## Discharge and Going Home Policy

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<thead>
<tr>
<th>Reference Number</th>
<th>POL/NG/0005A</th>
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<tbody>
<tr>
<td><strong>Title</strong></td>
<td>Discharge and Going Home Policy</td>
</tr>
<tr>
<td><strong>Version Number</strong></td>
<td>10.1</td>
</tr>
<tr>
<td><strong>Document Type</strong></td>
<td>Policy</td>
</tr>
<tr>
<td><strong>Original Policy Date</strong></td>
<td>August 2004</td>
</tr>
<tr>
<td><strong>Review &amp; Approval Committee</strong></td>
<td>Clinical Standards and Therapeutics Committee - Quality and Healthcare Governance Committee</td>
</tr>
<tr>
<td><strong>Approval Date</strong></td>
<td>22 March 2016</td>
</tr>
<tr>
<td><strong>Next Review Date</strong></td>
<td>22 March 2019</td>
</tr>
<tr>
<td><strong>Originating Directorate</strong></td>
<td>Nursing</td>
</tr>
<tr>
<td><strong>Document Owner</strong></td>
<td>Associate Directors of Nursing Corporate and Care Group</td>
</tr>
<tr>
<td><strong>Lead Director or Associate Director</strong></td>
<td>Director of Nursing and Patient Experience</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>Trust-wide / Specific Department / Directorate / etc.</td>
</tr>
<tr>
<td><strong>Equality Impact Assessment (EIA) Completed on</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Approved</td>
</tr>
<tr>
<td><strong>Confidentiality</strong></td>
<td>Unrestricted</td>
</tr>
<tr>
<td><strong>Keywords</strong></td>
<td>Discharge, Home, Transfer, Patient Flow, Medication</td>
</tr>
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### Ratification

<table>
<thead>
<tr>
<th>Signature of Chairman of Ratifying Body</th>
<th>[Signature]</th>
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<tr>
<td><strong>Name / Job Title of Chairman of Ratifying Body:</strong></td>
<td>Prof. Chris Gray, QHGC Chair</td>
</tr>
<tr>
<td><strong>Date Ratified</strong></td>
<td>22/3/2016</td>
</tr>
<tr>
<td><strong>Signed Copy Held at:</strong></td>
<td>Corporate Records Office, DMH</td>
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### Version Control Table

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<tr>
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<th>Version Number</th>
<th>Status</th>
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<tr>
<td>2004</td>
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<td>Superseded</td>
</tr>
<tr>
<td>2007</td>
<td>2.0</td>
<td>Superseded</td>
</tr>
<tr>
<td>2008</td>
<td>3.0</td>
<td>Superseded</td>
</tr>
<tr>
<td>2010</td>
<td>4.0</td>
<td>Superseded</td>
</tr>
<tr>
<td>June 2011</td>
<td>5.0</td>
<td>Superseded</td>
</tr>
<tr>
<td>July 2011</td>
<td>6.0</td>
<td>Superseded</td>
</tr>
<tr>
<td>August 2011</td>
<td>7.0</td>
<td>Superseded</td>
</tr>
<tr>
<td>February 2012</td>
<td>8.0</td>
<td>Superseded</td>
</tr>
<tr>
<td>October 2012</td>
<td>8.1</td>
<td>Superseded</td>
</tr>
<tr>
<td>October 2013</td>
<td>9.0</td>
<td>Superseded</td>
</tr>
<tr>
<td>October 2015</td>
<td>10.0</td>
<td>Active – approved 23rd December 2015</td>
</tr>
<tr>
<td>March 2016</td>
<td>10.1</td>
<td>Approved</td>
</tr>
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### Table of Revisions

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<th>Date</th>
<th>Section</th>
<th>Revision</th>
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<tr>
<td>April 2010</td>
<td>Full</td>
<td>To ensure policy meets service requirements, current practice and the requirements of NHSLA</td>
<td>D Clark</td>
</tr>
<tr>
<td>June 2011</td>
<td>Full</td>
<td>Merging of Acute &amp; Community Organisations</td>
<td>D Clark</td>
</tr>
<tr>
<td>July 2011</td>
<td>Full</td>
<td>RPIW</td>
<td>D Clark</td>
</tr>
<tr>
<td>August 2011</td>
<td>Full</td>
<td>To ensure policy meets the requirements of NHSLA</td>
<td>D Clark, D Kirkup</td>
</tr>
<tr>
<td>February 2012</td>
<td>Full</td>
<td>Amendment to wording following peer review and feedback from NHSLA assessors. Addition of QHCG’s duties and insertion of an additional appendix</td>
<td>D Kirkup, D Clark, P Fish, G Kirkpatrick, G Hunt</td>
</tr>
<tr>
<td>October 2012</td>
<td>Full</td>
<td>Minor amendments made to sections 3, 5 &amp; 8 following consultation on content of policy</td>
<td>P Fish</td>
</tr>
<tr>
<td>September 2013</td>
<td>Full</td>
<td>To provide specific clarity on discharge - planning for home from CDDFT</td>
<td>J Race</td>
</tr>
<tr>
<td>October 2015</td>
<td>Full</td>
<td>To ensure policy meets service requirements, current practice and planning for home from CDDFT - full rewrite</td>
<td>J Race, J McClelland &amp; M Armstrong</td>
</tr>
<tr>
<td>March 2015</td>
<td>Amended</td>
<td>To include legal advice in respect of managing discharge from hospital to care homes &amp; patients who refuse discharge. Includes requirements for patients discharged from ED.</td>
<td>J Race and J McClelland</td>
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1 INTRODUCTION

