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Date: Nov 2011  
Author: Mandy Leigh

## DOCUMENT DETAILS

| Author: | Mandy Leigh |
| Signed: | [Signature] |
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| Chairman: | Chief Executive |
| Signed: | [Signature] |
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## DOCUMENT HISTORY

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<th>Nature of Change</th>
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SUMMARY

1. This document sets out Poole hospital’s agreed standards for safe, effective and timely discharge of inpatients. It provides a framework to ensure:

   - Discharge is a coordinated, patient-focused, transparent process that starts either before admission or as soon after admission as appropriate.

   - Patients, family and carers are treated with dignity and respect, and encouraged to be actively involved in all plans and decisions about their future care.

   - Staff work together supportively and understand how their own role and that of others can support the patient’s discharge plans. Staff members know what they and others are responsible for doing and who to ask for help.

   - Assessment and plans consider health and social care as a joined-up service to help patients achieve their best outcome. Care provided follows a ‘whole system’ approach that helps local social care, acute and community health services reach the people who need them most.

2. At the pre-admission assessment or as soon as possible after an unplanned admission, hospital staff will ask the patient what care they needed previously and start discussing possible changed needs after discharge. The process of planning for discharge will continue throughout the patient’s stay in hospital, and the patient, family and/or carers will be involved in all discussions and plans. Staff will record discussions, referrals, assessments and actions in the patient’s record to ensure plans are communicated and progressed effectively, and practice is evidenced.

3. Staff will maintain good communication with patients, family and carers throughout the admission, providing or directing them to written information if required. Patients, family and carers will be told who to contact to discuss plans and staff will actively seek their views. If a patient finds it difficult to understand or make decisions about discharge plans, staff will support them to be involved as much as they are able to be. Staff will contact independent advocacy if support is needed and there are no family or carers to consult.

4. Health and social care professionals involved will learn about each other’s roles so that they know the best way to support the patient together with others. Staff will treat colleagues with respect and work together where possible.

5. Trust staff and others supporting discharge, such as community hospitals, community rehabilitation teams, social services teams and community nursing teams will work in partnership with the patient and their family or carers to plan for discharge from hospital. Patients who no longer need acute hospital assessment or treatment will be offered help to move to a more appropriate location, which will also enable acute hospital services to be ready for those who need them.
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FLOWCHART OF THE DISCHARGE PROCESS

Discharge planning started at pre-admission for elective patients or within 24 hours of unplanned admissions, and recorded on discharge planning tool throughout hospital stay

Estimated date of discharge, discharge leaflet and named nurse all discussed with patient/carer

Likelihood that discharge plans will be complex assessed within 24hrs of admission

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**Complex or unmet care need**

- Patient-centred plan developed for specific needs and appropriate complex pathway started
- Specialty matron and discharge services consulted for support with complex discharge plans
- Referrals sent for assessment and/or provision, e.g. mental health/ social care/ intermediate care

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**Simple pathway started**

**Named nurse consults ward lead for support regarding discharge plans, who advises when to change to complex pathway**

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**Type of need after acute episode**

- **Social**
  - Shared
    - Referred to local authority to assess & arrange services
  - Joint care from local authority & NHS (e.g. district nursing, NHS-funded nursing care, joint-funded care package)

- **Health**
  - Rehab complete
    - Yes
      - Referred for NHS continuing healthcare (CHC) or community provision, e.g. district nursing
    - No
      - Referred for community or inpatient rehab via single point of access (SPoA)

BEFORE DUE OUT DATE

- Local authority and community teams notified as soon as likely ready date identified
- Discharge arrangements confirmed with patient and/or carers and concerns addressed
- Immediate discharge summary (IDS) prepared
- Medication to take away (TTA) ordered by working day before due out date

ON DAY OF DISCHARGE - BEFORE MIDDAY

- Patient confirmed medically fit and safe to transfer from acute care
- Three copies of IDS printed, for patient record, GP and patient or carer
- TTAs issued and medication counselling undertaken
- Discharge checklist completed and signed
- Patient transferred to discharge lounge to await transport
1 RELEVANT TO
All staff working for or with Poole Hospital NHS Foundation Trust (hereafter referred to as the Trust).

2 PURPOSE
2.1 This policy document sets out guiding principles and provides a framework for safe, effective and timely transfer of care when inpatients are discharged from acute, inpatient care at this Trust to a new service or back to the care of previous services, such as their general practitioner (GP).

2.2 Responsibility for a patient’s care is transferred to the Trust on admission. If a patient attends the outpatient or emergency department but is not admitted, responsibility for their care remains with existing services.

2.3 This procedure should be read in conjunction with all Trust policies or procedures and national guidance referenced. Core principles, processes and implementation apply to all areas. Service specific variations regarding roles, responsibilities, procedures and pathways may be agreed and published within each Directorate.

3 DISCHARGE GUIDING PRINCIPLES
3.1 Discharge is not an isolated event but a process that starts as soon as possible and continues throughout the hospital stay.

3.2 Assessment for services such as healthcare, social care or housing is organised so that the patient and/or carers understand the continuum of these services, and that they receive advice and information to enable them to be fully involved with care planning and to make informed decisions about their future care.

3.3 Patients and carers are engaged with discharge planning from pre-assessment or admission, they understand what has happened and feel valued as partners in the discharge process, whose knowledge has been used appropriately. Plans are clearly defined and agreed with them at every stage, including each time the estimated date of discharge is amended. Carers are aware of their right to have their needs identified and met and who to contact, so that they feel confident of continued support in their caring role. They are given the right information and advice to help them decide whether they can undertake or continue a caring role.

3.4 Effective discharge is facilitated by a ‘whole system’ approach to the patient’s care pathway, including effective use of transitional and intermediate care services, so that acute hospital capacity is used appropriately and individuals achieve their optimal outcome. Inpatients whose acute episode is over are discharged as soon as they are medically stable and safe to transfer.

3.5 Multidisciplinary health and social care staff understand how their own role and that of others contributes to the discharge process, sharing and receiving key information in a timely manner. Expertise is recognised and used appropriately, practice is patient-centred and carer/family-focused, and all professions, disciplines and agencies involved work collaboratively. Patients are assessed and services delivered in a timely manner without unnecessary gaps or duplication of effort, ensuring care is experienced as a coherent pathway, rather than a series of unrelated activities.

3.6 The Trust and partner health, social care, housing or voluntary agencies use their resources to best effect to provide services valued by the local community, to meet service delivery quality targets and receive fewer complaints. Positive interagency relationships provide a system that supports effective collaborative working, and ensures staff can access training to develop skills that support discharge planning.
3.7 Trust staff will underpin their practice with the principles of cooperation and understanding. Patient and carer involvement includes good communication, involving patients and carers at all stages of discharge planning, giving good information and ensuring patients and carers are helped to make planning decisions and choices.

3.8 The Trust and colleagues from local health and social care organisations have agreed discharge quality standards including collaborative, supportive working to manage all aspects of the discharge process and ensure that discharge is facilitated at the earliest opportunity.

3.9 Staff record all assessments, discussions, referrals and actions relating to discharge on the discharge planning tool or communication sheets alongside to aid coordination of discharge plans. Trust discharge services staff audit compliance with these standards twice yearly by reviewing patient records for documented evidence of actions (see page 24). This record also provides evidence of practice for audit.

3.10 All staff will read and comply with the Trust discharge procedure and will access training to familiarise themselves with Trust documents relevant to their role in discharge planning. Staff will raise any queries about implementation with their line manager and/or Trust discharge services staff.

3.11 Staff are mindful of personal responsibility, professional accountability and governance issues, including treating patients with kindness, dignity and respect, taking account of diversity and the patient’s right to positive risk taking. They are also responsible for reporting discharge-related issues to their line manager, and completing adverse incident reports in line with Trust policy.

3.12 Patients are able to maximise independence, feel part of the care process, understand and sign up to the care plan, experience care as a coherent pathway, are involved in decisions about their care, and asked their views and preferences.

3.13 Carers feel valued as partners in the discharge process, consider their knowledge is used appropriately, understand what has happened and who to contact, are confident of continued support, information and advice to help them undertake or continue a caring role, and are given a choice about this.

3.14 Staff expertise is recognised and used appropriately and systems enable staff to receive timely information, understand their part in the system, develop new skills and roles, have opportunities to work in different settings and in different ways. Staff act in a sensitive way that respects patients’ views. They take time to involve patients and carers in planning discharge and to explain what different options mean for the patient.

3.15 Trust practice meets targets, reduces complaints, concentrates on service delivery, and has positive relationships with other local providers of health, social care and housing services.

4 DEFINITIONS

4.1 Carer: A person who cares for another such as a relative or close friend. This may be the next of kin but not necessarily. In this document the term includes family.

4.2 EDD: Estimated date of discharge recorded in two ways:

- An expected ready date that the patient, carers and all agencies can work towards, which may change several times during the admission according to the patient’s needs.
- A due out date which is recorded when required services are arranged and plans in place.

4.3 Multi-Disciplinary Team (MDT): A team of professionals who provide health and/or social care to patients.
4.4 Ready date: When a clinical decision has been made that the patient is ready for transfer, an MDT decision has also deemed the patient ready for transfer, and the patient is safe to transfer.

4.5 Transfer: The process whereby a patient is moved between clinical areas on a transient or permanent basis, either within the organisation or on transfer of care to another organisation.

4.6 Symbols Used Within This Document

- 😊 = Verbal communication with the patient and/or carers
- 📄 = Written information given to the patient and/or carers
- 🌟 = Verbal communication with health or social care colleagues
- 💌 = Written information or email sent to health or social care colleagues
- 📁 = Documentation within the patient record, whether written or electronic

5 STARTING DISCHARGE PLANNING

5.1 Discharge planning is started at pre-assessment or by the admitting nurse within 24-hours of unplanned admissions. If it is clinically appropriate to delay this on admission, the admitting nurse records the rationale.

5.2 😊 The discharge planning tool supports seamless discharge planning, provides evidence of actions taken and is the focal point for written multidisciplinary communication. The tool and communication sheets alongside are the place that all professionals record discussions and actions relating to the discharge process. The baseline assessment on page 1 of the discharge planning tool (see next page) helps identify the need for new or changed services on discharge.

