Wrightington, Wigan and Leigh NHS Foundation Trust

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AUTHOR(S) (JOB TITLE)	**HEAD OF NURSING - MEDICINE**
DIVISION/DIRECTORATE:	**MEDICINE**
LINKS TO OTHER STRATEGIES, POLICIES, SOP'S, ETC.	**TW10-043 SOP 1 Discharge Procedure**
CONSULTED WITH	**DQEC Members**

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The WWL Way

AT ALL TIMES, STAFF MUST TREAT PATIENTS WITH RESPECT AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY.

1. POLICY STATEMENT

1.1 Wrightington, Wigan and Leigh NHS Foundation Trust acknowledge that appropriate and timely discharge planning is fundamental to the provision of effective health care.

1.2 The Trust endeavours to ensure that all patients have a safe and effective discharge, taking into account the patient's own individual needs and views, along with those of their carers.

1.3 It is anticipated that over the coming years that the established inter-agency working and collaboration will continue, and build on the foundation that discharge planning is a process and not a single event.

2. KEY PRINCIPLES

2.1 This Discharge Policy and Standard Operating Procedure (SOP) are intended to give a local guide for good discharge planning for the discharge of patients from Wrightington, Wigan & Leigh NHS Foundation Trust, taking into account national policies and guidelines, amalgamated with local practice, and to ensure that patients are discharged from hospital in a planned and timely manner to a safe and clinically appropriate environment. Nursing discharge documentation will assist in this. (Appendix 3).

2.2 To ensure that patients (and, with their permission) relatives and carers are informed and involved in the planning of their care and subsequent discharge.

2.3 Where a patient lacks capacity under the MCA to take part in discussions or make decisions regarding their discharge, there is a duty to consult with the patient's family and those close to the patient, and/or patient advocate including an IMCA (Independent Mental capacity Advocate).

2.4 Where a patient who lacks capacity has no one close to them with whom health professionals can consult, and decisions are being made about discharge arrangements, a referral should be made to the local Independent Mental Capacity Advocacy service for an IMCA to be appointed for the patient. In such cases, the role of the IMCA is to check that the best interests principle has been followed and to ensure that the person's wishes and feelings have been appropriately considered and to seek a second opinion if necessary. This referral should be made by the decision maker, who, in the instance of discharge, will be the social worker.

2.5 To support the provision of a planned transfer of care ensuring that health and social care services are in place when the patient is discharged. Ensure that the contact assessment form is completed and sent to our social partners. (Appendix 5).

2.6 To support the provision of a continuity of care through effective communication between hospital and community professionals.

2.7 To support the provision of timely information/medication/equipment to enable independence for the patient and carer.

2.8 To reduce admissions to residential and nursing homes across the Borough of Wigan, Leigh and Ashton.

2.9 This policy and SOP applies to patients being discharged only. For patients transferred to other locations please refer to the patient transfer policy.

2.10 To ensure that the Greater Manchester Hospital Discharge (Prevention of Homelessness) protocol is available on Wrightington, Wigan and Leigh NHS Intranet and is adhered to on admission for those persons classed as No Fixed Abode.

2.11 To reduce delays in discharge and support optimal bed management, and safe patient flow.

2.12 To ensure timely access for elective and emergency admissions.

2.13 To ensure that discharge planning takes into consideration patients who have special needs, sight, hearing impairment, whose first language is not English, or who have learning difficulties are involved in the discharge plan and understand the agreed plan, before agreeing to it.

2.14 To ensure where appropriate that patients are screened for NHS continuing healthcare or fast tracked as appropriate. In the event that residential/nursing home placements are required, consider if the person requires assessment for Funded Nursing Care. (FNC)

2.15 If concerns are raised by health/social care professionals or patients relating to a discharge or transfer to other healthcare organisations, the Integrated Discharge Team Leads need to be made aware and will assess and escalate to senior management in the event discharge is problematic.

2.16 To ensure that for patients who wish to leave hospital against medical advice, every effort should be made to appeal to the patient and carer to stay if the patient is vulnerable clinically or socially. Regardless of the decision by the patient to self-discharge, a copy of the HIS discharge letter will be sent to the patients GP and all medication should still be offered to the patient. The patient's next of kin will be notified to advise that the patient has taken self-discharge against medical advice.

3 CRITERIA FOR DISCHARGING PATIENTS AFTER 20:00 HOURS

3.1 Patient consents and wishes to go home late at night.

3.2 Appropriate transportation available with agreement and consent of patients/carer/nursing home facility.

3.3 During inclement weather, confirmation of adequate heating in home and patient has adequate clothing, food supplies, packed sandwiches and sundries will be provided by the ward.

3.4 Confirmation that next of kin/carers will ensure the patients safety on discharge, including the provision of food and beverages.

3.5 Confirmation with relevant nursing/residential care facility that a named person will accept patient back to the care facility home after 20:00 hours. Patients must be offered a pre transfer beverage and meal/snack and all relevant medication will be administered prior to discharge.

3.6 Patient is adequately clothed to maintain privacy and dignity.

3.7 All the above will be documented in the patients nursing notes and will be counter signed by the nurse in charge of the shift.

3.8 Statement in the nursing documentation confirming that the patient has agreed to be discharged after 20:00 hours and that the care facility has also agreed. See Appendix

3.9 Frail Elderly patients, Patients with Dementia or Learning disability who lack capacity (Mental Capacity Act policy) will not be discharged after 20:00 hours.
The exceptions to this will be:

3.9.1 End of life rapid discharge.
3.9.2 Carer/relative agrees and consents to the discharge after 20:00 hours whether the discharge is home or residential/nursing home.
3.9.3 The residential/nursing home agrees to discharge after 20:00 hours.

3.10 If the decision is taken to discharge this vulnerable group of patients after 20:00 hours, this must be clearly documented in the patient's notes, discharge document and in the "Discharge after 20:00 hours" document. (Appendix 4)

4. RESPONSIBILITIES

4.1 Whilst it is recognised that the discharge process is a multi-disciplinary team process, it is also necessary to acknowledge that within any multi-disciplinary working there will be certain responsibilities assigned to particular staff members and/or staff groups.

4.2 Below are the key responsibilities covered within this policy to support implementation of the discharge procedure and any Specific roles and responsibilities relating to the various stages and types of discharge process are set out in greater detail within that procedure.

4.3 **Trust Board**
The Trust Board will:

4.3.1 Receive reports, as appropriate, in relation to patient discharge letter, and compliance with the Discharge Letter processes.
4.3.2 Receive and make recommendations for further action in respect of issues relating to the discharge process which are raised or presented to the Board by the Director of Nursing and/or Medical Director.
4.3.3 Ensure principles in this policy are disseminated throughout the organisation via the usual channels.