Effective hospital discharge can only be achieved when there is cohesive joint working between all organisations, including hospital, primary care, social care, housing departments, independent and voluntary sector. These working arrangements must be effective not only in supporting individual discharges, but also in commissioning and delivery of services.

County Durham and Darlington NHS FT recognise that a planned, safe dignified and timely process for patients going home is paramount. This policy is intended to ensure that all patients receive quality care in relation to their discharge from hospital.

The core principles and processes are the same for all inpatient areas but there will be a service specification regarding roles, responsibilities procedures and pathways that will need to be considered within each Care Group.

Remaining in hospital unnecessarily places patients, particularly older people, at risk of increased dependency and hospital acquired infection. Delayed discharge also leads to problems with the flow of patients into the organisation as beds are occupied by patients who could be cared for outside of the hospital setting. The health and welfare of the whole community is affected by unhelpful delays in discharge from hospital to the patient's place of residence, including care homes. Service providers, patients and their families have a responsibility to the wider community to reduce any unnecessary delays in discharge.

2 PURPOSE

This policy is intended to assist all staff, working across all sites with County Durham and Darlington Foundation Trust, who are involved in the discharge process. It aims to improve and strengthen discharge planning and the timely discharge of patients from the Trust.

2.1 Policy Statement

Discharge planning is a process, not an isolated event, which will start at the point of admission for patients undergoing non-elective care, or before (for those undergoing elective care). It is a systematic integrated process within the patient's plan of care the result being a safe and timely discharge.
Patients will always be treated fairly and without discrimination regardless of age and on the basis of clinical need alone. To this aim a plan will be developed and agreed with each patient and/or carer to ensure a smooth transition from hospital care to their discharge destination. Patients, where able, will be involved in any discussion in preparation for discharge and any associated choice. Continuity of care will be maintained if a patient transfers from one care setting to another.

3 Scope

This policy applies to:

- All CDDFT staff involved with the discharge of patients, including the multi-professional discharge team and partner agencies.
- All discharges from any ward or department within County Durham and Darlington NHS Foundation Trust.
- Those patients being discharged home, or to their usual or new place of residence.
- Although discharge from hospital should take place between 8am and 9pm, there are occasions when discharge will occur outside these times. This policy is to be followed out of the stated hours also.

The policy aims to ensure that unplanned re-admissions do not occur as a result of poor discharge planning.

For those Patients who are deemed medically fit but require a period of further rehabilitation in another healthcare setting please refer to the Patient Transfer Policy.

4 Duties

4.1 Quality and Healthcare Governance Committee (QHCGC)

The QHCGC is responsible for approving and review the compliance results from the monitoring of this policy and will monitor action plans produced by Care Group Clinical Leaders, Matrons, Clinical Services Managers or Ward Managers to address the deficiencies identified.

4.2 The Consultant and Medical Team

The Consultant and medical team:
• Identify and communicate an ‘Expected Date of Discharge’ (EDD) which will be agreed on the first ward round review on the base ward. (excludes those patients expected to go home the same day or within 24 hours)
• Fully communicate the EDD to the wider nursing and MDT team.
• Prescribe take home medication 24 hours prior to the EDD.
• Complete an electronic discharge summary for each patient 24 hours prior to the EDD.
• Inform nursing staff of any required follow up appointments or tests post discharge, as appropriate.
• Ensure that any results of diagnostic tests that arrive after a patient’s discharge that require specific action are communicated to the GP by telephone and/or letter as soon as possible.
• Document any decisions / plans relating to discharge planning in the patients file including ‘medically fit for discharge’.

All discharges, if appropriate, will be discussed within the MDT 48 hours prior to EDD’s to ensure all medical, nursing and therapy plans are on schedule and to identify and block any that might prevent that discharge.