5.3 😊 The named nurse is the nurse, midwife or discharge facilitator responsible for coordinating the patient’s discharge plans. The process for allocating a named nurse on admission is agreed at ward level. It could be the ward lead, the admitting nurse or midwife, another registered nurse, or a healthcare support worker with training in discharge planning. The named nurse is accountable to the ward clinical lead.

5.4 😊🌟 Giving and recording a name ensures carers know who to contact about discharge plans and that a named health professional will follow up plans and referrals. When the named nurse is not on duty, responsibility for coordinating and progressing discharge plans is delegated to the registered nurse or midwife caring for the patient on that day.

5.5 😊🌟 The medical team predict an initial EDD, discussing this with the patient and/or carers, explaining tests or treatment proposed and what rate of progress to expect. They will discuss what support might be required to enable discharge on the EDD and how the EDD is reviewed and revised. They review the patient’s progress and EDD daily, and revise it taking account of the patient’s physical and mental health.
EXAMPLE OF 1ST PAGE OF THE DISCHARGE PLANNING TOOL

**PATIENT DETAILS**
Name: Mr Joseph Bloggs
Hospital/ NHS number: 1231231234
Date of birth: 01/12/1935
Home address: 1 Any Street, Any Town
Home postcode: AB12 3CD

**Named Nurse:** Sr F Nightingale
**Ward:** Duo Ward
**Contact No:** 01234 x 5678

**DISCHARGE PLANNING TOOL**

**Initial/revised EDD:** 01/06/11, 07/06/11, 03/06/11

**INITIAL ASSESSMENT OF POTENTIAL COMPLEXITY**
Complete within 24hrs of admission to identify potential risk of delayed transfer of care (DTOC)

- Completed with patient/ next of kin/ carer: Bournemouth & Poole
- Comments: Sarah Baker
- Sign, date & print name:

<table>
<thead>
<tr>
<th>PCT patient’s GP is registered with:</th>
<th>Bournemouth &amp; Poole</th>
</tr>
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<tbody>
<tr>
<td>Health or social care needs prior to admission:</td>
<td>Cleaner, DN dressings twice weekly</td>
</tr>
<tr>
<td>Health or social care needs previously met by: (if a care home start pathway 2 without delay):</td>
<td>Daughter weekly shopping, cleaner weekly, DN dressings twice weekly</td>
</tr>
<tr>
<td>Likely changed support needs identified:</td>
<td>May need social care after rehab 07/05/11</td>
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<tr>
<td>Patient’s expectation re: discharge destination:</td>
<td>Home from acute hospital</td>
</tr>
<tr>
<td>Relatives expectations re: discharge destination:</td>
<td>Transfer to local community hosp</td>
</tr>
<tr>
<td>Initial EDD and review process discussed with (e.g. patient, relative):</td>
<td>Son on admission. 12/05 Daughter, $B $B 07/05</td>
</tr>
<tr>
<td>Discharge planning leaflet given to and discussed with:</td>
<td>Son and patient $B 07/05</td>
</tr>
<tr>
<td>Probable discharge destination discussed with:</td>
<td>Son and patient $B 07/05</td>
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**POTENTIAL COMPLEXITY (risk of delayed transfer of care)**

- Multiple co-morbidities/ complexity: Yes
- Recent admission with long LoS or EDD not met: Yes
- Mental Health Issues: Yes
- Family network/ social support issues: Yes
- Inappropriate admission: Yes
- Poor pre-morbid functioning: Yes
- Changed accommodation requirements: Yes
- Other (note): No LPA, IMCA

- Assessed overall risk of DTOC: Medium

**Low Risk**
**SIMPLE DISCHARGE PLANNING**
If this patient is likely to be discharged without rehabilitation or ongoing care:
- Start discharge checklist overnight and complete on day of discharge
- Agree required authority to discharge prior to EDD

**Medium or High Risk**
**COMPLEX DISCHARGE PLANNING**
If this patient is likely to need rehabilitation or ongoing care after discharge:
- Start chosen pathway on Complex Discharge Tool within 24hrs
- Refer early to relevant teams and external partner agencies
- Ward lead review daily and escalate unresolved obstacles
- Discuss as MDT and document agreed actions
- Agree required authority to discharge prior to EDD

**USE COMMUNICATION SHEET FOR DISCHARGE PLANNING TOOL CONTINUATION**
For example contact details of person or service referred to, such as Physio or OT’s

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5.6 At pre-admission or admission

- 😊 📄 📄 The admitting nurse discusses previous support and possible future needs. If the patient used community health or social care services before admission, the nurse records this on the discharge planning tool and writes contact details on a single assessment process (SAP) demographic or communication sheet filed alongside. The nurse seeks the patient’s permission to discuss discharge plans with carers or others, records verbal consent given, and contacts those involved to engage them in supported discharge. The patient’s GP is sent an electronic notification of the patient’s admission within 24 hours.

- 😊 📄 📄 The nurse gives the patient/carers the Trust discharge planning leaflet, using it to guide discussions about the discharge process and possible pathways. Discussions explore patient/carer expectations, address concerns, and agree achievable goals. The nurse writes the ward, phone number, named nurse and initial estimated date of discharge (EDD) on the back page of the leaflet and ensures this information is also on the the discharge planning tool. The nurse recommends that valuables are given to carers to take home, and records property remaining in hospital to check on discharge.

- 😊 📄 📄 The nurse informs the patient and/or carers about the health information centre, explaining that patient advice and liaison service (PALS) staff are able to offer advice and written information about many services in the community. The nurse will also arrange interpretation or translation through the clinical management team to enable communication about care and arrangements for leaving hospital if the patient and/or carers are not fluent English speakers.

6 COMMUNICATION AND PLANNING THROUGHOUT THE ADMISSION

6.1 All multidisciplinary team (MDT) members

- 😊 📄 Ensure the patient and/or carers are involved with all plans, take time to communicate with them clearly and respectfully, invite carers to MDT meetings and keep the views and needs of carers central to the discharge process.

- 📄 Document discussions, decisions, actions, referrals, assessments, changes to the EDD, referrals etc on the discharge planning tool.

- 📄 Ensure changes to the EDD or discharge destination are recorded on the ward patient status board and eCaMIS patient administration system.

- 📄 📄 Refer patients for required services as soon as the need is identified, which may be before admission.

- 📄 📄 Consider rehabilitation potential or NHS continuing healthcare (CHC) eligibility before referral for social care.

- 📄 📄 Check that all assessments are completed and documented as the EDD approaches, highlighting any issues with the ward sister/charge nurse, medical staff and/or discharge services.

- 😊 📄 📄 Plan for the patient to return to their previous residence, with pre-existing support. At the same time gather assessments to establish if changed care might be required, and who might fund that care. The principle of considering the possible need to change to another pathway should not result in multiple referrals. Inappropriate referrals could delay resources from reaching those who require them and an unclear pathway might delay the patient.

- 📄 😊 Follow the Pan-Dorset managing choice process to minimise the risk of misunderstandings or unrealisable expectations.
7 AS THE DAY OF DISCHARGE APPROACHES

7.1 Prior to discharge

- The named nurse (or their representative) starts the discharge checklist in
  the discharge planning tool as early as possible and addresses any issues.
  Some arrangements are signed off prior to the day of discharge, such as
  arranging for outdoor clothing, food and heating to be available and
  confirming the discharge address. If the patient is returning home, the
  nurse will suggest that a friend or relative stays or visits regularly.
  Discussions might also include how the patient will access food, drinks,
  and basic painkillers, such as Paracetamol or Ibuprofen.

- Arranges discharge for before midday wherever possible and arranges
  transfer to the discharge lounge. Explains to patients and/or carers
  that they may need to rest in the discharge lounge until medication or
  other services are ready, so that they do not become anxious whilst
  waiting.

- Records the response to referrals on the discharge planning tool or
  communication sheets filed alongside. Confirms that receiving
  professionals are aware of the patient's EDD and can provide the
  required care. Completes a transfer of care form or letter if specific
  information is required that is not in the IDS.

7.2 Transport

- All staff encourage patients and/or carers to make their own
  arrangements for transport home, such as paying for a taxi themselves
  but offer to help make arrangements. The named nurse explains that
  if they will not be collected by 11am on the day of discharge, they
  will need to wait in the discharge lounge to support effective
  management of bed capacity. Where medical/social circumstances
  indicate such need, and all alternatives have been explored, transport
  is offered and booked through the discharge lounge, at least 24hrs
  in advance. When arranging transport, the nurse confirms the
  discharge address and postcode, highlighting on the discharge planning
  tool if this differs to the address on the patient's addressograph labels.

- If the patient requires an ambulance, the nurse arranges this at least
  48hrs prior to discharge and clarifies whether a stretcher or
  wheelchair (sitting) is needed. The nurse ensures medication, house
  keys and discharge documentation are ready for when the ambulance
  crew arrive on the ward. Wards will book transport in advance and
  cancel it if the discharge does not go ahead.

7.3 Medication

If medication administration will be complex, staff liaise with the
receiving team prior to discharge. The doctor or pharmacist give the patient
or carers medication counselling, i.e. ensure a clear understanding of
dose, times, routes, possible side-effects, special instructions, where and how
to get further supplies and what to do if there are any problems. Possible
need for help or aids with taking medication is also considered. Instructions
given are documented on the communication sheets filed alongside the
discharge planning tool.

The Trust supplies sufficient medication and/or medical consumables on
discharge to prevent the need to ask the GP for a repeat prescription within 28
days for medication started in hospital or 14 days if taken prior to admission.
The hospital and GP may agree in advance that less will be supplied (e.g.
if the GP intends to review the patient sooner or if medication is boxed in
25-day amounts). If so, this arrangement is recorded on the IDS and/or
discharge planning tool.
8  DAY OF DISCHARGE

8.1 When required, patients are provided with written information to complement discussions about the nature of their illness or condition, advice about self-care, lifestyle etc. If information leaflets are not available on the ward, patients/carers are directed to the on-site health information centre.

8.2 The IDS is given to the patient or those responsible for ongoing care, such as carers or care homes, which includes details of treatment, diagnosis, complications, outstanding medical or social issues, medications and follow-up arrangements.