4.4 **Chief Executive responsibilities**
Ensuring that this policy and SOP is implemented within all areas of the Trust through responsible Executive Directors, Divisional Chairs and Divisional Director of Operations and Performance.

4.5 **Director of Nursing responsibilities**
The Director of Nursing is responsible, through their leadership, for the safety and quality function for:

4.5.1 Supporting the Chief Executive and Trust Board in their responsibilities.
4.5.2 Providing assurance that the discharge process is monitored, managed and reviewed in line with national guidance.
4.5.3 Supporting the Divisional Chairs, Divisional Director of Operations and Performance and Head of Nursing in implementing this policy across the Trust.
4.5.4 Support implementation and embed safe working practices in relation to Discharge Letters and the use of the process
4.5.5 Together with the Medical Director, deliver assurance in relation to the safe operation and use of the Discharge Letter processes.

4.6 **Medical Director responsibilities**

4.6.1 Supporting the Chief executive and Trust Board in their responsibilities.
4.6.2 Supporting the Divisional Chairs and Divisional Director of Operations and Performance in implementing this policy.
4.6.3 Deliver assurance that clinicians are completing Discharge Letters for the patients, where appropriate, in a timely manner.
4.6.4 Support divisional teams in implementing the principles of this policy.
4.6.5 Together with the Director of Nursing, delivering assurance in relation to the safe operation and use of the Discharge Letter processes.

4.7 **Divisional Director of Operations and Performance and Head of Nursing responsibilities**

4.7.1 Ensure that the principles outlined within this policy and SOP are effectively implemented and embedded within their respective divisions.
4.7.2 That they notify the Director of Nursing and/or Medical Director of any issue or problem, which does, or may impact, on the implementation and effectiveness of the discharge process.

4.8 **Matrons Responsibilities**

4.8.1 Ensuring that the principles outlined within this policy and SOP are implemented within their own areas of responsibility.
4.8.2 Ensuring that the principles of effective discharge processes are maintained at ward level.
4.8.3 Ensuring staff have access to training and competency of staff for nurse-led discharge.
4.8.4 Ensure ward teams are safely and effectively using the Discharge Letter processes within HIS.

4.9 **Ward Managers/ Nurse in Charge Responsibilities**

4.9.1 Ensure discharge planning whiteboards are updated twice daily.
4.9.2 Escalate complex discharge up to the Complex Discharge Team as appropriate.
4.9.3 Co-ordinating a smooth discharge process.
4.9.4 Maintenance of up to date, accurate discharge documentation and documentation of ongoing discharge planning and arrangements, required to meet the patient's needs.
4.9.5 Ensuring the involvement of, and communication between, all multi-disciplinary team members, agencies and the patient and/or carer(s).
4.9.6 Ongoing review of Expected Date of Discharge. (EDD)
4.9.7 Ensuring patients are screened for NHS continuing healthcare.
4.9.8 Achieving and maintaining the skills and competencies to facilitate and lead on patient discharge.
4.9.9 Ensuring adequate staff within the clinical area are trained to use CSC/HIS to facilitate real time discharge.
4.9.10 Ensure safe and effective use of the nursing aspects of the Discharge Letter process within their wards/departments.
4.9.11 Maintain HIS lists of previously discharged patients to provide assurance that all relevant patients' Discharge Letters have been sent to their GP.
4.9.12 Regularly review the above lists and resolve any issues with patients without a 'Letter Sent' status, together with MDT.
4.9.13 Escalate to medical colleagues those patients without a completed Discharge Letters.

4.9.14 Resolve, together with ward team those patients requiring nursing interventions to the Discharge Letter process.
4.9.15 Escalate any technical/IT issues with the Discharge Letter process to ensure issues are resolved in a timely manner.

4.10 **Nursing/Midwifery staff responsibilities**

4.10.1 Complete a section 2 notification if applicable on admission. (Appendix 6)
4.10.2 Ensure that the contact assessment form is completed and sent to our social care partners. (Appendix 5)
4.10.3 Complete a Section 5 (appendix 7) when all assessments are complete and delay is attributable to social services.
4.10.4 Assess patients discharge needs within 24 hours of admission.
4.10.5 Complete referrals to other agencies as required.
4.10.6 Identify Adult at risk. (refer to MCA/DoLS Policy)
4.10.7 Identify, document and communicate the patients discharge needs to the ward manager.
4.10.8 Maintenance of up to date accurate discharge documentation and documentation of ongoing discharge planning and arrangements required to meet the patients need.
4.10.9 Ensure the involvement of and communication between all multi-disciplinary team members, agencies and the patient and /or carer(s)
4.10.10 Ensure that immediately a potential discharge problem is identified, that this is communicated so that referral to the appropriate member of the Multi-disciplinary team can be made at the earliest opportunity
4.10.11 To ensure real time discharge of the patients by updating CSC/HIS at the point of discharge.
4.10.12 Ensure patients are transferred to the Discharge Lounge in a timely manner adhering to the transfer policy.
4.10.13 Ensure the discharge checklist is completed on discharge and a copy retained in the medical notes.
4.10.14 Ensure a copy of the HIS discharge letter is sent to the GP within 24 hours of discharge (Appendix 8)
4.10.15 To ensure patients discharge to nursing/residential/intermediate care and community beds have a discharge check list completed.
4.10.16 To ensure continuity of infection control precautions are required to be carried out in relation to nursing and rest homes.
4.10.17 Work together with MDT to identify patients for discharge to ensure timely creation of the Discharge Letter.
4.10.18 Ensure adequate communication with patient/carer in relation to medication issues on discharge.
4.10.19 Complete the ‘Pharmacy Discharge Checklist’ document on HIS accurately and liaise with pharmacy to ensure timely processing of Discharge Letters and medication dispensing
4.10.20 Use HIS functionality to monitor progress of Discharge Letter prescription in pharmacy and ensure timely collection of medication when complete, to ensure timely discharge and improved patient experience.
4.10.21 Ensure medication and Discharge Letter are checked on ward, and that patient is counselled on relevant changes or follow-up required.
4.10.22 Ensure letters are sent using the HIS system once completed, and patient is being discharged.
4.10.23 Exercising particular care where letters are being processed after patient discharge to ensure these are correctly sent to the GP.
4.10.24 Use the ‘Bypass Pharmacy’ HIS order appropriately to ensure patients who do not need any medication have their letter processed correctly, and sent to their GP.