These standards comply with ‘Achieving timely ‘simple’ discharge from hospital’ (DOH 2004)

4.3 Matrons/Clinical Service Managers
Matrons/Clinical Service Managers are responsible for ensuring that the policy is implemented within their area of management. This may be determined by discussion at a Matrons huddle, regular audit forums and the development of any resultant service improvement.

4.4 Ward Manager/Sister/Charge Nurse
The Ward Manager and Sister/Charge Nurse are responsible for ensuring that systems and procedures are in place to facilitate safe and timely discharge in line with this policy. This includes clear communication with the patient and his relatives/carers about the discharge process, utilising the EDD and ‘Your Ticket Home’ (see Appendix 10) as well as managing the patient and families/ carers expectations.

4.5 Ward/Department Nurses
The discharging nurse must ensure that patients are aware of all arrangements for their ongoing management and review and that they receive any relevant information leaflets as well as a copy of their Electronic Discharge Letter. All discharges should, where possible, be planned to take place before 11am (There are additional requirements for discharges
from the Emergency Department see Appendix 4). This enables beds to be prepared for new patients in a timely way, reduces delays within the admission process, and leaves patients sufficient time within the working day to contact the ward or appropriate professional (SN, Community Matron) to discuss any remaining concerns they may have. These concerns, if left unanswered, may result in a further unnecessary admission.

4.6 Integrated Discharge Management Team
The Integrated Discharge management Team (IDMT) provides expert clinical leadership in relation to Adult Complex and Delayed Discharges as well as Continuing Care. They will:

- Actively seek solutions to delays in discharge and pursue all options for effective discharge in order to expedite a safe, smooth and seamless transfer of care.
- Work at a strategic level across the health and social care community, fostering and facilitating multi-professional interagency working and training in respect of adult complex, intermediate care, delayed discharge management and the continuing care process.
- Act as an expert resource on Adult Complex and Delayed Discharges, Continuing Care providing accessible, accurate and relevant information to managerial, medical and nursing staff within the Trust as well as to the Local Authority staff (social workers).

4.7 Allied Health Professionals (AHP’s)
Allied Health Professionals include, but are not limited to Physiotherapists, Pharmacists and Occupational Therapists. Their duties include:

- Making accurate and clear assessments, management plans and referrals appropriate to the patient’s needs, in a timely manner.
- Supporting and educating patients /carers in preparation for discharge
- Providing contact names and numbers in case of difficulties
  
  Appendix 1 (p28) Useful Names and Telephone Numbers.
- Maintain records relating to discharge planning and decisions in the patient record, this may include the Symphony system if a patient is in the Emergency Department.
- Liaise with community-based counterparts and partner agencies as required.

4.8 Patient Flow Team (PFT)
The Patient Flow Team manage the daily flow of adult patients into and out of the acute hospitals and promotes/initiates the use of appropriate services and schemes to enable safe
early transition to home. They will maintain and communicate accurate information on bed status and liaise with clinical staff to support an overview and understanding of pressures within the service to inform operational and clinical decision making processes. They will work with clinical colleagues to enable morning transition of patients to home whenever possible so that sufficient beds are available to enable patient’s timely access to the most appropriate care setting and level of care.

4.9 Roles of other Multi-disciplinary Team Members

Any member of the multi-disciplinary team who has been trained and is competent to undertake discharge responsibilities can co-ordinate the transfer/discharge of the patient. This requirement will be determined by the needs of the patient and the skills of the relevant professional. At present it is usually the Named Nurse who undertakes the role.

The nominated professional will:

- Ensure that all processes, investigations and interventions have been undertaken and completed prior to discharge or transfer.
- Ensuring any identified carer is willing and able to continue in the caring role.
- Offer individual carers an individual carers assessment as required.
- Ensure that arrangements for discharge or transfer are in place 24 hours prior to the agreed discharge/transfer date.
- Aim to ensure that all requirements to facilitate a safe discharge are in place. This may include dressings, medication and equipment.
- Educate or train patients, carers and/or relatives in the use of medicines, dressings or equipment prior to discharge if required.
- Provide the patient and/or carer with all relevant information in written form.

5 DISCHARGE AND GOING HOME PROCESS

Discharge Planning will commence at the pre-admission stage for elective cases. For unplanned admissions discharge planning will be initiated within 24 hours of admission. All discharges including complex discharges should be planned to take place before midday. If there are delays and patients are waiting for transport they should be asked to wait in a suitable area on the ward if appropriate. (There are additional requirements for discharges from the Emergency Department see Appendix 4)

An EDD will be agreed and communicated to the patient and their family/carer at the pre-admission stage for elective cases and within 24 hours of admission for unplanned admissions
using ‘Your Ticket Home’.

During the planning process individual needs should be identified to expedite any referrals to the Integrated Discharge Management Team. If a patient’s discharge is identified as likely to be complex, a referral should always be made to the Integrated Discharge Management Team.

