Vulnerable adult'</li> <li>• Person with dementia or cognitive impairment</li> </ul>	<p><b>E.g.</b></p> <ul style="list-style-type: none"> <li>• Person with terminal illness</li> <li>• Transfer to a hospice</li> <li>• Transfer to another intermediate care facility</li> </ul>

**Note: These examples are for simplicity only. Care MUST be individualised to the patient's own specific circumstances**

## Patients with complex ongoing health and social care needs – complex discharges

The following groups of patients require particular attention and are considered to have complex discharge needs:

- Patients with frequent attendances for diabetes emergencies i.e. diabetic ketoacidosis. Involvement of the mental health team or psychologist should be sought at the earliest possible opportunity and followed up post discharge.
  - Patients with complex ongoing health and social care needs who are being discharged home with a package of care e.g. the frail, elderly, or those with mental ill health/dementia especially those who live alone. Where possible the DST should provide liaison/support in the initial transition period post discharge.
  - Discharge to another care setting e.g. community hospital, nursing home.
  - Patients who lack capacity to make a decision about their long term care needs (includes patients with learning disabilities). Involvement of the learning disabilities team and mental health team, if appropriate, should be sought at the earliest possible opportunity and followed up post discharge.
- Healthwatch England (2015) focused on the experiences of older people and those who were homeless or with a mental health condition. Their enquiry demonstrated that the effects of poor co-ordination of care and services leading to failed discharges were especially detrimental. Co-ordination of services is key to preventing 'revolving door' admissions and poor health outcomes.
- Ensuring prompt referral to all services involved will aid the discharge process.
  - For all these groups of patients individual assessment is required and consideration should be given to referral to the 'safeguarding vulnerable adults' team.

## Table 8. Roles and responsibilities

It is important to clearly define roles and responsibilities to ensure all aspects of discharge planning are covered but not unnecessarily duplicated.

Roles & responsibilities	
<b>Assessment</b>	Ward Nurse  Ward pharmacist - Ensure accurate medicines reconciliation of drug/insulin brand, doses and formulation to enable clear decisions and changes to be made  Diabetes Inpatient Specialist Nurse (DISN) or other member of the Diabetes Specialist Team (DST) on receipt of referral
<b>Referral to MDT or DST</b>	Ward nurse
<b>Care-planning</b>	Patient and / or significant other(s)  Ward Nurse  DISN  Ward pharmacist or Diabetes specialist pharmacist
<b>Review of discharge plans</b>	Medical team  Ward Pharmacist  Ward Nurse  DISN  Discharge co-ordinator for complex discharges  MDT members as appropriate
<b>Provision of diabetes equipment and literature</b>	Diabetes Inpatient Specialist Nurse  Ward pharmacist
<b>Ensuring equipment sent on discharge</b>	Ward Nurse
<b>Provision of diabetes care plan</b>	DISN  Ward Nurse
<b>Discharge summary</b>	Medical staff  Ward pharmacist  Ward Nurse
<b>Liaison with GP, district nurse, community psychiatric nurse (CPN), carers and care home as appropriate</b>	DISN  Ward Nurse
<b>Follow up provision clearly documented</b>	Medical team  DST

# Conclusions

These guidelines have been produced by a writing team of active diabetes specialist clinicians, and are meant to be a brief and practical summary on diabetes discharge planning for clinical teams. Diabetes discharge planning should take place within the wider framework of safe discharge planning, but there are diabetes specific issues that

can sometimes be overlooked and are summarised in the checklists (Tables 3–8).

‘When discharge goes wrong, it comes at significant cost, both to individuals and to the health and social care system’, (Healthwatch England Special Inquiry: Safely Home, 2015).

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