4.11 **Consultant responsibilities**

4.11.1 Agree a medical plan on admission and write this in the case notes.
4.11.2 Review patients on a regular basis See Senior Review Policy.
4.11.3 Ensure all investigations are completed, reviewed and documented as part of the patients medical plan based on an Expected Date of Discharge.
4.11.4 Review the Expected Date of Discharge daily.
4.11.5 Decide when the patient is medically fit for discharge and ensure that this is communicated to the medical team, the ward manager and the nurse in charge of co-ordinating the patient discharge process.

4.12 **Medical Staff responsibilities**

4.12.1 Patients are reviewed daily and that all investigations are completed, reviewed and documented as part of the patient's medical plan based on an Expected Date of Discharge.
4.12.2 Ensure the HIS discharge letter to GP is completed 24 hours before discharge where appropriate.
4.12.3 NOTE Senior medical staff are also able to make a decision about whether the patient is medically fit for discharge.

4.13 **Pharmacy Senior Management**

14.13.1 Ensure principles of this policy are effectively implemented and embedded within their department.
14.13..2 Escalate any technical/IT issues with the Discharge Letter process to ensure issues are resolved in a timely manner.

4.14 **Pharmacy Staff**

4.14.1 Ensure Discharge Letters presented to pharmacy are processed in a timely manner
4.14.2 Work, on the wards, together with other MDT members, to identify patients for discharge, and to assist in resolving medication related issues prior to discharge
4.14.3 Process, and enter, the relevant 'Pharmacy process' orders within HIS to enable the patient list column in HIS to update correctly, and keep the wards informed regarding processing of the Discharge Letter prescription.

4.15 **Complex Discharge Team Lead**

4.15.1 Managing discharge arrangements for simple and complex discharges.
4.15.2 Escalating discharge planning issues to their line manager as soon as delays are anticipated.
4.15.3 Co-ordinating and leading the multi-disciplinary team when required for complex discharges.
4.15.4 Working in partnership with all key professionals in the delivery of care for patients throughout their journey within the hospital setting, and transfer points to and from primary, intermediate and social care.
4.15.5 Promote active discharge of non-complex patients as determined by the medical plan.
4.15.6 Provide support and training for ward staff on all aspects of discharge planning.
4.15.7 Attend daily whiteboard meetings with other members of the multi-disciplinary team when capacity does not meet demand.
4.15.8 Attend grand rounds with other members of the multi-disciplinary team when capacity does not meet demand.
4.15.9 Attend telephone conferences when the Trust is in escalation.
4.15.10 Ensure fast Track NHS continuing Healthcare assessments are completed in a timely manner.

4.15.11 Ensure that Home of Choice letters are issued in a timely manner for those patients assessed as requiring residential or nursing care homes where applicable

4.15.12 Manage and co-ordinate the discharge of vulnerable adults.

4.16 **Discharge co-ordinators responsibility**

4.16.1 Co-ordinate all timely referrals.

4.16.2 Work closely with the ward managers to ensure timely meetings are scheduled for multi-disciplinary meetings, Continuing Healthcare Screening and meetings, Capacity and Best interest meetings.

4.16.3 Escalate any problems to the Complex Discharge Team Leads.

4.16.4 Attend daily whiteboard meetings.

4.16.5 Ensure patients and families are involved in their discharge plan.

4.16.6 Co-ordinating multi-disciplinary teams for all patients who are positively screened into the NHS Continuing Healthcare process and collating all assessments and documentation for consideration by the Continuing Healthcare team.

4.16.7 Identify patients who are suitable for Community step downs beds if applicable.

4.17 **Multi-Disciplinary Team Members**

4.17.1 The Trust, Bridgewater Foundation Trust and Social Services Department are committed to the continuation of a fully multi-disciplinary team model to manage the hospital discharge process.

4.17.2 In addition to the consultant and supporting medical team who are responsible for the identification, planning and delivery of the patient's medical plan, there are a number of Trust and non-Trust staff that offer or provide the link to accessing services and other care which is vital to safe and effective discharge – collectively these are the multi-disciplinary team.

4.17.3 Staff involved in planning for discharge are required to familiarise themselves of the services and care available for patients through the multi-disciplinary team as set out below:

4.17.4 Note staff should access the discharge referrals guide for more information about what services are available and how to make a referral.

4.17.5 **Nominated Key Worker**: A nominated key worker/named nurse will be designated for each patient in the hospital setting. The key worker will attend multi-disciplinary team meetings and maintain lines of communication with the patient in respect for their discharge. In addition a nominated associated nurse will undertake these tasks in their absence.

4.17.6 **District Nurses Services**: A wide range of nursing services are provided within the home environment and within the treatment room sessions held at health centres and clinics across the Borough. There are district nursing teams based within the local clinics and health centres. However, between the hours 17:00-07:45, the district nursing team is based at Clare House. Referrals into the District nursing service should be made to the local district nursing team or via the district nurse liaison service. Refer to the hospital district nurse liaison service between the hours 08:00 and 16:30 hours, Monday to Friday.

4.17.7 **Social Worker**: Early liaison with Social Services is essential for successful and timely discharge planning. The role of the Social Worker includes offering advice and support, counselling the patient and significant carers, advocating on their behalf and planning for the patient's safe discharge from hospital. The social worker as an employee of the Local Authority, has a statutory responsibility to ensure patients receive appropriate community care services following an assessment of their needs and decision on eligibility for services. Both hospital and community based social workers work in partnership with multi-disciplinary teams to plan for discharge, enabling a patient to return to independence in their own home with supporting services if needed, or to alternative care in a

residential or nursing home of their choice. Acts as lead professional with those clients identified as safeguarding.

4.17.8 **Triage Officer**: The Triage Officer Triage-Support Officers are allocated cases for screening and monitoring purposes. In any instance where a person is deemed to require a full Social Care Assessment, the Triage Officers submit the case for re-allocation to a Social Worker. It has been part of the Triage-Support Officer role to liaise with the complex Discharge Team and to collect from Discharge Co-ordinators information concerning any cases of Delayed Transfers of Care. The officers then report this to Social Workers managing those cases.

4.17.9 **Occupational Therapist**: The Occupational Therapy Service will be accessed in order to assist patients to achieve and maintain the highest level of personal functioning in all activities of daily living, and to minimise the need for re-admission to secondary care by ensuring initial discharge is safe and appropriate. On discharge, the Occupational Therapy staff will arrange longer-term intervention from the most appropriate Health and Social Services Team.

4.17.10 **Physiotherapist**: The Physiotherapy Service will be accessed in order to provide early assessment and subsequent treatment and maintenance programmes that maintain the highest level of functional activity and independence. On discharge follow up will be arranged, if appropriate within the most appropriate setting.