In all cases:

- Discharges should be planned to take place before midday.

- Patients should not be discharged from inpatient ward areas after 9pm unless a late discharge has been discussed and agreed with the patient, family or carers and is deemed to be appropriate.

- Ward staff must clarify with Residential and Nursing Homes the latest time they will accept repatriation of their residents or admission of new residents.

- Discharges/transfers of care to Community Hospitals should take place as early in the day as possible. Later discharges after 8pm need to be discussed and agreed with the receiving ward. (Refer to Clinical Handover of Care on Transfer Policy POL/NG/0005B)

- The final discharge letter must be proof read and checked through with the patient before they leave to ensure they understand the next steps, any medication changes and what treatments and investigations they have had.

- The final discharge letter will be issued to the patient’s general practitioner for receipt within 24hrs of the patient going home.

Out of hours arrangements for patients going home should be avoided where possible. Out of hours may be defined as being between the hours of 20.00hrs and 08.00hrs and any patients discharged between these hours will be recorded by the Integrated Discharge Management Team (acute). Examples of unplanned arrangements out of hours’ may occur include:

- Self-discharge
- Ambulance transport issues
- Transportation by patient relative/friend/next of kin

The reasons for all out of hours discharge should be clearly documented in the care plan, and in the patient records for patients who are self-discharging.
Children often require a very short period of assessment / admission. Therefore they may be assessed during the out of hours period and considered well enough for home. With parents’ consent they can be discharged.

N.B In times of heightened escalation and extreme bed pressures, later discharges and transfers may be necessary and should be discussed and agreed with patients, carers, families and the receiving care facility and noted in the patient record.

5.1 Communication
One of the main themes of patient dissatisfaction and patient complaints in relation to preparation for going home is poor communication and involvement. All professionals involved in the care of patients will make every effort to communicate and involve the patient at every opportunity, together with their relatives and carers (as appropriate) to plan for the patients’ discharge.

It is the responsibility of all individuals involved in the patients care to maintain effective and consistent communication with:

- The patient their relatives and/or carer
- Relevant members of the Multi-Disciplinary Team involved in the patients care
- Other relevant departments within the Trust
- Other agencies and organisations.

All patients should be involved at every stage of planning for discharge, understand their proposed length of stay, and EDD. This communication should be underpinned by supplementary information including the ‘Ticket Home’ and ‘Your stay in Hospital’. To ease the transition of patients to their normal or new place of residence, any plans for discharge should also be discussed with the patients carers and/or relatives so that patients home environment is appropriately prepared for going home.

If a patient has complex requirements, there may be a need for a case conference at which the patient and carer should be present wherever possible. When arranging a case conference, all professionals involved in the patient's care should be invited, including Home Care Manager, Community Liaison Nurse etc.

For those patients who are unable to communicate in English, then a translation service is available from Translation Service North and can be contacted via the hospital switchboard. For those patients who use Sign Language but do not have their own communicator ward
staff can arrange for a ‘signer’ through the First Point Solutions who can be contacted via the hospital switchboard. Interpreting services and appropriate communication aids are available if required.

All communication should be documented in the patients care record or on the Symphony system if in the Emergency Department.

5.2 Mental Capacity
Where there is reason to believe that an individual may lack capacity to make a decision regarding the provision of (or change to) their care or accommodation a mental capacity assessment will be undertaken. If the assessment confirms that the individual lacks the relevant capacity best interest decision making shall be undertaken in accordance with the Mental Capacity Act 2005 (including the Deprivation of Liberty Amendment 2009). The Trust will appoint an Independent Mental Capacity Advocate to support the individual in decision making where necessary.

5.3 Simple/ Non Complex Discharge
For the majority of hospital admissions there will be a planned or a simple discharge as depicted in the flow chart at Appendix 2. The length of stay and the discharge plan will have been agreed prior to admission or as soon after admission as possible. The discharge plan could include for example care provision by relatives, restart of care package or return to usual care home (pending assessment by the care home to check that they can still provide the level of care required). There are additional requirements for discharges from the Emergency Department.

5.4 Complex discharge
A complex discharge relates to those patients who have been identified as having on-going health and/or social care needs and at the point of discharge do not require care within an acute care environment.

Complex discharges may also include patients deemed vulnerable who may be less able than others to voice their wishes and any concerns. These groups include people with learning disabilities, mental health problems or dementia, victims of neglect or of sexual or domestic violence, and those people who are particularly frail or nearing the end of their life. (Please refer to Safeguarding adult’s policy).

Once a patient has been identified as having complex needs:
They should be referred, as soon after admission as possible, to the Integrated Discharge Management Team.

Consider at this point as to whether a referral to an Elderly Care Physician needs to be made (the majority of the referrals to the IDM team will be frail elderly with complex needs, physical, social and mental).