8.3 The discharge checklist is completed to confirm that: ongoing support, such as medication administration has been agreed; the patient has the required paperwork, dressings, medication, leaflets or equipment; the IDS has been clinically verified and medication provided by a registered pharmacist; the patient, carers or care provider have a copy of the IDS.

8.4 The discharging nurse arranges for the doctor to provide a ‘fit note’ or information for the patient's employer or insurance company if requested. The nurse ensures patients receive any required specific information about their condition, gives them their Single Assessment Process (SAP) paperwork where appropriate and checks that they have all their belongings, including any cash or valuables.

8.5 Files a copy of the IDS, gives a copy to the patient and arranges for a copy to be posted to the GP.

8.6 Patient’s GP and other community staff involved

   • Healthcare professionals involved in ongoing care are notified on discharge or within 24 hours. The GP receives an electronic notification on discharge and printed IDS by post.
   
   • In some cases the consultant dictates a formal discharge summary letter to be sent to the GP within 5-days of discharge. If a patient is discharged to an address other than their usual residence, the patient's GP is informed. If the address is outside the patient's GP practice area, the patient is advised to register with a local GP.

9  DISCHARGE OUT OF HOURS

9.1 It is not usual practice to discharge inpatients after 8pm without agreement from the patient/carers and receiving service providers. Transfers to community hospitals are usually arranged so that the patient arrives prior to 5pm. Special consideration is given to discharge of patients at weekends and bank holidays, such as considering availability of community-based services and transport requirements. The MDT responsible for discharge decisions will take account of service availability and carers needs. Particular care is taken to ensure adequate support is in place.

9.2 Patients who attend the Emergency Department or for clinical assessment only and do not require admission to an inpatient ward will return to their usual place of residence without delay.

9.3 Nurse-led discharge is a framework that allows patients to be discharged by nurses rather than medical clinicians. The parameters for discharge are determined by the patient’s medical team. Discharges must be arranged in advance and staff follow Trust guidelines for nurse led discharge.

9.4 The ward contact the clinical management team for assistance booking transport, take home medication, transfer to community hospitals or any other clinical considerations.
### EXAMPLE OF DISCHARGE CHECKLIST ON PAGE 2 OF PLANNING TOOL

#### PATIENT DETAILS (attach addressograph)
- **Name:** Mr Joseph Blogs
- **Hospital/ NHS number:** 123 123 1234
- **Date of birth:** 01/12/1935
- **Home address:** 1 Any Street, Any Town
- **Home postcode:** AB12 3CD

#### DISCHARGE CHECKLIST

**Start on admission and complete on day of discharge**

**Discharge Date:** 03/06/2011

<table>
<thead>
<tr>
<th>Prior to or on day of discharge</th>
<th>Comments</th>
<th>Sign, date &amp; print name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharge address</strong> confirmed (record here if different from usual address)</td>
<td>The Royal Any Community Hospital (may need temporary residential placement after this)</td>
<td>Jon Wilkinson 30/05/11</td>
</tr>
<tr>
<td><strong>Keys/ key holder available</strong></td>
<td>Daughter has key if access to home needed later</td>
<td>Sarah Baker 07/05/11</td>
</tr>
<tr>
<td>If house empty, who has been asked to check heating etc prior to discharge?</td>
<td>Daughter looking after house</td>
<td>Sarah Baker 07/05/11</td>
</tr>
<tr>
<td>Who has arranged transport (e.g. patient or representative)?</td>
<td>Hospital transport arranged for transfer</td>
<td>Jon Wilkinson 30/05/11</td>
</tr>
<tr>
<td><strong>Outdoor clothes and shoes available</strong></td>
<td>Not yet required for ambulance transfer</td>
<td>Jon Wilkinson 30/05/11</td>
</tr>
<tr>
<td><strong>Mobility aids with patient and equipment in situ if required</strong></td>
<td>Patient has own walking stick, which must be taken on ambulance</td>
<td>Jon Wilkinson 30/05/11</td>
</tr>
<tr>
<td><strong>Community nursing needs discussed and agreed with DN or CPN if required</strong></td>
<td>DN aware of transfer</td>
<td>Jon Wilkinson 30/05/11</td>
</tr>
<tr>
<td><strong>Medication to take out (TTOs) ready and available if required</strong></td>
<td>Weekend transfer agreed, so TTAs required discussed &amp; agreed with receiving ward</td>
<td>M Seacole 01/06/11</td>
</tr>
<tr>
<td><strong>Medical consumables ready and available if required</strong></td>
<td>None required</td>
<td>Dr. Nick Pace 02/06/11</td>
</tr>
<tr>
<td><strong>Suitability of IDS or photocopied drug chart for medication administration checked if required</strong></td>
<td>Drug chart rewritten and signed</td>
<td>Dr. Nick Pace 02/06/11</td>
</tr>
<tr>
<td><strong>TTOs checked if being issued</strong></td>
<td>TTAs all ready</td>
<td>M Seacole 01/06/11</td>
</tr>
<tr>
<td><strong>TTO counselling done if being issued</strong></td>
<td>Ward happy with all administration</td>
<td>Dr. Nick Pace 02/06/11</td>
</tr>
<tr>
<td><strong>Follow-up arranged if required</strong></td>
<td>Not required</td>
<td>JW 03/06/11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>On Day of Discharge</th>
<th>Comments</th>
<th>Sign, date &amp; print name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property returned and checked if required</td>
<td>Daughter currently washing one pair of pyjamas brought in</td>
<td>JW</td>
</tr>
<tr>
<td><strong>Cannula removed if required</strong></td>
<td>N/a</td>
<td>JW</td>
</tr>
<tr>
<td>Advice leaflet given if required</td>
<td>Physio has given copy of exercises</td>
<td>JW</td>
</tr>
<tr>
<td><strong>Next of kin or other informed of confirmed discharge</strong></td>
<td>Daughter aware and will let son know</td>
<td>03/06/11, JW</td>
</tr>
<tr>
<td><strong>Patient sent to Discharge Lounge (if not, give rationale, e.g. collected from ward 10am)</strong></td>
<td>Transport due 10.30am, so not sent as might have confused pt</td>
<td>JW</td>
</tr>
<tr>
<td><strong>Patient given copy of IDS</strong></td>
<td>Daughter has copy</td>
<td>JW</td>
</tr>
<tr>
<td><strong>GP sent copy of IDS</strong></td>
<td>Yes</td>
<td>JW</td>
</tr>
<tr>
<td><strong>Copy of IDS filed in patient notes</strong></td>
<td>Yes</td>
<td>JW</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharging Nurse Name</th>
<th>Signature</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>SN Jonathan Wilkinson</td>
<td>Jonny Wilkinson</td>
<td>Duo Ward 01202 445678</td>
</tr>
</tbody>
</table>
10 DISCHARGE DOCUMENTATION

10.1 Documents required for every patient discharged includes the planning your discharge patient leaflet given as soon after admission as clinically appropriate and a patient copy of the IDS, which provides information about their treatment, medication changes, future care needs, and follow up appointments. Patients with impaired vision might require information in large print format. Information relating to specific clinical conditions may also be provided.

10.2 When patients with reduced mental capacity are discharged information passed to receiving teams might include a mental capacity assessment (form A), best interest balance sheet, best interest decision checklist (form B), a registered lasting power of attorney for health and welfare. It might also include advocacy paperwork and records of meetings with family, carers or advocates and SAP documentation.

10.3 Women leaving hospital after giving birth may also require the maternity case summary, completed and accessed via eCaMIS, and the client-held pregnancy notes given to the woman. Parents or carers of children or young people being discharged may also require patient/parent information documentation where applicable and open access documentation where applicable.

10.4 Patients transferring to district nurses, intermediate or palliative care might also require wound care guidance and prescriber authority to administer medication.

10.5 Patients transferring to community hospitals may also require the transfer of care (TOC) form, the single point of access (SPoA) referral, nursing wound care guidance and prescriber authority to administer medication, the patient’s hospital record. If transferring to an out-of-area hospital, a copy of the current admission documentation is sent with a rewritten, signed medication administration sheet. The medical notes are retained.

10.6 Patients being discharged with NHS continuing healthcare (CHC) might also require the CHC consent and checklist, social services referral, part B (checklist summary), Department of Health CHC patient information, and a CHC care plan.

10.7 Patients discharged with social care might also require social services referrals A, B and C, social care assessment documentation and SAP consent. Patients needing housing support on discharge may require social services referral, part A and the housing referral. Asylum seekers or foreign nationals may require referral to social services and discharge information in a language other than English.

10.8 Patients who self-discharge will also require a self-discharge form and the IDS to be sent to the GP within 48hrs of the patient leaving.

10.9 Patients discharged under the managing choice protocol may also require: Factsheets 1 and 2, and Formal Letters 1, 2 and 3.

11 VULNERABLE PATIENTS OR CARERS

11.1 Safeguarding Adults or adult protection is a process to investigate potential violation of an adult’s human or civil rights. All clinical areas have a printed copy of the pan-Dorset protection of vulnerable adults policy and procedure, which is also available on the intranet. The ward lead ensures their team follow safeguarding procedure, are aware that there is potential for vulnerable adults to be abused, and are aware of their duty to report concerns to the hospital social services team, even if the patient is reluctant for them to do so.

11.2 Staff take seriously any allegation of abuse, are aware of signs that may indicate someone is being or could be abused upon discharge, and escalate concerns to the senior nurse on duty if abuse or neglect is suspected. The Trust adult protection lead is contacted through the switchboard for advice and support. The police are
called if indecent, sexual or serious physical assault is reported.

11.3 📬 📦 📝 Child Safety is considered if a child lives at the discharge destination. Referral is made to social services to ensure appropriate assessment and support if the patient's discharge may place the child at risk, or a person under aged under 18 is likely to be carrying out regular and significant caring tasks that assume a level of responsibility normally associated with an adult. Young carers will not be expected to undertake unreasonable levels of care. Staff refer to Department of Health Assessment of Children in Need and their Families and Trust Child Protection/Safeguarding Children Policy and Procedures.