4.17.11 **Pharmacist:** Ward Pharmacists will assist the multi-disciplinary team at all times throughout the patient journey. Any patients who may have medication related problems on discharge should be referred to their ward pharmacist at the earliest opportunity. In addition to the ward pharmacist, pharmacists are available in the dispensary and may be contacted to advise on any acute problems with discharge prescriptions, including their need to be written in a way which satisfies legal and local requirements.

4.17.12 **Speech and Language Therapist:** The speech and language therapy service will be accessed in order to provide early assessment and subsequent therapy or ongoing monitoring of communication and/or feeding difficulties which may have arisen as a result of surgery or acute medical episodes, or as part of a progressing condition. On discharge, follow up will be arranged, if appropriate, within the most appropriate format.

4.17.13 **Podiatrist:** The Podiatry service will be accessed in order to ensure that podiatry problems are not compromising the safety and/or independence of patients in preparation for discharge and following discharge. Following treatment, patients are either discharged or referred to the appropriate service. Every effort will be made to see all patients referred.

4.17.14 **Access to Community Service Team (ACST):** The Access to Community care team is an admission avoidance team who will provide early assessment and discharge in the Emergency Care Centre and assessment areas. On discharge follow up will be arranged as appropriate.

4.17.15 **Community Matrons:** The Community Matrons will support early discharge for those patients on their existing caseloads. On discharge, follow up will be arranged if appropriate, within the most appropriate format. New patients identified as requiring assessment will be referred on discharge.

5 PATIENTS WHO TAKE THEIR OWN DISCHARGE/LEAVE/REFUSE ADMISSION

5.1 Staff should refer to TW14-036 Self Discharge against Medical Advice and complete the documentation in accordance with this policy.

5.2 A discharge summary letter (HIS) letter must be completed and sent to the patient's GP and if possible, the patient's copy should be given to the patient.

5.3 If not discussed before the patient's leaves, the patient/family should be contacted to discuss and provide action about medication. Pharmacy should be advised accordingly

6 DISCHARGE LOUNGE

The Discharge Lounge is an area within the acute hospital where patients are transferred to when medically and clinically discharged awaiting final arrangements to be made i.e. transport and medication to take home. This allows wards to free up beds for acutely ill patients.

7 HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this policy and they have, where appropriate, been fully reflected in its wording.

8 INCLUSION AND DIVERSITY

The Policy has been assessed against the Equality Impact Assessment form from the Trust's Equality Impact Assessment Guidelines and, as far as we are aware, there is no impact on any personal characteristics.

9 MONITORING AND REVIEW:

9.1 This Policy and SOP will be subject to bi-annual review to ensure that they continue to meet changing patient and service needs, and will be subject to approval by the Divisional Quality Executive Committee.

9.2 The three main clinical divisions: Medicine, Surgery and Specialist Services undertake annual audits around the discharge process which are presented and discussed at Divisional audit meetings, then put into report format for circulation with the meeting minutes. Actions are taken as appropriate within the Division. An annual clinical audit report is also presented to the Divisional Quality Executive Committees.

10 ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats e.g. large print, Braille and audio cd.

For more details, please contact the HR Department on 01942 77 (3766) or email equalityanddiversity@wwl.nhs.uk

APPENDIX 1

Definitions

Acute Care
Acute medical care is defined as “intensive medical treatment provided by or under the supervision of a consultant which is for a limited time after which the patient no longer benefits from that treatment”.

Abuse
Abuse is a violation of an individual's human and civil rights. It may consist of a single act or repeated acts. It can be physical, verbal or psychological; it may be an act or omission to act,

Types of Abuse

- **Physical:** including hitting, shaking, biting, grabbing, withholding food or drink, force-feeding, wrongly administering medicine, unnecessary restraint, failing to provide physical care and aids to living
- **Sexual:** including sexual assault, rape, inappropriate touching/molesting, pressurising someone into sexual acts they don't understand or feel powerless to refuse
- **Emotional or psychological:** including verbal abuse, shouting, swearing, threatening abandonment or harm, isolating, taking away privacy or other rights, bullying/intimidation, blaming, controlling or humiliation
- **Financial or material:** including withholding money or possessions, theft of money or property, fraud, intentionally mismanaging finances, borrowing money and not repaying
- **Neglect:** including withholding food, drink, heating and clothing, failing to provide access to health, social and educational services, ignoring physical care needs, exposing a person to unacceptable risk, or failing to ensure adequate supervision
- **Discriminatory abuse:** including slurs, harassment and maltreatment due to a person's race, gender, disability, age, faith, culture or sexual orientation

Consent
This is a patient’s agreement for a health professional to provide care. Patients may indicate consent non-verbally, orally or in writing. For the consent to be valid, the patient must:

- Be competent to make the particular decision
- Have sufficient information to make the decision
- Not be acting under duress

Complex discharge
A complex discharge is:

- On admission it is identified that there have been significant changes in the care needs of a patient either on admission or as an inpatient.
- Unable to return to their normal place of residence
- Requires increased input from health and social care provider due to change in physical health
- Difficulty in finding an alternate place for discharge
- Those patients identified as safeguarding on admission

Discharge
Discharge is the process leading to the patient being discharged from the care of the hospital.

Deprivation of liberty safeguard

- Provision under the Mental Capacity Act 2005 is to protect those individuals who for their own safety and in best interest needs to be accommodated to undergo treatment or care. This may deprive an individual of their liberties whilst they lack the capacity to contents (Refer to the MCA/DOLs Policy)

Estimated Date of Discharge

Estimated date of discharge is identified early as part of patient's assessments and with 24 hours of admission (or in pre-admission for elective patients). It is based on the anticipated time needed for tests and interventions to be carried out and for the patients to be clinically stable and fit for discharge.

Intermediate care

Intermediate care services are those which meet **all** the following criteria:

a. Are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long-term residential care, or continuing NHS in-patient care.
b. Are provided on the basis of a comprehensive assessment resulting in a structured individual care plan that involved active therapy, treatment or opportunity for recovery.
c. Have a planned outcome of maximising independence and typically enabling patient/users to resume living a home.
d. Is time limited, normally no longer than 6 weeks and frequently as little as 1-2 weeks or less and involve cross professional working with a single assessment framework, single professional records and shared protocols.
e. Social care provided within Intermediate Care Services as in this definition are not chargeable.
f. Intermediate Care Services should not include any transitional or 'holding' service e.g. awaiting appropriate housing. Further work is required on pathways and services for people who are not able to return home but no longer fit the definition of Intermediate Care

Ready for discharge or transfer

The Department of Health states that a patient is ready for discharge or transfer from an acute hospital bed when:

a. a clinical decision has been made that a patient is ready for transfer and
b. a multi-disciplinary team decision has been made that the patient is ready for transfer and
c. the patient is safe to discharge/transfer

NHS Continuing Health Care:

Is a package of Continuing care that is arranged and solely funded by the NHS whose primary need is Health. If someone is eligible then the NHS pays for all costs incurred for their care. If a patient is found to be eligible it may affect state benefits and allowances previously used to fund care.