Consider any issues around housing and finance.

Consider which patients need to be assessed for Continuing Health Care (CHC) funding. Generally patients should be assessed for NHS Continuing Healthcare before they are referred to social services (see section 5.5).

5.5 Discharge Requiring Continuing Healthcare and/or Referral to Social Services

Patients assessed for Continuing Health Care (CHC) funding may subsequently be referred to Social Services. CDDFT & Social Care staff will adhere to the principles of reimbursement as set out in the Community Care (Delayed Discharges) Act 2003, and work in partnership to avoid delays and take a joint approach to problem solving. The following should be noted:

- A trained nurse or social worker can complete the CHC screening checklist.
- The checklist should be completed when the patient’s needs on discharge are clear
- The patient should be made aware that the checklist is to be completed, it should be explained to them and informed consent secured.
- The patient and carer should be told that the outcome of the checklist does not necessarily mean they will be eligible for CHC funding as the full assessment needs to be completed.
- If the outcome of the screening checklist does not indicate a need for CHC a referral to Social Services can be made.
- If the outcome of the screening checklist is that the patient meets the criteria for CHC, a copy will be forwarded to the CHC office to initiate a full assessment of the patient.
- Referrals to Social Services made from CDDFT will be accepted as formal notification even if the patient is already in receipt of social care services.
- Referrals to Social Services on admission can be made for assessment about the best care options on discharge (it is not necessary to wait for a clinical decision of medically fit).

It is essential that a person centred approach is taken throughout the CHC assessment and/or referral to Social Services and that the patient is fully and directly involved in the decision making process. The process for CHC and/or referral to Social Services (Adult) is summarised in the flow chart at Appendix 3.
5.6 Managing Discharge from Hospital to Care Home

Some patients require discharge to a care home that has not previously been their normal or permanent place of residence. It is essential that the process for discharge to a Care Home is timely and delays are mitigated. Where the patient’s choice of Care Home is available, the process for discharge is as described previously. However there are circumstances where discharge to a Care Home can incur significant delays including when:

- Individuals have expressed a preference towards a particular care home where there are no current vacancies.
- A place in a particular home chosen by the individual is not currently available, and is unlikely to be in the near future

If the patients’ in-patient care is complete remaining in an acute bed is not an appropriate option. All stakeholders will take reasonable steps to gain an individual's agreement to suitable alternative arrangements. In doing so they will ascertain all relevant facts and take into account the individual’s desires and preference. The right to occupy an NHS bed for a prolonged period of time in these circumstances is not acceptable for several reasons:

- Exposure of the patient waiting to be discharged in an inappropriate care setting for their health, social and pastoral needs.
- Negative impact on the ability to provide the most appropriate care setting for patients requiring admission to hospital.
- Potential for increased patient wait times, cancellations and delays for patients scheduled for elective admissions.

Decision to discharge agreed

When multidisciplinary assessment of the patient indicates that the individual is medically fit for discharge, their medical condition cannot be further improved by in-patient rehabilitation, and placement in a care home is the most appropriate option to meet the individuals assessed needs, the following procedures should be followed.

On completion of the assessment, or within 24 hours, the multidisciplinary team (MDT) will inform the patient or relatives/carers as appropriate, both verbally and in writing (using a Proforma letter [Appendix 5a and 5b]) that the assessments have been completed and confirm that:

- They are ready for discharge from hospital
- Discharge to a care home is necessary
- It is expected that they should find a suitable home within 5 days with the support of a social worker if required.
- The name of the person who will be responsible for assisting them in this process
- It may be necessary for them to consider alternative care homes for an interim period if a vacancy in the home of their first choice is not available

Prior to the start of the 5 day period, the Social Worker will ensure all of the relevant information is available to enable them to select an appropriate care home. This will include details of the patient’s care needs, financial limits appropriate to meet such needs, and lists of vacant care homes able to meet such needs. Social Care and CHC will provide a list of all Care Homes with vacancies regardless of the source of funding.

Within 5 days of providing this information the patients and/or their families will be asked to select 3 homes from the vacancy list. These should be placed in order of preference.

If the patients preferred Care Home has no vacancies:
- Their name will be placed on the waiting list of the preferred accommodation
- They will be asked, and expected, to select an alternative Care Home with a current vacancy to facilitate their discharge.
- The social worker will facilitate discharge to the alternative care setting until their first choice Care Home becomes available.
- Arrangements will be made by Social Care and Health team to transfer the individual to their preferred Care Home as soon as possible once a vacancy is available.

The Department of Health’s position is clear that, as long as an interim placement meets the needs of an individual, it is acceptable for a person to move from an acute setting to an interim placement until a permanent/alternative choice becomes available.