12 MENTAL HEALTH CONSIDERATIONS

12.1 📬 📦 📝 Patients with reduced mental capacity (e.g. dementia) are still involved in assessment and discharge planning where possible. If the patient is known to the community mental health team and/or has a CPA care coordinator, these professionals are engaged with the discharge process.

12.2 📬 📦 📝 Patients who have been previously detained in hospital under the Mental Health Act (1983 & amendment 2007) may still be entitled to funded aftercare under section 117. A meeting formally designated for considering this is held prior to discharge. Patients currently detained under the Act are not discharged or transferred before guidance has been sought from the appropriate mental health team or the Mental Health Act Administrator. The Responsible Clinician can authorise the removal of the section and sign the appropriate discharge form.

12.3 📬 📦 📝 Staff are sensitive to the fact that acute hospital admission can be frightening and confusing for a patient with mental health problems. Staff will ask about the patient’s routines, likes and dislikes, and follow guidance in the patient’s ‘This is me’ leaflet or Hospital Grab-sheet. The MDT will aim to ensure the patient does not stay on a busy acute hospital ward longer than necessary. Mental health problems do not preclude a patient from being offered intermediate care if there is a goal that could be addressed within the 6-week period. Social services allocate a mental healthcare professional to complete an assessment for patients with mental health problems.

12.4 Mental Capacity & Deprivation of Liberty Safeguards (DOLS)

- 📬 📦 📝 Mental Capacity Act (2005) legal safeguards are followed for adult patients who lack capacity to make decisions relating to discharge. Staff will assume the patient has capacity unless it is established otherwise. If a patient appears to lack capacity staff will take all practical steps to empower them to at least take part in the decision process where possible. Staff will ask carers if the patient usually needs help to make decisions, whether they have made a Lasting Power of Attorney (LPA) for health and welfare or if a Welfare Deputy has been appointed by the Court of Protection. Staff will not assume a patient lacks capacity to make a decision merely because they make an unwise or eccentric decision.

- 📬 📦 📝 If the patient is found to lack capacity to make discharge planning decisions and there is no-one with legal welfare rights, the MDT act in the patient’s best interests, having consulted with the patient’s family or friends and using a best interest checklist. If there are no family or friends to consult about a change of residence that will last more than eight weeks, a referral is sent for an Independent Mental Capacity Advocate (IMCA) to support the best interest decision process.

- 📬 📦 📝 People with reduced mental capacity because of conditions like dementia usually need further long-term help after leaving hospital. However, staff will not assume the patient needs admission to a specialist care home. Staff will consider whether the patient can be supported safely in their own home or in the home of a relative or friend.
Deprivation of liberty safeguards (DOLS) prevent arbitrary decisions being made regarding people who lack capacity that deprive them of their liberty. Staff will refer to the Department of Health Deprivation of Liberty Safeguards: Code of Practice. Before an action is carried out, or a best interest decision made, staff give regard to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

- If restrictions are placed on a patient for their own safety, depending on the degree and intensity of the restriction it does not always result in a legal deprivation of liberty, e.g. a locked ward where a patient is not actively trying to leave. Deprivation might include: using force to prevent a person leaving hospital if they are persistently trying to leave, severely restricting relatives and carers’ access to the patient, denying a carer’s request to have the patient discharged into their care, or severely restricting the patient’s movement within the hospital.

- 🛋️ 🧿 If it is believed a patient is being deprived of their liberty, the ward sister/charge nurse or matron will seek DOLS authorisation from the relevant supervisory body. If this is granted in hospital, it can cover transfer to a care home.

### 13 INFECTION CONTROL CONSIDERATIONS

13.1 The prevention and management of infectious diseases is a high priority. Any infection risk to the patient or others is included in all decision-making. When transferring or discharging a patient known to have an infection/colonisation with an alert organism such as MRSA, staff refer to the Trust infection prevention and control policy for guidance on the care and management of the infection and the precautions to put in place.

13.2 When transferring a patient with a known infection/colonisation to another health setting, a care home or the patient’s own home the patient’s specific infection control issue is made known to health or social care professionals taking over the patient’s care and are included on the IDS or handwritten transfer documentation.

13.3 The Trust endorses the Pan Dorset Infection Control protocol for the management of discharge planning within wards/areas partially of fully closed due to infection control measures.

13.4 If the patient is returning to their previous nursing home, residential home or sheltered accommodation, discharge is delayed until symptoms such as diarrhoea stop but could be arranged whilst a course of medication is ongoing. However, where isolation for infection control reasons is required, transfer to community hospital may be delayed until a suitable room is available.

13.5 🛋️ 🧿 The Trust will provide suitable and sufficient information on the patient's infection status when arranging transfer so that any infection risks to the patient and others can be minimised.

### 14 MANAGING CHOICE ON HOSPITAL DISCHARGE

14.1 NHS and social services departments across Dorset have agreed a procedure for Managing Choice on Hospital Discharge. A patient will usually be offered a choice of available suitable care options but if their needs can be met equally well through different options the commissioner can legitimately decline to fund more expensive options. Also there are often financial limits to how much care can be provided in a patient’s own home, so commissioners may only offer funding for residential care.

14.2 😞 If a patient or carer persistently refuses options offered, social services may inform them that it has fulfilled its duty and the patient or carers will need to make their own arrangements. However, the patient/carers can ask for an alternative option if the home offered would not meet the patient’s physical or psychological needs.
14.3 A patient does not have the right to occupy an acute hospital bed once they no longer need acute care and must move to a more appropriate location when ready, possibly to a temporary care home whilst they wait for a home of their choice.

14.4 😊 A patient or carer may feel that a move to a temporary care home, followed by a move to a permanent placement is undesirable. The MDT will discuss concerns with family and explain that a prolonged stay on a busy acute hospital ward exposes the patient to the risk of depression, low mood, boredom, hospital acquired infection, reduced mobility, reduced sense of autonomy and loss of independence.

15 SIMPLE DISCHARGE

15.1 When a patient has minimal ongoing need for health or social care, the discharge process is said to be simple, as it does not need complex planning or delivery. This might include when the patient's level of independence is relatively unchanged, and neither they nor their carers need significantly changed support in the community, so the patient can return to their usual place of residence. Simple discharge planning includes reviews and checks for possible changed needs. Simple discharges might include discharge of adults, newly delivered mothers and their babies (obstetric), children and babies (paediatric). At least 80% of patients discharged from the Trust are likely to need only simple discharge processes, so improving these has the potential to impact significantly on patient/carer experience and the effective use of bed capacity.

15.2 Simple discharge of patients who have recently given birth

- 😊 Staff will refer to Trust obstetric guidelines and policies. The majority of maternity discharges are routine and only need involve the patient, family and attending Midwife responsible for the woman’s care. Where a multidisciplinary case conference is necessary this is organised and chaired by the attending Midwife responsible for the women's care or a Midwifery Senior/Matron. The open-Access system (return within 48hrs) may be used to expedite discharge. Staff will refer to the Trust Guidelines for the Transfer of Women and Babies within Maternity Services.

15.3 Simple discharge of babies or children

- 📧 The community children’s nurse is informed as soon as a child/young person's discharge planning becomes complex and plays a vital role in planning. Assessment forms and/or CHC applications are started early for children with complex medical needs. The paediatric board holder/coordinator is responsible for early identification of children/young people with a potential problem that might delay discharge. They expedite children/young people’s discharge through MDT communication with internal and external agencies, attend the paediatric doctor’s morning handover where possible, and assist in organising the safe, timely transfer from hospital to community. Complex paediatric discharge may involve several primary and secondary services. Effective and timely communication between the hospital and the community is essential.

16 COMPLEX DISCHARGE

16.1 The discharge process is said to be complex when a patient will need support from one or more services after discharge. Discharge planning may require complex coordination of services to enable safe discharge. The delayed transfer of care escalation process (see page 25) is followed, as well as the appropriate pathway to address the patient’s specific needs.

16.2 The complex discharge planning process includes assessment of the patient's home environment, referral to the hospital social services team for assessment of the patient
and support network, a written care plan that records health and social care needs, referral for ongoing NHS services to monitor and, if necessary, adjust the care plan, and confirmation that services will be in place on discharge.

16.3 Patients who need rehabilitation or intermediate care

- If it appears the patient may not be able to return to their own home, the potential for improving independence and self-care ability is considered before seeking residential care. Patients are referred to intermediate care to support timely hospital discharge, reduce falls risk, support medication management and identify preventable causes of recurrent hospital admissions. This integrated, multi-agency service is offered for up to 6 weeks in any suitable non-hospital setting. Patients must have identified rehabilitation goals and cognitive ability to work towards these. Referrals are entered on the discharge planning tool.

- Poole Intermediate Care Service (PICS) have a team based within the Trust who case-find inpatients with a Poole address. They focus primarily on preventing inappropriate admissions, which includes supporting early discharge from the Rapid Assessment and Consultant Evaluation (RACE).

- Patients with dementia may be transferred to temporary residential care for a longer period of intermediate care than 6 weeks but are only transferred from acute care to long-term residential care in exceptional circumstances, such as following specialist stroke rehabilitation, after unsuccessful attempts at supporting the patient at home, or if temporary residential care followed by a move is expected to be distressing.

- If the patient does not meet the criteria for intermediate care but has rehabilitation goals, inpatient rehabilitation at a community hospital may be considered. There are some similarities between rehabilitation and intermediate care. Both aim to promote recovery and maximise the patient's independence after an acute episode. Rehabilitation may be provided in hospital or the patient's own home, and includes physiotherapy, occupational therapy and speech therapy. Intermediate care does not start until the patient leaves hospital, is only offered on a short-term basis and may involve help from social services.

- 😊 🌐 📩 The single point of access (SPoA) manage referrals to intermediate care services in Dorset, Bournemouth and Poole, including community hospitals, long term condition support, district nursing, community matrons and the generalist palliative care team. To refer via the SPoA, the therapist confirms rehabilitation goals and discuses with the MDT. The therapist telephones or emails the SPoA to refer for intermediate care on: 0 3000 33 4000 or Swast.Referral@bp-pct.nhs.uk. Referral information is filed beside the discharge planning tool. Whilst community hospitals require a transfer of care (TOC) form, referrals are faxed via the discharge services office because the SPoA do not accept faxes. The therapist leads completion of the TOC and faxes to discharge services, who enter on the delay database, email referral to SPoA and fax the TOC on to the community hospital. Verbal referrals are recorded on the discharge planning tool and TOC forms filed alongside as a record of information given.