Simple Discharge

A simple discharge is one that:

- Involve minimal disturbance to the patients activities of daily living
- Able to return to return to their normal place of residence
- Will not require a significant change in support to the patient or carer
- Have simple ongoing needs that do not require complex discharge planning and delivery

Vulnerable Adult

A person aged 18 or over who is or may be in need of community care services by reason of mental or other disability, age or illness, and who is or may be unable to take care of him or

herself, or unable to protect him or herself, against significant harm or exploitation' (Department of Health, 2000, 2.3).

Transfer
Transfer is the process whereby a patient transfers from one hospital ward or site to another

Appendix 2

References and further information

Legislation and guidance

Discharge of patients – Circular HC (89) 5
This outlined the responsibility of the NHS to prepare and implement a safe hospital discharge policy and to ensure that patients discharged from hospital are transferred to the care of a GP.

Department of Health (2009) The National Framework for NHS Continuing Healthcare and NHS Funded Care
This legislation requires Social Services to assess the needs of vulnerable adults and to provide services to meet assessed needs within available resources. Social Services Departments are required to respond to requests to meet assessed need and arrange services to support discharge from hospital.

Fair Access to Care: Eligibility for Social Care Services – 2003 Replaced by the Department of Health (2014) Care Act 2014
The New Act is built around giving a person greater choice and control in what care and support a person's needs.

The Community Care (Delayed Discharges etc.) Act 2003 Replaced by the Department of Health (2014) Care Act 2014

The Act updates and re-enacts the provisions of the Community care (Delayed Discharges etc.) Act 2003 that relate to delayed discharges of NHS hospital patients from NHS acute care. The NHS is still required to notify relevant local authorities of a patient's likely need for care and support and (where appropriate) carers support, where the patient is unlikely to be safely discharged from hospital without arrangement for such report being put into place first. (An assessment notice Section 2) Appendix 8. The NHS also has to give 24 hours' notice of when it intends to discharge the patients (discharge notice Section 5) Appendix 9.

From the 1st April 2015 if a local authority has not carried out an assessment or put in place care and support or (where applicable) cares support, and that is the sole reason for the patient not being safely discharged, the NHS body has a discretion as to whether to seek reimbursement from the relevant local authority for each day that an acute patients discharge ids delayed.

Safeguarding
If the patient is undergoing safeguarding investigation in respect of discharge destination, the discharge must not go ahead until communication has taken place with the lead investigating social worker or Head of Adult Safeguarding

Appendix 3

Nursing Discharge Documentation

Discharge Planning Form				
NAME/ID NO				
	Proposed date of discharge: _____/____/_____		Discharging area:	
	Discharge to:	Home☐	Intermediate care☐	Residential/Nursing Home☐
			Date signature and Print	**Comments**
On admission	Transport Patient has made own transport arrangements or Hospital Transport pre-booked (if medical need)			
	EDD recorded on whiteboard			
	Contact Assessment Form completed if applicable			
	Section 2 sent to Social services, if required			
Multidisciplinary Team	Medically discharge by speciality team			
	Physiotherapist agreement if applicable			
	Occupational Therapist agreement if applicable			
	Social Work agreement to discharge date			
	Care package in place if applicable			
Comms	Patient aware of discharge date			
	Relatives/Carers aware of discharge date			
	Heating on/food available			
	House Keys available/ Key safe Number available- Please ensure code given on a need to know basis			
24 hours prior to Discharge	Patients' own transport arrangements confirmed or Hospital Transport booking confirmed			
	EPR discharge letter completed(To have 28 days for transitional beds)			
	Take home medications dispensed and explained to patient/carer			
	Outpatient appointment made, if required Date:- Who with:-			
	Wound care–see next page			Yes/No
	District nurse/dressings – see next page			Yes/No
	Sec 5 sent to Social services, if required			Yes/No
On the day	Patient transferred to Discharge Lounge? (Contact number of ward given)			Yes/No
	Discharge letter sent to GP/ Copy given to Patient/family			Yes/No
	Have you checked that the patients cannulae has been removed?			
	Has the Family/Friends test been completed			Yes/No

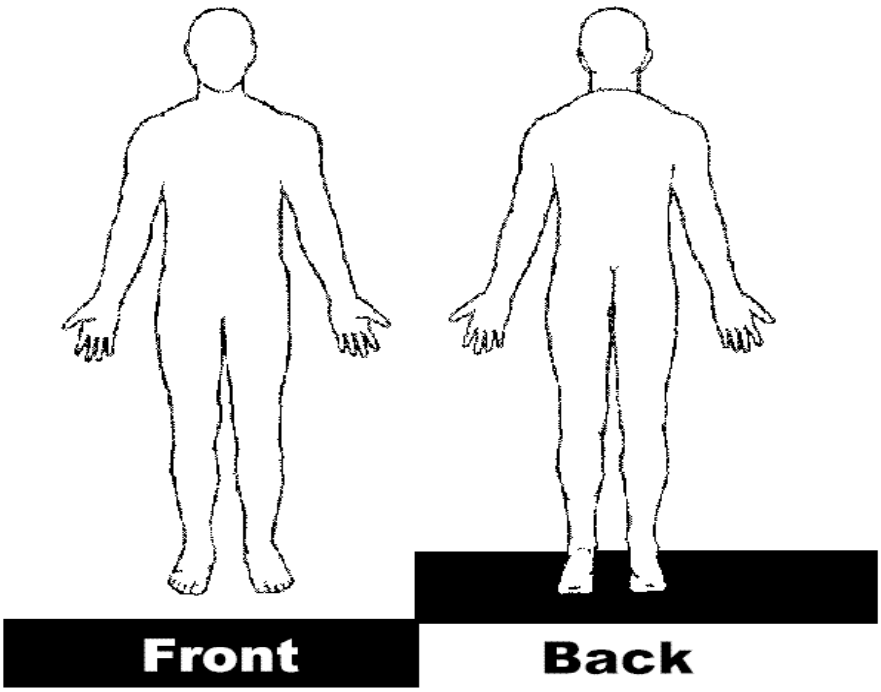
Discharge Planning Form
NAME/ID NO

Please complete the 2nd page if transferring to Nursing home/Residential home or transitional bed