**No suitable Care Home placement identified within 5 days**

In the event that the patient has not identified an appropriate placement, the MDT should first ensure that all appropriate actions have been taken. Once they are assured that the key principles have been met, the patient’s clinical condition has not altered, and the patient refuses to leave hospital unless a place in the care home of their choice is available, the following guidance should be followed:

- A representative from the Integrated Discharge Management Team/Senior Nurse will arrange a meeting with the patient/relative/carer within 24 hours of the expiry of the first 5 days deadline and this will be confirmed in writing. The MDT will ensure that all appropriate actions have been taken before the meeting is arranged.
• The social worker will be invited to attend.

• The Matron/Clinical Service Manager for the area will be in attendance. If a community hospital a GP may wish to attend

• The invitation will advise on the role of PALS and also provide contact details.

At the meeting the individual will be advised that he/she no longer requires a NHS hospital bed and that they should make alternative arrangements. The Integrated Discharge Management Team will confirm the following:

• The patient is fit for discharge

• The inappropriateness of remaining in hospital, as this may be detrimental to the patient's health and well-being

• That there is a defined time period within which a suitable care home placement should be found by the patient (within 5 days)

• That this period is normally expected to be within 5 days and commences from the point at which written notification is given to the patient for the need for a care home placement

• That information and support is available to the individual to enable them to find an appropriate placement.

• A further time period up to a maximum 2 days, from the date of the meeting, can be allowed in which an appropriate placement can be found

• That the patient may be moved to another bed within the Trust

This discussion will be confirmed with the patient and/or carer by letter (Post 5 day action letter) and copied to those present at the meeting. A further copy will be retained in the patient’s health records.

**No suitable Care Home placement identified within 2 day extension period**

If, after the extended time period, the individual has yet to be discharged and there is no indication from the patient and/or carer that discharge is imminent, the Integrated Discharge Management Team will inform the relevant Matron. The Matron will arrange a meeting with the patient/relative/carer to discuss their discharge plans within 24 hours of the expiry of the
first 2 days deadline. The invite to the meeting will be confirmed in writing and will advise of the role of the PALS, together with their contact details.

The Matron/Clinical Service Manager will inform the Associate Director of Nursing for the care group who will offer support if necessary.

The Consultant/GP responsible for the patients care, Ward Manager and Matron/Clinical Service Manager should be present at this meeting.

If, at the second meeting, it becomes apparent that the individual does not intend to find a placement immediately, the Matron/Clinical Service Manager will advise him/her that the Trust will instigate legal proceedings to ensure the patient is discharged from hospital to safeguard the health and wellbeing of other patients by providing capacity for those who require admission to hospital.

The Matron/Clinical Service Manager will confirm the discussion in writing and provide a copy to the patient and/or carer and to those present at the meeting. A further copy will be retained in the patient’s health records.

A meeting should then be convened with the following personnel:

- Trust Executive Director of Nursing
- The Head of Adult Services for the appropriate Social Care and Health Department
- Trust Litigation Manager
- Matron/Associate Director of Nursing (Care Group)
- Appropriate Integrated Discharge Team member

At this meeting the arrangements for starting legal action to facilitate discharge will be considered.

The process for managing discharge from hospital to care home is summarised in the flow chart at Appendix 6

There are additional requirements for complex discharges for children as depicted in Appendix 7

5.7 Transport

When starting the discharge planning process, staff need to discuss transport arrangements with the patient and or carer. The Trust will only provide transport if there is a clinical need to do so. Patients who do not require any assistance for their journey home will be asked to organise their own transport arrangements via family or friends. If there is no one available to
do this and the patient wishes to travel home by taxi, this must be booked as a private arrangement between the taxi firm and the patient.

Some patients will require hospital transport and this should be booked as early as possible on the day of discharge through the transport co-ordination team. Patients eligible for transport home organised by the Trust are:

- Patients recovering from anaesthetic
- Patients who are immobile and require assistance
- Frail elderly patients who under normal circumstance would not be able to use public transport
- Patient requiring oxygen on discharge
- Patient on a syringe driver

If an ambulance is required one must be booked as soon as the discharge date is known following the Ambulance Booking Procedure & Guidelines. Bookings made to the North East Ambulance Service (NEAS) without 24 hours’ notice cannot be guaranteed, as the routine planning of non-emergency Patient Transport service vehicles will have already taken place. Transport requests should highlight any special requirements, e.g. oxygen or any equipment that will be accompanying the patient to ensure an appropriate vehicle and crew are made available. Accurate information is essential and should include information regarding DNACPR, the mobility of the patient and/or infection status (e.g. MRSA or Clostridium Difficile and DNACPR) and any other relevant information.