- 🌐 📩 The SPoA triage and pass to the most appropriate team, e.g. care closer to home, a community hospital, community nursing team etc. SPoA confirm referral to discharge services, who inform the ward that the intermediate care team or community hospital will contact them to agree suitability within 48hrs.

- 🌐 ☎️ Community staff may need further clinical handover, such as wound care advice or authority to administer medication. The referrer informs the SPoA whether this will be faxed direct to the professional concerned or sent home with the patient. Community hospital staff contact the referring ward for clinical handover within 48hrs of referral to confirm that the patient meets the admission criteria.
16.4 Patients who may be eligible for NHS continuing healthcare (CHC)

- NHS continuing healthcare (CHC) is a package of health and social care services arranged and funded in full by the NHS for people whose overriding need on discharge is for healthcare. CHC can be delivered in any setting and can include the full cost of a place in a nursing home. The process followed for this specialist assessment is laid out in the revised National Framework for NHS Continuing Healthcare & NHS-funded Nursing Care (DH 2009).

- If the patient has a rapidly deteriorating, terminal condition, they may require an immediate support package to enable urgent discharge. If current NHS provision, such as community nurses or the palliative care team are unable to support discharge, a health professional leads completion of the Fast Track Tool.

- The process is explained to the patient and/or carers, and written consent is sought on the CHC consent form. Patients and/or carers are given every opportunity to participate in the process and are directed to the health information centre for a copy of the Department of Health’s CHC patient leaflet or other information. If the patient is unable to give written consent, a health professional can sign to confirm verbal consent has been given. If the patient lacks capacity to consent and there is no-one with registered lasting power of attorney for health and welfare a best interest decision (BID) is completed (see page 14).

- As soon as the patient is medically stable, before considering social care input, a registered nurse assesses whether the patient may be eligible for CHC, usually by completing a CHC checklist. Social services referral (part A) may be sent to request SW input with the checklist. If the checklist indicates a decision support tool (DST) should be completed, the complete checklist, social services referral B and consent/BID are faxed to the discharge services office. Discharge services check, record and forward to the CHC team. CHC advise the ward if a DST will be completed before or after discharge.

- Ward staff copy supporting records in advance of the CHC assessor’s visit if possible to speed the process or help the CHC assessor to identify and copy them. Staff arrange for any additional assessments required to be undertaken. CHC review the checklist with patient/ carer, ward and social services, and inform all parties of the decision.

- If the patient is not eligible for CHC but will be discharged to a care home with nursing (nursing home), a registered nurse will complete a funded nursing care (FNC) determination. FNC is money paid by the NHS direct to a care home to fund registered nursing input. An FNC determination confirms that the patient needs nursing care or overview.

16.5 Patients requiring social services funded care

- Many patients do not require changed support on discharge and can return to their previous residence. If this appears to be the case, the admitting nurse confirms with any existing care provider on admission what conditions must be met on discharge. Any criteria are recorded on the discharge planning tool. If the care provider wishes to reassess before discharge they are advised that this should be within 48hrs of the request from the ward. Rehabilitation or intermediate care is always considered to maximise self-care ability.
• Care commissioned by social services might include help with washing, dressing, respite care or care home fees. Social services also arrange aids, such as grab rails, raised toilet seats, lever taps and ‘Telecare’ equipment (e.g. pendant alarms, falls detectors and bed occupancy sensors).

• 😷 🚃 🛍️ If the patient is likely to have social needs on discharge, written consent to refer to social services is sought on referral part A, which is faxed to the discharge services team. The patient, carer, OT and a social care professional are involved in plans. If the patient is unable to give written consent, a health professional can sign to confirm verbal consent has been given. If the patient is unable to consent, a best interest decision may be made (see page 14).

• The Community Care (delayed discharges etc) Act 2003 places a duty on the Trust to notify the local authority if a patient needs assessment and to give advance notice of the proposed discharge date. The Act also places a duty on the local authority to complete an assessment and provide services within a defined time scale. The Trust can ask for reimbursement for each day a patient is delayed in hospital awaiting social care services only. Trust and social care staff have a duty to work in partnership and complete shared assessments, in order to help patients receive the right care in the most appropriate setting. Staff will help each other complete required assessments prior to arranging discharge, working collaboratively and with mutual respect.

• 😷 🚃 😷 If CHC eligibility is ruled out, a section 2 (referral part B) is issued to inform social services that the patient is likely to need community care services. This can be issued up to 8 days prior to admission. The referral is faxed to the discharge services office and the original retained in the patient’s record. Discharge services issue the referral to the appropriate local authority, who have 3 days (not including Sundays or bank holidays) to complete their assessment and decide on the provision they will make. The OT arranges a home visit if needs have changed and required care changes are agreed by all. Social services will commission either temporary placement or care in the patient’s previous residence.

• 😷 🚃 Ward staff fax the section 5 (referral part C) to the discharge services team to notify social services of the date that a clinical and MDT decision has been made that the patient will no longer need acute care, and will be safe to discharge, giving as much notice as possible and at least 24-hours. Wards may need to issue a section 2 and section 5 together if the patient is ready for discharge by the time CHC is ruled out.

• 😷 🚃 Discharge services record the notification and issue to social services before 2pm. The proposed discharge date must be at least 3 days after the section 2 was issued, to allow time for the patient to be assessed. The section 5 becomes reimbursable if services are not in place to enable discharge by 11am on the proposed discharge date. If a section 5 is issued after 2pm, the delay is not reimbursable until at least 2 days after issue. If there will be a delay awaiting social care, equipment and/or home adaptations, the patient may need a temporary care package in alternative accommodation until the adaptations are complete.

• 😷 🚃 If there is a change in the patient’s circumstances affecting readiness for discharge, the Trust issues a de-notification to social services that ‘stops the reimbursement clock’. When a decision is made that the patient is again ready for discharge, a new section 5 is issued, again giving at least 24-hrs notice to allow time to set up required care. A new section 2 is sent if the patient remains unfit for a long period, their ability has changed significantly and they need reassessment.

16.6 Patients ‘self-funding’ their care

• Some patients self-fund their social care. The term ‘self-funder’ means a patient
who has financial means above the social services threshold for funding, so they have to pay for any social care they require. It is also used when a patient would be eligible for care funded by social services but they or their family choose to pay for a different option instead. Sometimes a patient will 'top-up' the funding from social services, or family members will contribute to fund a more expensive option. These patients are not self-funders but may say that they pay for their care when asked. Patients are given the opportunity to have a financial assessment to see if they are eligible for social services funded care.

- When a patient’s self-funding status is confirmed, the social care professional document this on the discharge planning tool. The local authority will continue with a community care assessment if the patient or their carers request this. A Hospital Discharge Support Service (HDSS) for self-funders is currently being piloted until at least April 2012. The providers of this service at this Trust are ‘Help and Care’

16.7 Patients who need palliative care

- Palliative care is a holistic package of services offered when a patient has been diagnosed with a progressive illness that cannot be cured. Services are provided as and when needed, to keep the patient comfortable and ensure the best quality of life at all stages of their illness. This might include help to control and manage pain and other physical symptoms or to provide emotional support to the patient and carers. Support may be provided in the patient's home, in a hospice or hospital. Palliative care is provided by the NHS free of charge. Services are intended to keep the patient comfortable and ensure that they have the best quality of life possible.

- If someone does not have long to live, consideration is given to whether it is appropriate to be discharged from acute care. If so, options considered include transfer to a hospice, a community hospital palliative bed or discharge home with support from the palliative care team or funded by CHC. Availability of options is investigated to avoid offering something that is not available and causing distress. Advice or guidance regarding patients with cancer is sought from the Generalist Palliative Care Team at Forest Holme. The patient’s CHC department is contacted for patients who require rapid discharge for palliative care.

16.8 Patients who wish to self-discharge

- If a patient expresses the wish to discharge themselves from hospital against medical advice the nurse in charge of the ward determines through an immediate review of risk, including discussion with the responsible medical clinician, whether the patient is safe to discharge themselves. The nurse will contact the most senior nurse and doctor on duty for support.

- The only grounds to prevent a patient discharging themselves are if they do not have capacity to understand the risks associated with discharge or it is felt that their mental condition might constitute a danger to themselves or others. In this case the MDT seeks advice from a psychiatrist. Ward staff may detain the patient under Common Law if a psychiatric assessment is required. If the patient attempts to leave hospital before the psychiatric assessment, assistance from within the hospital and the police may be requested urgently.

- If the patient appears to lack mental capacity, a mental capacity assessment and best interest decision is undertaken. If there are concerns about the patient’s safety due to other mental health needs the nurse invokes Section 5(4) of the Mental Health Act (1983 & amendment 2007), contacting the clinical coordinator and psychiatrist immediately, or the psychiatrist invokes Section 5(2) triggering full assessment under the Act.

- If the patient understands the risks and still chooses to discharge themselves...
from hospital, they have the right to make this decision. The most senior nurse and doctor available will make an assessment of the patient’s health, explain why it is in their interest to remain in hospital. If the patient chooses not to take the advice, the nurse and/or doctor will record the reason the patient wishes to self-discharge and any mental capacity assessment in the patient’s record.

- The patient is asked to sign a self-discharge form, witnessed, signed and dated by a nurse or doctor, which is filed in the patient’s record. If the patient is unwilling to sign the form, a record is documented in the patient’s record in the presence of a witness. Any medication required at that point will be offered. If the patient refuses to wait for this medication then all reasonable steps will be taken to ensure they receive the medication after discharge. The nurse or doctor will contact the patient’s GP immediately to summarise the treatment the patient has received to date and highlight any clinical or social concerns. They will also contact social services and carers if appropriate. An AIRS (Adverse Incident Record Sheet) is completed after the event and all actions and discussions recorded, dated, timed and signed in the patient’s record.