Comms for NH/RH	**SKIN INTEGRITY** • Was the patient admitted with a pressure sore? • Grade of pressure sore on admission • Medical illustration requested and tracked • Grade of pressure sore on discharge • Dressings supplied (3 days supply) and frequency of dressings • Does the patient require a district nurse referral – Date referred and faxed	**Please Circle** Yes/No Grade Yes/No Grade Yes/No Yes/No Date
Comms for NH/RH	**NUTRITIONAL STATUS** • Nutritional Score on admission • Nutritional Score on discharge • Please state type of modified diet • Consistency of Fluids	Score Score
Comms for NH/RH	**FALLS/MOBILITY** • Falls risk assessment score • Has the patient had any falls whilst in hospital • Is the patient a high risk of falls • Does the patient require a walking aid • Walking aid discharged with patient	Score Yes/No Yes/No Please state Yes/No
Comms for NH/RH	**CONTINENCE** • Does the patient have a catheter passport? • Does the patient require an emergency supply of continence pads? and supplied	Yes/No Yes/No
Comms for NH/RH	**MEDICATION** • Are there any changes to medication? • Please list below any changes in medication on other Information • Does the patient require a blister Pack (Ensure EPR is completed 24hrs in advance of EDD)	Yes/No Yes/No
Comms for NH/RH	**BREATHING** • Does the patient require Oxygen • Does the patient require Mask or Nasal Cannulae (Please state) • Please state % of oxygen and No number of hours to be used • Has Oxygen been ordered? • Date for delivery of Oxygen	Yes/No Yes/No Date
Comms for NH/RH	**INFECTION CONTROL** • Has the patient any history of infection • Was the patient on any antibiotics pre admission • Has the patient any infection on discharge e.g CDT /MRSA • Are there any precautions that need to be followed on discharge, please state • Will the patient be discharged on antibiotics	**Yes/No** **Yes/No**

Signature and Print name Date

Discharge Planning Form
NAME/ID NO

Signature and Print name Date
   **<u>OTHER INFORMATION</u>**

Signature and Print name Date

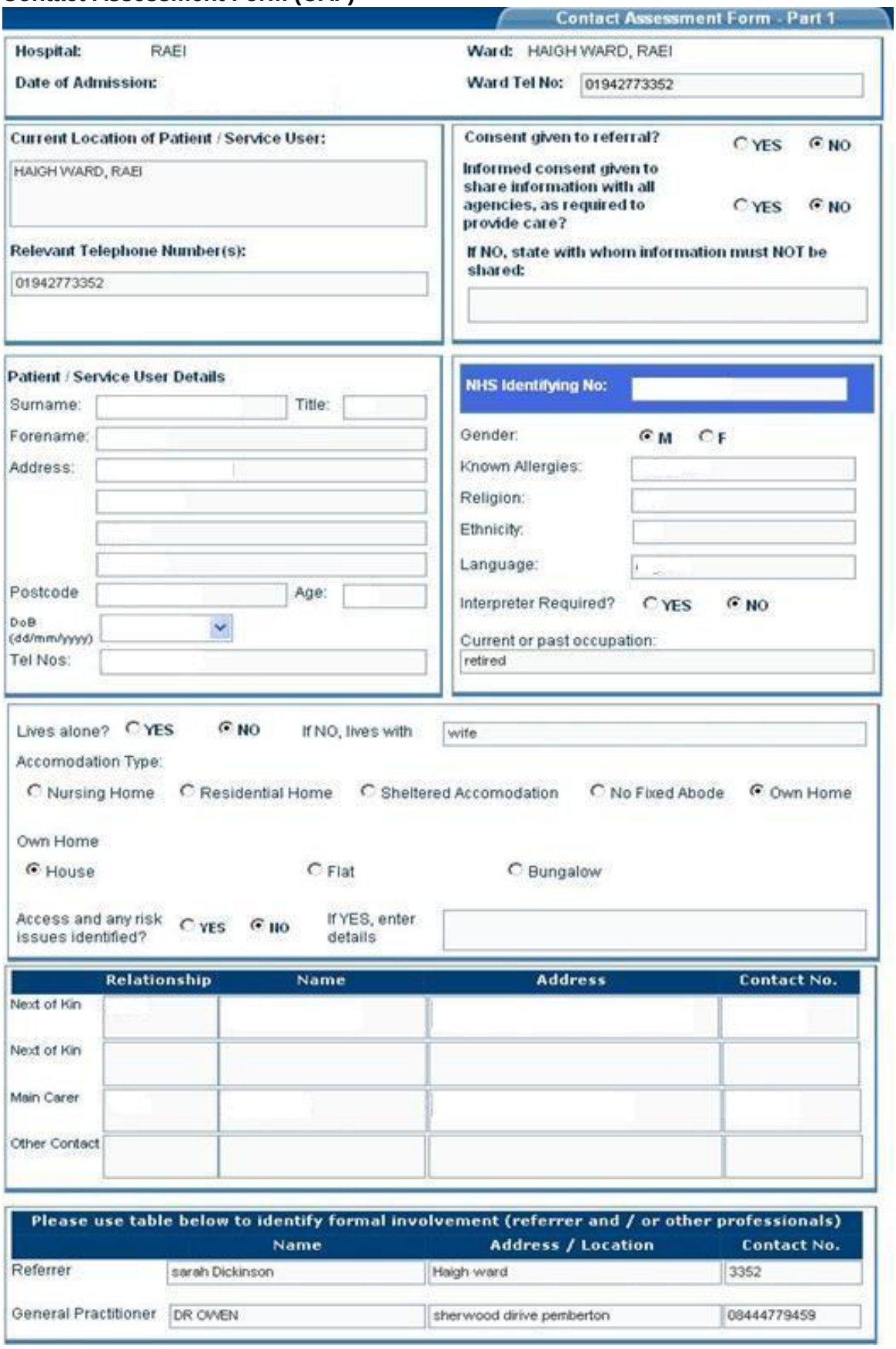
Appendix 4

Criteria for discharging patients after 20:00 hours

DISCHARGING PATIENTS AFTER 20.00HRS			
Patient Name/ Address/Unit number	**D.O.B**	**Discharging Ward**	**Has Patient Given Consent to be Transferred After 20.00hrs**
	Consultant		
		Patient's Signature/Verbal confirmation	
Time confirmed of transport arrangements, ambulance, private, family transport			
		Date & Time of discharge	
Record name of destination of patient being discharged to, home, care facility		**If home confirmation of adequate provisions of/Food/Heating and Patient carer if required.**	
		Relative/Carers Signature or verbal confirmation	
If Nursing or Residential Home please provide conformation of acceptance After 20.00hrs. Name of Acceptor			
Confirmation that the patient had a meal/snack/beverage/relevant medications before discharge		**Has patient adequately dressed before discharge**	
Discharging Nurse Signature			