5.8 Homeless Patients

Adult homeless people are not automatically the responsibility of Social Service Departments unless they have other on-going social care needs such as mental health, substance misuse or substantial disabilities. All homeless people or people living in temporary accommodation must be identified on admission. Primary health care services and homeless service providers will be notified on preparations for the patient leaving the hospital. CDDFT staff has access to local Homeless Units for advice to pass on to the patient.

All children and young people under 18yrs of age must have a safe and secure discharge address. If there is no such address then Social Services will be informed and the child will remain on the ward until appropriate arrangements can be made. (This may include transition to a relative's address etc.).

5.9 Nurse/Therapy Led Discharge

In designated areas i.e. day Surgery where a clear treatment plan or pathway is in place, the patient does not need to await a medical review prior to going home if they have reached completion of the plan/pathway without complications. An effective treatment plan/pathway, which includes the criteria that must be met prior to the patient being going home, should be in place for the majority of patients. Where a patient’s notes do not contain clear criteria the Ward Manager will ask the responsible Consultant or Community Hospital Medical Practitioner to insert them.
5.10 Fast Track- Patients with End of Life Care Needs

A fast track decision will be made where a patient’s preferred place of care is home or hospice and an appropriate clinician considers that a person has a primary health need arising from a rapidly deteriorating condition which may be entering the terminal phase with an increased level of dependency. The allocated nurse should contact the District Nursing Team and GP and liaise with the MDT (including CHC, Macmillan Carers, and Marie Curie) to support coordination and meet the needs of these patients. Specific needs will be communicated to enhance the patient experience and reduce the risk of incidents, complaints or claims which may result from the sub-optimal clinical handover of care. If a DNAR and/or advanced care plan is in place the transferring nurse will ensure that the original documents accompany the patient. The nurse will ensure the GP is notified upon discharge rather than waiting for the discharge letter being forwarded within 24 hours.

5.11 Pharmacy requirements & discharge medication

Where an Electronic Discharge Letter (EDL) format is utilised the medication information section needs to be completed to enable medication to be supplied. Where practicable this will be done 24 hours prior to the planned discharge date. The dispensing of medication for going home should be a planned event during a patient’s stay and therefore prescriptions should be dispensed by the Pharmacy department during normal opening hours. The Pharmacy department at UHND and DMH is open Monday to Friday 9am – 5pm, with a 4pm cut off for work to be done that day, and a Saturday morning service. The service operates a Pharmacist-run on-call service. This is a trust wide service available to provide emergency information and supply but is not available to dispense discharge prescriptions out-of-hours. In exceptional cases out of hours an FP10 should be used, preferably printed from iCM, to avoid risks of transcription errors.

Where medication is to be administered by a Community Nurse, the Community Nurse will be notified of medication required. Arrangements will need to be made for the medication to be prescribed on the appropriate community drug administration chart (see Controlled Drug Policy and the Trust Medicines Policy).

Patients will be counseled on their medication, doses & duration of treatment prior to discharge with particular attention made to medication changes. The EDL must be clearly annotated to ensure that only medicines which the patient does not already have an adequate supply of (either with them or at home) or are not available as an ‘over label’ pack are requested for pharmacy to supply. For items requested from Pharmacy, a minimum of 7 days medication will normally be provided unless otherwise requested. Further advice or
support can be provided by a pharmacist or pharmacy technician by contacting the pharmacy department. Further guidance is available at Appendix 8.

**Medicine reconciliation**
Immediately prior to discharge, whom ever is supplying the medication to the patient (this will normally be a nurse) must obtain an up to date copy of the discharge letter (where this is an Electronic Discharge Letter this will require them to reprint a copy of the ‘Pharmacy Copy’ of the letter). They must then use the list of medications on the discharge letter to reconcile the medications the patient is being supplied with are consistent with the list of medications on the discharge letter. Care must be taken to ensure that any medication stopped is not supplied to the patient at the point of discharge and that either all the medication the patient will need when they leave the hospital has been supplied or adequate alternative arrangements are in place.

5.12 **Discharge Letter**
A discharge letter must include the following information:

- Patient demographic details (name, gender, date of birth, address, CRN – unique identifier)
- Consultant
- Date of admission
- Date of discharge
- Presenting problem/reason for admission
- The name of key person responsible for the patients’ care
- Discharge Diagnosis
- Treatment/outcome/ investigations and results (Clinical Summary)
- Information given to patient and relatives
- Pharmaceutical information – medication on discharge and details of any medication changes
- Allergy status
- Infectious status
- Follow-up arrangements
- Social care situation
- Medical certificate – whether issued and for how long
- Whether or not a more detailed summary is to follow
In situations where an admission has been particularly complex, or if further investigation results are anticipated, an additional summary may be produced within 14 working days and sent to the patient’s GP practice.