16.9 Patients who are homeless or have no fixed abode

- When the nurse completes the preadmission assessment, they consider the patient’s accommodation needs and document this in the patient’s record. The nurse asks what the patient’s usual address is, whether this is the address from which they were admitted, and to which addresses they will be discharged. If the patient indicates that they are unable to return to the address from which they were admitted, declares that they are of ‘no fixed abode’ or is living in private rented accommodation and indicates that they may be evicted whilst in hospital, they may need referral to housing.

- The nurse will ask where their last address was and if they are able to return there. If not, the nurse will ask if there is an alternative address they could go to, e.g. a family member or friend. This possibility is explored as soon after admission as possible, to try to resolve the problem and avoid delay. If no discharge address is available, social service referral, part A is sent to request support. A housing referral is completed (available via the intranet) and faxed to the discharge services team, who establish the local authority and issue referrals.

- Referrals are made at least 48 hours in advance of discharge where possible. On the day of discharge it is essential that the person attends for interview at the housing office as soon as it opens. If the ward are unsure whether or not to refer, they can, with the patient’s permission contact the social services team or housing department for advice.

Housing referral criteria

<table>
<thead>
<tr>
<th>Does the patient have accommodation to return to?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
</tr>
<tr>
<td>Is the patient local?</td>
</tr>
<tr>
<td>NO 😞 частности Refer to social services to ask for support and advice</td>
</tr>
<tr>
<td>YES 😞 частности Refer to housing as soon as possible</td>
</tr>
<tr>
<td>YES BUT 😞 частности Other housing concerns discussed with housing dept.</td>
</tr>
</tbody>
</table>

| YES                                               |
| Is the accommodation suitable for safe discharge? (e.g. warm/safe/accessible) |
| NO 😞 частности Refer to social services for advice |
| YES 😞 частности There is no need for housing involvement |

Please check Policies, Procedures and Guidelines on intranet to ensure printed copy is current version

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The allocated housing officer will liaise with the patient and ward staff. If it appears that homelessness is unavoidable, the housing officer will make a decision about whether or not temporary accommodation should be provided in line with the Housing Act 1996 Part VII and provide advice as necessary. They may arrange for a placement in a hostel for the person to be discharged to. This process is not expected to delay discharge. The ward or social care professional inform housing when discharge is imminent.

16.10 Patients who are asylum seekers or foreign nationals

Asylum Seekers may have very complex social situations and each patient’s discharge would be dealt with according to individual need and circumstance. Information and advice may be sought from the hospital social services team, social services out-of-hours staff, or the Community Relations Officer based at the Police Station. The council responsible for providing community care services for a patient who is an asylum seeker or foreign national is also liable to pay reimbursement for any hospital delay.

17 Roles and Responsibilities

17.1 All professional working in the hospital will:

- Record actions, referrals, discussions, assessments etc in the patient’s record.
- Encourage patients and carers to engage in the discharge process as equal partners, treating them with kindness, dignity and respect, and taking account of their needs, wishes and rights, including the patient’s right to positive risk taking.
- Work towards the patient’s discharge using a ‘whole systems’ approach to the assessment, commissioning and delivery of services.
- Work collaboratively with multidisciplinary colleagues to provide information, medication, equipment or specialist input, being aware of how each person’s role supports the patient, and how all parts work as a whole, to meet their needs.
- Ensure that discharge is timely, as soon as the patient no longer requires acute inpatient investigation, treatment or therapy, and that the patient is medically fit and safe to be transferred to another setting.
- Ensure all discharge documentation is complete and filed in the patient’s record in chronological order. Confirm that the professionals referred to are aware of the patient’s EDD and can provide the required care.

17.2 The pre-assessment or admitting nurse will:

- Start discharge planning, including assessment of risk prior to elective admission or within 24 hours of unplanned admission if possible.
- Identify what services are currently provided, note contact details, and make initial contact to engage them in plans for supported discharge.

17.3 The ward nurse will:

- Ensure effective verbal and written hand-over of assessments and care plans, negotiate timely and appropriate decisions, coordinate discharge plans, and act as a point of contact for effective communication between MDT members.
- Communicate with the patient and/or carers, including discussing the initial and reviewed estimated discharge date (EDD), provide advice and support when needed, agree transport arrangements before discharge, and ensure carers are informed of their right to an assessment of their own needs.
- Screen the patient for potential risks that may result in discharge delay, follow the
appropriate complex discharge pathway if risks are apparent and refer to other professions/agencies as soon as it becomes clear they might need support.

- Work towards the EDD, doing everything possible to arrange a safe and effective discharge by ensuring all discharge requirements are complete, and that the patient, carers or independent advocates are involved with all decisions.

- Escalate complex issues to the ward lead and delegates to other ward staff.

17.4 The ward lead (sister/ charge nurse/ midwife) will:

- Ensure their teams are aware of this procedure and that discharge planning practice complies with it. Decide the process for identifying a named nurse to coordinate discharge plans and inform ward staff of this.

- Ensure operational systems are in place to support timely and safe discharge of medically fit patients, and that their team work towards the EDD set by the medical team and record changes in both the patient's electronic and paper record.

- Organise and coordinate multi-disciplinary meetings, escalate discharge concerns to the specialty matron for support to ensure patient safety.

17.5 The specialty matron/ lead nurse will:

- Hold ultimate responsibility for ensuring operational systems are in place to support timely and safe discharge of medically fit patients and that discharge is implemented in a standard way right across the Trust.

- Support the ward lead to resolve issues at a local level and share learning across the Trust by presenting case studies to the Nursing and Midwifery Executive Group chaired by the Director of Nursing.

- Delegate to the ward lead, escalate operational matters to the specialty director and escalate clinical matters to the Director of Nursing.

17.6 The director of nursing will:

- Ensure appropriate discharge clinical processes are in place to support safe discharge. Escalate clinical concerns to the Chief Executive and delegate clinical responsibility to the Discharge Services Matron.

17.7 The discharge services matron/ lead nurse will:

- Develop and review discharge processes, ensuring these comply with local and national guidance and remain responsive to the changing needs of the Trust. This will include maintaining and updating systems and tools to meet the needs of users, such as the discharge planning tool, discharge planning leaflet or education.

- Provide day-to-day operational leadership and management of discharge services and represent the Trust at multi-agency discharge related meetings.

- Seek the views of patients, carers and partner organisations and promote collaborative working with these organisations, including social services, housing, independent mental capacity advocacy (IMCA), other hospitals, community health services, specialist nurses, care homes and voluntary organisations.

- Receive information on adverse incidents or near misses relating to patient discharge and arrange for these to be acted on by the appropriate clinical lead.

- Escalate unresolved operational issues to the Operations Manager, and clinical issues to the Director of Nursing, such as matters relating to patient care, patient safety and other quality issues. Delegate as appropriate to discharge services administrative and clinical staff.
**NURSING RESPONSIBILITIES AND ESCALATION**

**Named nurse leads discharge planning throughout escalation process**
- Ensure discharge planning tool is completed and plans are progressed from admission.
- Give patient/representative discharge planning leaflet, discuss discharge process, clearly define EDD and identify named nurse. Ask for SAP folder if patient has one at home.
- Contact GP surgery on admission to liaise with those involved, e.g. DN, CMHT, CLDT.
- Involve all MDT members in discharge plans and document input.
- Identify potential for DToC using first page of discharge planning tool and follow appropriate pathway to manage any discharge dependencies proactively.
- Agree actions at discharge planning meetings – progressing, reviewing and updating actions between meetings.
- Liaise with allocated social care professional, CHC nurse or others throughout process.
- Access support from ward lead as soon as complexity is identified.
- Inform discharge services team of potential DToC, who track through process.

**Ward lead supports named nurse with potential DToC**
- Ensure named nurse continues to follow and document actions above.
- Ensure required DOLS/IMCA/safeguarding referrals arranged in a timely manner.
- Contact, agree actions and continue to liaise as required with patient’s consultant, GP, social services/CHC manager/community hospital ward lead or others as appropriate.
- Arrange MDT meetings with patient, representatives and others as appropriate. Document specific actions agreed. Send letters without delay afterwards to confirm discussion and agreements reached, as per Trust choice process.
- Access support from specialty matron as soon as challenging situations or ongoing barriers to discharge (potential or actual DToC) identified.
- Consult discharge support nurse for guidance as required.

**Specialty matron supports ward lead with complex discharge/ DToC**
- Ensure all actions above continue to be followed and documented.
- Continue Managing Choice process if required, and send appropriate letters.
- Contact, agree actions and continue to liaise as required with social service/CHC senior manager, community hospital matron or others as appropriate.
- Attend or ensure representation at discharge meetings.
- Access support from Divisional Director as soon as ongoing barriers to discharge are identified, if legal advice is required or if length of stay (LOS) is 30+ days.
- Consult discharge services matron for guidance as required.

**Divisional Director supports specialty matron with ongoing difficulties**
- Ensure responsible staff members as above continue to follow and document agreements and actions.
- Contact, agree actions and continue to liaise as required with senior manager or director at relevant partner organisation.
- Identify clear actions and hold individuals to account.
- Implement Trust policies, e.g. possession order/eviction proceedings if required.
- Consult Trust legal advisor as necessary.
- Ensure Trust policies are reviewed to negate future occurrences.
PEOPLE AND SERVICES WHO MAY SUPPORT THE DISCHARGE PROCESS

Hospital Team
- Medical staff
- Nursing staff
- Directorate managers

Intermediate Care Services

Primary Health
- General practitioner (GP)
- Practice nurse
- Community/district nurse
- Community matron

Community Mental Health
- Community psychiatric nurse (CPN)

Specialist Nurses
- e.g. Macmillan COPD
- Continence service
- Tissue viability

Specialist discharge staff
- Orthopaedic team
- Stroke team
- Discharge services
- Ward link nurses & facilitators

Therapy services
- Hospital occupational therapists (OTs)
- Physiotherapists
- Speech & language therapy (SALT)
- Dieticians
- Psychologists
- Chiropractors

Voluntary Organisations
- e.g. Carer support
- Advocacy
- Advice

Palliative Services
- Forest Holm
- General palliative care team

Social Services
- Hospital and community social work teams
- Community OTs
- Interim and Intermediate care
- Commission care

Housing Department
- Housing & homelessness

Social Care Agencies
- Independent care agencies

Transport
- Discharge lounge
- Ambulance
- Hospital transport services

Continuing Healthcare (CHC)
- Needs based assessment based on evidence from medical, nursing and allied professions, as well as social care

Pharmacy
- Medicines management

Patient
- Carers
- Family

Family
17.8 The discharge services team will:

- Assist the MDT to plan patient discharge, advising on complex discharge issues during office hours. Offer training and guidance regarding the discharge planning process, under the direction of the discharge services matron. Support the discharge planning process through liaison with internal and external MDT members, and encouraging collaborative working.