Appendix 5

Contact Assessment Form (CAF)



Contact Assessment Form - Part 1

Hospital: RAEI	**Ward:** HAIGH WARD, RAEI
Date of Admission:	**Ward Tel No:** 01942773352

Current Location of Patient / Service User: HAIGH WARD, RAEI

Relevant Telephone Number(s): 01942773352

Consent given to referral? ○ YES ◉ NO

Informed consent given to share information with all agencies, as required to provide care? ○ YES ◉ NO

If NO, state with whom information must NOT be shared:

Patient / Service User Details

Surname: Title:
Forename:
Address:
Postcode Age:
DoB (dd/mm/yyyy)
Tel Nos:

NHS Identifying No:

Gender: ◉ M ○ F
Known Allergies:
Religion:
Ethnicity:
Language:
Interpreter Required? ○ YES ◉ NO
Current or past occupation: retired

Lives alone? ○ YES ◉ NO If NO, lives with wife

Accomodation Type:

○ Nursing Home ○ Residential Home ○ Sheltered Accomodation ○ No Fixed Abode ◉ Own Home

Own Home

◉ House ○ Flat ○ Bungalow

Access and any risk issues identified? ○ YES ◉ NO If YES, enter details

	Relationship	Name	Address	Contact No.
Next of Kin				
Next of Kin				
Main Carer				
Other Contact				

Please use table below to identify formal involvement (referrer and / or other professionals)

	Name	Address / Location	Contact No.
Referrer	sarah Dickinson	Haigh ward	3352
General Practitioner	DR OWEN	sherwood drive pemberton	08444779459

Part 2 of 2 — **Contact Assessment Form - Part 2**

Patient Name: Location:

NHS No: PAS No:

ALL SECTIONS MUST BE COMPLETED

Reason for referral / presenting problems / diagnosis:

Attendance at Day Centre, please give details:

Potential solutions identified by the patient / service user / carer (in their own words)

The nature, significance and length of time the problem has been experienced (include any recent life events or changes relevant to the problem)

Previous relevant medical history / essential clinical information / medication, etc. Specify hospital attendance and/or admission in the past 12 months

Initial Assessment: include any other important information, including communication difficulties

Potential Risk Issues before initial contact

Is there any information about the person, relatives or their home environment that staff should be aware of to ensure their safety?

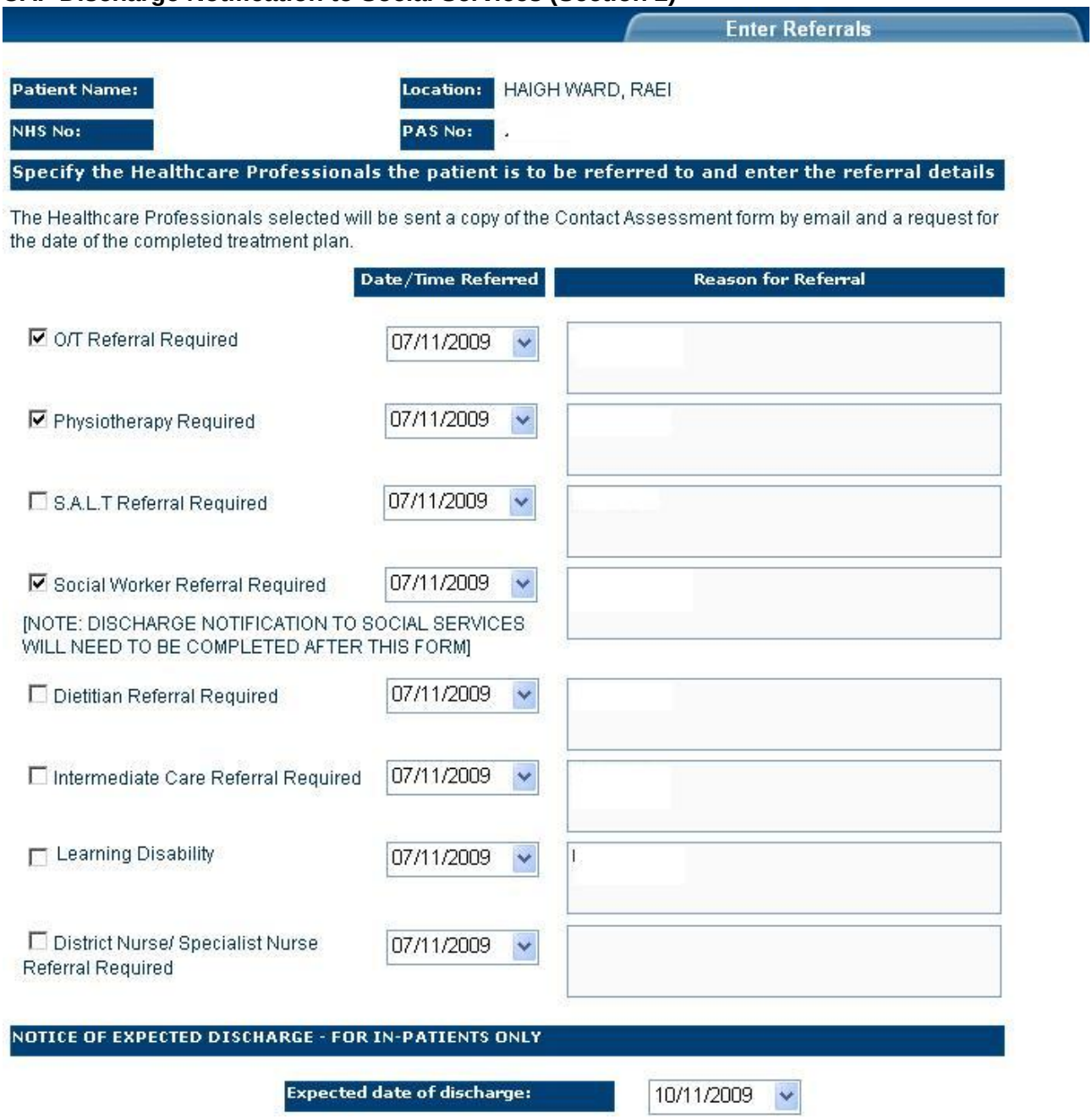
PLEASE STATE CLEARLY

Checklist completed for NHS Continuing Care: ○ YES ◉ NO

If applicable, date referral for full consideration for Continuing Healthcare:

Appendix 6

CAF Discharge Notification to Social Services (Section 2)



Enter Referrals

Patient Name:		**Location:**	HAIGH WARD, RAEI
NHS No:		**PAS No:**	.

