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Deputy John Brady,
Dáil Eireann,
Leinster House,
Dublin 2

1st July 2025

PQ: 29341/25
To ask the Minister for Health the procedures hospitals should follow regarding move on plans for patients with dementia from hospital to convalescent care; whether hospitals must consult families in the decision-making process; and if she will make a statement on the matter.

Dear Deputy Brady,

I refer to your parliamentary question, which was passed to the HSE for response.

I refer to a key document entitled *Integrated Care Guidance: A practical guide to discharge and transfer from hospital* which was developed by the HSE Quality & Patient Safety division. It offers a practical guide to support healthcare providers to improve their discharge and transfer processes from the acute hospital setting. This guidance document describes nine steps for effective discharge planning and transfers from hospital which are outlined below:

1. Begin planning for discharge or transfer before or on admission
2. Identify whether the service user has simple or complex needs
3. Develop a treatment plan within 24 hours of admission
4. Work together to provide comprehensive service user assessment and treatment
5. Set an Estimated Length of Stay /Predicted Date of Discharge, transfer within 24-48 hours of admission
6. Involve service users and carers so they make informed decisions and choices
7. Review the treatment plan on a daily basis with the service user
8. Use a discharge checklist 24-48 hours before discharge
9. Make decisions to discharge/transfer service users each day

This Integrated Care Guidance framework acknowledges that good communication, irrespective of diagnosis and discharge destination will help the service user and their carer understand the discharge and transfer process, thereby allaying any fears and confusion. It encourages effective sharing of up-to-date information between service users, carers and providers and highlights that service users must have sufficient information and understand the information being offered to be able to participate in decisions regarding their discharge or transfer.

Whilst I have outlined above what the appropriate discharge planning process should entail, additional consideration needs to be given to people with dementia who will present with some level of cognitive impairment, which may impact on their ability to understand and interpret information relevant to their discharge. In this instance the person's capacity to make decisions may be in question.

The Assisted Decision-Making (Capacity) Act (2015) fully commenced on 26th April 2023 and relates to supporting decision-making and maximising a person's capacity to make decisions.

Under this Act, a person's capacity must be assessed based on their ability to make a specific decision at a specific time. The assessment used under this law is called a 'Functional Test' for capacity. Healthcare professionals may not make a blanket assessment that a person has no capacity. Applying the functional test, a person can be said to lack capacity to make a decision if they are unable to do one of the following:

- Understand information relevant to the decision,
- Retain that information long enough to make a voluntary choice,
- Use or weigh up that information as part of the process of making the decision,
- Communicate their decision in whatever way they communicate (not only verbally).

The HSE has set up a Patient Flow Academy and the aim is to support staff to identify, define and improve processes, pathways and systems for the safe and timely delivery of care of all patients. This is driven by a culture of continuous improvement, collaboration and sharing of what works well for sites. The Patient Flow Academy section of the HSE website offers a significant number of national and international resources that support and advise in relation to the acute hospital discharge process. Available at https://www.hse.ie/eng/about/who/national-services/patient-flow-academy/

As I have outlined above, the discharge planning process can be complex, it is multifaceted and requires regular communication between the service user, their family/carers and the respective multidisciplinary team. When a person with dementia is being discharged from an acute hospital there are added considerations to be cognisant of to ensure compliance with the Assisted Decision-Making (Capacity) Act (2015).

I trust this is of assistance.

Yours sincerely,

Geraldine Crowley,
Assistant National Director,
Enhanced Community Care Programme &
Primary Care Contracts