- Facilitate the referral process to external agencies, monitor and where possible help prevent delayed discharges. Liaise with community healthcare professionals and teams to ensure referrals are received and acted on. Support staff in the transfer of patients and with complex process such as assessment for NHS continuing healthcare (CHC).

- Assist the discharge services matron to review and develop discharge-related policies, procedures and tools, to ensure they continue to meet the requirements of the Trust and its patients. Escalate concerns to the discharge services matron.

17.9 The ward clerk:

- Updates the live bed state (LBS) management system with the admission date, expected ready date, revised ready dates, expected discharge destination, delay reason if the patient is not discharged on the ready date, and due out date when all services required are arranged.

- Updates LBS within 30 minutes of discharge, files a copy of the IDS in the patient’s hospital record and posts a copy to the surgery. Files all tests, letters, and investigations in the appropriate section of patient's health records in date order. Keeps discharged patients’ health records on the ward until clinical coding has taken place, and then takes them to the Consultant's personal assistant, updating the computerised case note tracking system.

17.10 The clinical management team:

- Present a summary of activity at daily patient flow meetings to ensure that obligations are recognised and any specific difficulties are addressed. Take action to safeguard emergency beds and ensure the Trust meets contractual obligations. Authorise escalation when appropriate (see Trust escalation policy). Manage out-of-hours issues relating to patient discharge, coordination of medication to take away and completion of electronic inpatient discharge summaries (IDS). Escalate to the on-call duty manager and delegate to clinical staff.

17.11 Medical staff:

- Consider alternatives to hospital admission where appropriate and write to the patient’s GP to direct care for patients attending the Emergency Department.

- Assess the likely outcome of the admission, length of stay and support likely to be needed, working collaboratively towards safe and timely discharge. Predict a possible date of discharge on admission, discussing details and support required after discharge with patients/ carers at the earliest opportunity.

- The consultant delegates medical discharge issues as appropriate, holding regular MDT discussions to share progress reports and facilitate effective discharge planning. Records MDT decisions in the patient's records, such as when the patient has become medically ready for discharge, consulting colleagues as required.

- Complete the discharge plan on the inpatient discharge summary (IDS) and request medications as required, ensuring the IDS medications page is fully completed, including whether the medication has been prescribed since admission and duration of course or instruction to GPs to continue prescribing.
Prescribe sufficient quantities of medication and/or medical consumables in to prevent the need for a repeat prescription within 28 days if new and 14 days if used prior to admission. If the patient has access to sufficient previously dispensed prescriptions or simple analgesia at home, the hospital does not supply more.

Write discharge prescriptions for medicines to take away (TTA) as soon as the decision to discharge has been made, ideally at least 24hrs before discharge to enable TTAs to be dispensed by pharmacy during opening times.

Contact the patient's GP by telephone on the day of discharge where there is concern about a condition, safety or compliance. Dictate a discharge letter, and ensure it is typed within 5 days of discharge, then the patient's record transferred to the records library and the computerised case note tracking system updated.

17.12 Therapy services:

- Prioritise referrals for patients whose discharge is dependent on therapy support. Refer discharge dependent equipment, adaptations or house cleaning in a timely manner and record on the discharge planning tool.

- Assess and treat in relation to potential, considering patient safety and reducing risk after discharge. Agree joint goals for rehabilitation and discharge when appropriate and share information accordingly. Keep abreast of changes within community teams, liaising with community colleagues where indicated.

- Regularly review the rehabilitation list to ensure the chosen destination for patients remains appropriate. Physiotherapy acute intervention will give an early indication of discharge issues, ensuring timely referral to occupational therapy.

- Share responsibility with the MDT for reviewing the EDD daily, identifying the appropriate discharge destination, and referring to colleagues in the community.

<table>
<thead>
<tr>
<th>Physiotherapy</th>
<th>Occupational Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Functional (and/or cognitive)</td>
</tr>
<tr>
<td>Mobility (including walking aids)</td>
<td>Daily living activities</td>
</tr>
<tr>
<td>Falls (including balance assessments)</td>
<td>Community (environmental/discharge)</td>
</tr>
<tr>
<td>Seating</td>
<td>Specialist Equipment needs (including moving and handling plans)</td>
</tr>
<tr>
<td>Specialist equipment needs</td>
<td></td>
</tr>
</tbody>
</table>

The dietician:

- Arranges for a 7-day supply of required supplements or enteral feed to be supplied on discharge, taken from the ward’s usual stock.

- Arranges ongoing oral supplements via the GP on prescription or enteral feed via the Nutricia Homeward home delivery service and follows up where necessary, via the outpatient department or Community Dietician.

The speech and language therapist (SALT):

- Accepts referrals for swallow disorders, aspiration risk or acquired communication disorders, initiating assessment within 2 working days of referral for dysphagia and within 5 working days for dysphasia.

- Facilitates intervention and recommends referral to other agencies as appropriate. SALT liaises with carers to reduce disability and limit handicap, and assist in the
development of care plans.

- Identify when it is safe for a patient to commence oral feeding in close liaison with the dietician. Inform the patient/carers of any necessary strategies, modifications or exercises to promote improvement in either swallowing or communication ability and provide any written literature if appropriate.

17.13 The hospital pharmacy:

- Offer medication counselling, oversee correct prescribing and issuing of medication and may transcribe medication to take away (TTA).

- Monitored dose systems (MDS) are tablets in day and time sections to aide patient concordance with the medication regime. The ideal time to assess for MDS is in the patient's own home but if a compliance assessment form is required, these are available from Pharmacy. MDS are provided on discharge if a patient is admitted with one but are time consuming to dispense, and the normal pharmacy requirement is for 24-hours' notice TTA.

- When the prescriber's e-signature automatically releases the IDS for completion by pharmacy, they will visit the ward to facilitate discharge.

- Routine TTAs written on the IDS for patients being discharged the same day will be dispensed until 6.30pm on weekdays and 3.30pm on weekends. An IDS written after these times would usually be dispensed the following morning. At the discretion of the clinical management team, late prescriptions may be dispensed the same day under the supervision of a prescriber. Bank Holiday services vary and are published at the time.

- Use the electronic patient record (EPR) to track IDS progress and respond to bleeps for required changes. Manage and prioritise discharge summaries, electronically estimating the time discharge medication will be ready.

- When a planned discharge has been delayed 5 days, unlock the electronic discharge prescription and delete all endorsements, ensuring prescribers review and resend the prescription once the patient is confirmed for discharge.

17.14 The operations manager

- Will resolve operational issues relating to the discharge of patients, as escalated by the Discharge Services Matron. Reports bi-annually to the Hospital Executive Group on matters relating to patient discharge. Ensures that any identified risks associated with transfer are included in that report, for consideration of entry onto the Trust Risk Register.

- Escalates operational concerns to the Chief Operating Officer and delegates appropriate operational responsibilities to the Discharge Services Matron.

17.15 The chief operating officer

- Is the executive lead for discharge services.

- Escalates operational concerns to the Chief Executive and delegates management responsibility to the Operations Manager.

17.16 The chief executive

- Is accountable for the strategic and operational management of the Trust, including ensuring safe processes are in place for the discharge of patients.

- Delegates management responsibility to the Chief Operating Officer and clinical responsibility to the Director of Nursing.
18 DOCUMENT DEVELOPMENT

18.1 This document has been developed in conjunction with hospital staff, local health and social care partners and patient user groups such as Poole LINk and patient advisory service (PALS). It supersedes the previous Poole hospital discharge procedure published April 2009.

18.2 All policies and procedures referenced are available on the hospital Intranet. When reviewing online, hyperlinks can be followed to access supporting information.

19 ASSOCIATED AND REFERENCED DOCUMENTS

- DH (1983) Mental Health Act
- DH (1990) NHS and Community Care Act
- DH (1995) Carers (Recognition & Services) Act
- DH (1998) Better Services for Vulnerable People
- DH (2000) Carers and Disabled Children’s Act
- DH (2001) Valuing People
- DH (2003) Discharge from Hospital: Getting it right for people with dementia
- DH (2003) Ensuring the Effective Discharge of Older Patients from NHS Hospital
- DH (2005) Mental Capacity Act and Code of Practice
- DH (2007) Mental Health Act Amendments
- DH (2009) The Delayed Discharges (Continuing Care) Directions
- DH (2009) NHS Continuing Healthcare (Responsibilities) Directions
- DH (2009) Vulnerable Adults
- DH (2010) Ready to go? Planning the discharge and transfer of patients from hospital and intermediate care.
20 APPROVAL PROCESS

20.1 This procedure will be presented to the Hospital Executive Group for approval. Approval will be recorded within the notes of the meeting.

21 DISSEMINATION

21.1 The procedure will be uploaded to the hospital intranet. All related policies, guidance, tools and forms are uploaded to these pages as a resource. Discharge services will inform relevant staff of the procedure, guidelines and any changes or updates that may be made. Changes will be presented at Nursing and Midwifery Expert Group (NMEG) meetings.

22 TRAINING

22.1 The Trust will develop training and support for Trust employees and social care staff working in the hospital on discharge planning. Governmental discharge strategies and possible effects they may have at ward/department level. Training will support those involved with the discharge process to understand their roles and responsibilities. Staff will be educated in relevant aspects of achieving a safe and timely patient discharge, and encouraged to disseminate knowledge to junior staff on wards. Communication with colleagues is encouraged to promote best practice, as well as active participation and debate when analysing the discharge pathway. Staff will be informed of current local health or social care initiatives relating to discharge and encouraged to contribute to future discharge initiatives.