Specify the Healthcare Professionals the patient is to be referred to and enter the referral details

The Healthcare Professionals selected will be sent a copy of the Contact Assessment form by email and a request for the date of the completed treatment plan.

	Date/Time Referred	Reason for Referral
☑ O/T Referral Required	07/11/2009	
☑ Physiotherapy Required	07/11/2009	
☐ S.A.L.T Referral Required	07/11/2009	
☑ Social Worker Referral Required	07/11/2009	
[NOTE: DISCHARGE NOTIFICATION TO SOCIAL SERVICES WILL NEED TO BE COMPLETED AFTER THIS FORM]		
☐ Dietitian Referral Required	07/11/2009	
☐ Intermediate Care Referral Required	07/11/2009	
☐ Learning Disability	07/11/2009	I
☐ District Nurse/ Specialist Nurse Referral Required	07/11/2009	

NOTICE OF EXPECTED DISCHARGE - FOR IN-PATIENTS ONLY

Expected date of discharge: 10/11/2009

Appendix 7

Discharge Notification to Social Services (Section 5)

Discharge Notification to Social Services

Hospital / Ward contact details:

Social Services contact details:

Patient Details

NHS No: | District No:

Surname: | Title: | DoB

Forename:

Address:

Postcode

KEY DATES LOG	DATE
1. Formal Section 2 notification of basic details/admission	
2. Notification of Expected Discharge date	
3. Multi-disciplinary agreement to care plan, including fitness/safety of discharge.	
4. Date of this formal section 5 notification.	
5. Confirmed date of discharge (at least 24 hrs after date 4 above).	

PART C - HEALTH SERVICES AVAILABILITY - (HOSPITAL TO COMPLETE)

The following health services, required in the agreed care plan, will be available on the confirmed date of discharge (date 5 in Part B above).

DATE **SIGNED** FIRTH_P

PART D - REQUEST FOR CONFIRMATION OF SOCIAL SERVICES AVAILABILITY (SOCIAL SERVICES TO COMPLETE)

The following social services are required in the agreed care plan and will be available on the confirmed date.

If any Social Services will not be available on the confirmed date, give reasons as to why and confirm when they WILL be available.

SIGNED (Social Services)

DATE (Social Services)

Appendix 8

Discharge Letter

DISCHARGE LETTER (Insert date)

GP COPY

DR IG OWEN
PEMBERTON SURGERY
PEMBERTON PCRC
SHERWOOD DRIVE
PEMBERTON,WIGAN
WN5 9QX

Dear Doctor

RE: xxxxxxx, xxxxxx **DOB:** xx/xx/xxxx
NHS No: xxx xxx xxxx, **PAS No:** xxxxxx
X xxxxx STREET, WIGAN, WNx xxx

Admission Date/Time:	xx/xx/xx xx:xx to (Insert) WARD
Discharge Date/Time:	xx/xx/2010 xx:xx from (Insert), RAEI
Discharging Consultant:	DR Y S ANG
Referred by:	A and E
Discharge Status:	xxxxxxxxxxxxxxxxxxxx

Patient's 18 Week Pathway
Not applicable - Emergency Admission

Primary Diagnosis i.e. main condition treated or investigated
xxxxxxxxxxxxxxxxxxx

Operations and Diagnostic Procedures performed during Admission
n/a

Outcome of Operations and Diagnostic Procedures performed during Admission
n/a

Diagnosis on Discharge & Recommendations
xxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxx

Clinical History
xxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxx

Clinical Findings & Pertinent Investigations
xxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxx

Changes to Admission Medications
xxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxx

Adverse Reactions or Allergies to Medications or Treatment
none

DISCHARGE MEDICATION	Dose	Frequency (Instructions)	No. of days supply	Notes
xxxxxxxxxxxxxxxxx	xxx	xxxxxxx	xx	
xxxxxxxxxxxxx	xx	xxxxx	xx	

Immediate Post Discharge Requirements
none

No Follow-up/Planned Investigations

Infections (other than M.R.S.A or C.diff)
none

Yours sincerely,

SHO

*CONTACT DETAILS FOR G.P.
(details of the most relevant person to contact regarding the discharge).

*Name:	Insert
*Position:	Consultant
*Contact Tel No:	01942 822336
*Address of Ward:	Insert Ward, Royal Albert Edward Infirmary, Wigan Lane, Wigan, WN1 2NN

APPENDIX 9

Equality Impact Assessment Form

STAGE 1 - INITIAL ASSESSMENT

For each of the protected characteristics listed answer the questions below using **Y** to indicate Yes and **N** to indicate No	Protected Characteristics														Reasons for negative/positive impact
	Male/Female	**Age**	**Ethnicity**	**Learning Disability**	**Hearing Impairment**	**Visual Impairment**	**Physical Disability**	**Mental Health**	**Gay/Lesbian/ Bisexual**	**Transgender**	**Religion/Belief**	**Marriage/Civil Partnership**	**Pregnancy & Maternity**	**Carers**	
Does the policy have the potential to affect individuals or communities differently in a negative way?	N	N	N	N	N	N	N		N		N	N	N	N	
Is there potential for the policy to promote equality of opportunity for all/promote good relations with different groups – Have a positive impact on individuals and communities.	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	
In relation to each protected characteristic, are there any areas where you are unsure about the impact and more information is needed?	N	N	N	N	N	N	N		N		N	N	N	N	If Yes, please state how you are going to gather this information.

Job Title	**Deputy Chief Pharmacist**	**Date**	January 2019

IF 'YES an NEGATIVE IMPACT' IS IDENTIFIED - A Full Equality Impact Assessment STAGE 2 Form must be completed. This can be accessed via http://intranet/Departments/Equality_Diversity/Equality_Impact_Assessment_Guidance.asp ***Please note: As a member of Trust staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete an EIA. By stating that you have NOT identified a negative impact, you are agreeing that the organisation has NOT discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in Equality Legislation.***

POLICY MONITORING AND REVIEW ARRANGEMENTS

Para	Audit/Monitoring requirement	Method of Audit/Monitoring	Responsible person	Frequency of Audit	Monitoring committee	Type of Evidence	Location where evidence is held
	Divisional Matrons to complete annual audit with required action plan	Data capture – review of documentation	Divisional Heads of Nursing	Annual	DQEC	Audit report	Divisional Governance