22.2 Staff may receive discharge training as part of their induction and development days. Training and information is also available through the discharge intranet pages. In addition, the Discharge Services Matron will develop discharge planning training and awareness sessions, and a range of learning materials to include on-line discharge training as part of work to reduce delay and improve patient flow.

22.3 Formal accredited continuing health care training is available through local NHS continuing healthcare departments to support completion of CHC paperwork. Speciality matrons are responsible for allowing staff time to access training provided.
23 REVIEW AND REVISION ARRANGEMENTS INCLUDING VERSION CONTROL

23.1 This policy is reviewed at least every three years or sooner if local or national changes indicate this would be appropriate. Compliance with standards in this procedure is reviewed annually by Discharge Services in conjunction with specialty matrons.

24 MONITORING COMPLIANCE AND EFFECTIVENESS

24.1 A formalised process for monitoring delayed discharge is collected and sent each Tuesday in a situation report (SitRep) to the Department of Health and on the PCT DTOC report. This information is used to highlight areas of discharge needing focus to address increased delays.

24.2 Annual review of the Trust discharge procedure ensures it continues to meet the operational needs of the Trust and its patients, and develop an annual policy review report (APRR). Implement an action plan with defined timescales to address required changes to the discharge process, as highlighted by the APRR and/or trends identified through adverse incidents and near misses.

24.3 Good record-keeping is essential in supporting safe and effective transfer of care. The discharge services team monitor and review recorded discharge planning through twice-yearly audit of patient records. These audits help demonstrate whether or not the process for managing risk on discharge is working across the Trust, identify aspects of the discharge process that are working well and highlight issues before an incident occurs. Audit reports measure compliance with quality standards, such as use of the discharge planning tool and communication sheets.

24.4 Patient surveys of discharged patients are also undertaken, in collaboration with user groups, such as the patient advice and liaison service (PALS) or the Poole local involvement network (LINk/ Healthwatch).

24.5 Discharge standards audited or surveyed 6-monthly.

<table>
<thead>
<tr>
<th>Discharge Quality Standard</th>
<th>Target compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mar 12</td>
</tr>
<tr>
<td>1. Discharge planning started at preadmission, within 24-hrs of unplanned admissions or a clinical rationale recorded if not appropriate to do so. Example of evidence: discharge planning tool 1st page started and dated.</td>
<td>75%</td>
</tr>
<tr>
<td>2. Patient’s GP notified within 24hrs of admission and discharge. Example of evidence: electronic notification</td>
<td>100%</td>
</tr>
<tr>
<td>3. Patient and/or carers involved with discharge planning and informed of the estimated date of discharge within 24hrs of admission. Example of evidence: discharge planning tool signed to confirm.</td>
<td>75%</td>
</tr>
<tr>
<td>4. Named nurse identified who coordinates or delegates discharge plans and communication with all relevant members of the multidisciplinary team. Example of evidence: name entered on discharge planning tool.</td>
<td>60%</td>
</tr>
<tr>
<td>5. Carers’ views and needs considered and, if appropriate, assessed within the discharge process, and carers involved in MDT meetings. Example of evidence: involvement recorded on discharge planning tool.</td>
<td>75%</td>
</tr>
<tr>
<td>6. Patients with social care or housing needs referred to hospital social services teams in a timely way from admission where these needs were clear. Example of evidence: Referral ‘part A’ filed &amp; recorded on discharge planning tool.</td>
<td>75%</td>
</tr>
</tbody>
</table>
Discharge Quality Standard | Target compliance
--- | ---
7. Patients and carers, or care homes responsible for ongoing care arrangements given written summary of the hospital care and forward plan of care (IDS) on discharge. Carers offered an assessment of their own needs. Example of evidence: discharge planning tool. | 80% | 90% | 100%
8. Discharge checklist completed. Example of evidence: discharge planning tool checklist. | 80% | 90% | 100%
9. Where medical/social circumstances indicate such need, and all alternatives had been explored, appropriate transport offered and booked in line with Trust Policy. Example of evidence: discharge planning tool checklist. | 100% | 100% | 100%
10. Patient, carer and/or care agency, receive medication advice and support before discharge. Patient discharged with sufficient medication and/or other medical consumables to prevent need for repeat request in less than 28 days of discharge if started in hospital or within 14 days if medication already taken on admission. Example of evidence: IDS and discharge planning tool checklist. | 100% | 100% | 100%
11. Equipment, adaptations and house cleaning required to enable a successful discharge identified and referred in a timely manner prior to discharge. Example of evidence: discharge planning tool. | 75% | 90% | 100%
12. Patients/carers treated with kindness, dignity and respect, including taking account of needs related to diversity and their right to positive risk taking. Example of evidence: communication sheets, patient survey. | 80% | 90% | 100%
13. MDT consider the need for advocacy if patient does not have capacity and no carer is available during the discharge process. Example of evidence: discharge planning tool. | 75% | 90% | 100%
14. If patient in receipt of community health or social care services prior to admission, hospital staff inform community team of the admission and engage them in supported discharge. Example of evidence: discharge planning tool. | 75% | 90% | 100%
15. Patient and/or carers given a copy of discharge planning leaflet. Example of evidence: discharge planning tool. | 75% | 90% | 100%

24.6 Audit and survey results are used to evaluate practice against agreed clinical criteria. Where monitoring identifies deficiencies, recommendations and action plans are developed, and changes implemented to reduce risks.

24.7 Compliance is managed through monthly contract review meetings, the Joint Commissioning Older Peoples Steering Group and the quarterly Joint Commissioning Executive Committee. Audits and surveys are submitted as part of the annual health record documentation review process and presented to the Clinical Audit and Effectiveness Committee. An annual policy review report (APRR) is presented to the Nursing, Midwifery Expert Group (NMEG) and the Hospital Executive Group (HEG).

24.8 Discharge-related issues highlighted in patient surveys, complaints, AIRS or through the patient advice liaison service (PALS) are investigated, using a root cause analysis process when required.

- Staff seek to resolve problems at an early stage. If this is not possible, the social care/housing team leader or manager and discharge matron consider for resolution within 2 working days.
• If the matter remained unresolved, it would be referred to a senior local authority manager and the Trust operations manager for resolution within 5 days. Further resolution would be undertaken by the Head of Adult Social Care or Housing & Community Services and the Trust Director of Operations. Formal disputes would be managed in line with the contractual dispute process.

• Adverse Incident Reporting System (AIRS) reports are monitored by Risk Management, the Safety Committee and the discharge services matron.

24.9 Process for monitoring risks associated with discharge and transfer of patients:

<table>
<thead>
<tr>
<th>What is monitored</th>
<th>How is it monitored</th>
<th>Frequency</th>
<th>Who is responsible</th>
<th>Where reported to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duties, roles and responsibilities</td>
<td>Discharge procedure review</td>
<td>At least every 3 years</td>
<td>Discharge Matron</td>
<td>HEG</td>
</tr>
<tr>
<td>Definition of patient groups</td>
<td>Discharge procedure review</td>
<td>At least every 3 years</td>
<td>Discharge Matron</td>
<td>HEG</td>
</tr>
<tr>
<td>Discharge requirements specific to each patient group</td>
<td>Discharge procedure review</td>
<td>At least every 3 years</td>
<td>Discharge Matron</td>
<td>HEG</td>
</tr>
<tr>
<td>Process for discharge out of hours</td>
<td>Discharge procedure review</td>
<td>At least every 3 years</td>
<td>Discharge Matron</td>
<td>HEG</td>
</tr>
<tr>
<td>Discharge documentation to accompany patients</td>
<td>Discharge planning audit</td>
<td>Twice yearly</td>
<td>Discharge Matron</td>
<td>HEG, NMEG</td>
</tr>
<tr>
<td>Information given to patients</td>
<td>Discharge planning audit</td>
<td>Twice yearly</td>
<td>Discharge Matron</td>
<td>HEG, NMEG</td>
</tr>
<tr>
<td>Process for monitoring compliance with the above</td>
<td>Discharge planning audit</td>
<td>Twice yearly</td>
<td>Discharge Matron</td>
<td>HEG, NMEG</td>
</tr>
</tbody>
</table>
## APPENDIX ONE – EQUALITY IMPACT ASSESSMENT

To be completed by following the Trust Equality Impact Assessment Guidance

<table>
<thead>
<tr>
<th>Date of assessment</th>
<th>28 October 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Group or Directorate:</td>
<td>Operations</td>
</tr>
<tr>
<td>Author:</td>
<td>Mandy Leigh</td>
</tr>
<tr>
<td>Position:</td>
<td>Matron – Discharge Services</td>
</tr>
<tr>
<td>Assessment area</td>
<td>Procedure</td>
</tr>
<tr>
<td>Purpose</td>
<td>To set out principles for safe, effective and timely discharge from Poole Hospital NHS Foundation Trust</td>
</tr>
</tbody>
</table>
| Objectives | To ensure:  
  • Discharge is a process that starts before or soon after admission.  
  • Patients and carers are actively involved in all plans and decisions about their future care.  
  • All staff work collaboratively and understand how their own role contributes to the process, what their responsibilities are, and what they are accountable for.  
  • Assessment for and delivery of services emphasises the continuum of these and follows a ‘whole system’ approach, so that local acute or community health provision and social care resources are used appropriately |
| Intended outcomes | Safe, effective and timely discharge that enables patients to achieve their optimal outcome |

### What is the overall impact on those affected?

<table>
<thead>
<tr>
<th>Ethnic Groups</th>
<th>Gender groups</th>
<th>Religious Groups</th>
<th>Disabled Persons</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

### Available information:

This procedure promotes equality for minority groups because it encourages the assessment of all patients and planning to meet their individual needs. Commissioners face some resource constraints, such as limited specialist care home provision but access to Trust services and assessments is the same for all groups, and this policy does not discriminate according to sexual orientation, culture, gender, religion, belief or disability.

### Assessment of overall impact:

This procedure does not discriminate against any individual or group on the basis of race, ethnicity, Nationality, gender, culture, religion, sexuality age or disability.

### Consultation:

Consultation undertaken with Trust multidisciplinary staff, partner agency health and social care professional, and patient representatives via PALS.

### Actions:

N/A