Key performance indicators for the provision of discharge letters include:

- Discharge letter to the GP practice within 24hrs of discharge
- Discharge letter handed to patient on discharge

5.13 Patient Information (Including ‘Your Hospital Stay’)  
To ensure safe transition home the patient must be provided with a copy of their relevant information prior to them leaving the hospital. The nurse will check that the patient has understood what has happened, what will happen next and that the patient understands any medication prescribed or any that has changed. This will include:

- Final discharge letter
- Medication information
- Other relevant information sheets e.g. post-operative advice sheets, warfarin booklets or infection control advice, point of contact details.

The patient will be given relevant information to ensure they are informed about their stay in hospital, realistic expectations and to avoid delays due to choice in relation to a requirement to being discharged to a Care Home.

5.14 Recording Patient Discharge from the Trust  
This must be recorded accurately at the time of discharge within the patient record and be registered accurately on the Trust patient information system (CaMIS) by the ward clerk or the nurse (this includes patients transferred to Sedgefield, Richardson & Weardale Community Hospitals). The patient may need to wait in the Patient Discharge Lounge (excluding children) or communal patient area i.e. ward day room, and consideration should be given to whether the patient’s carers or ambulance service may need to be informed.

5.15 Discharge from the Emergency Department  
Patients who are medically assessed and do not require admission to hospital leave the Emergency Department (ED) at the time, or shortly after, the decision is made. However in some circumstances frail elderly patients who are not able to use public transport remain in the department until transport can be arranged. In these circumstances the patients vital signs will continue to be recorded and the Early Warning Score (EWS) recorded in the allotted field of the ED electronic notes system Symphony. In addition within Symphony
under the transport Data Entry Protocol, the name of the person to whom the patient is returning will be recorded. This will ensure that, when necessary, a responsible adult at the patient’s residence can take responsibility for the patient’s safety and well-being.

5.16 Self-Discharge Against Medical Advice

Self-discharge against medical advice may be a significant risk to both the patient and the Trust and on occasions the public. Patients are under no obligation to follow the medical advice but it is crucial that they understand the implications of a decision to self-discharge and whether they have the capacity to refuse treatment and/or admission.

Any request by a patient to discharge themselves should be taken seriously. A self-discharge form (Appendix 9) will be completed and retained in the patient record. Further guidance and the required document to be completed can be found in the Trust policies.

In all instances of children self-discharge the Consultant should be informed. A senior decision should then be made as to whether this constitutes a children’s safeguarding issue.

5.17 Information to be given to receiving Healthcare Professionals

A discharge letter must be completed by the medical and/or nursing team for all patients for receipt by the general practice within 24 hours of the patient’s discharge. This must include detail around infectious status of the patient. If an abnormal test result (i.e. microbiology or biochemistry) is received after a patient is discharged senior and middle grade medical staff will ensure the patients GP is informed.

A nurse to nurse handover is documented for provision to the receiving nurse if a patient is discharged to a nursing home, community nursing service or other provider.

All information provided to the receiving healthcare professional should be documented in the patient record.

Patients on medication compliance aids: the community pharmacist will have been notified regarding the admission and must be notified in advance of discharge.

How to guide: arrangement of multi-compartment compliance aids at point of discharge
Patients taking warfarin must have their medication chart faxed to relevant anticoagulation clinic as per “PROC/MM/0015: Oral anticoagulation with warfarin - adult patient management guidelines (including bleeding with NOACs)”.

5.18 Discharge Requirements for Specific Patient Groups

The principles underpinning the discharge process; patient & carer involvement, assessment, planning, communication and documentation are applicable for all patient groups. Some patient groups will have specific discharge considerations. For discharge planning and guidance that needs to be considered in addition to this policy please refer to the additional policies on the Trusts intranet site i.e. specific to maternity care, Paediatrics etc.

5.19 Training

The Integrated Discharge Management Team has responsibility for updating nursing staff on use of any new documentation and changes in discharge planning policy. Instruction on discharge process and planning will be provided at local induction and is included in the Preceptorship Programme for newly registered nursing staff.

5.20 Patient Who Refuse Discharge

On rare occasions a person who is fit for discharge, and who doesn't require a care package, may refuse to leave hospital. In these circumstances the person refusing should be evaluated by the doctor to establish the medical/psych/social basis for that patient's refusal. Their discharge plan should be coordinated with the nursing staff who should be present when the discharge plan is explained to the patient. The clinician should speak in measured tones and avoid negotiating with the patient.

A patient undergoing hospital care will have been admitted by the Trust by way of a licence (i.e. a permission to enter on to the premises). The licence does not entitle the patient to occupation of a hospital bed in circumstances where he or she is not currently in need of any medical or nursing care which would require ongoing admission to hospital. If a patient refuses to engage in the discharge process and continues to occupy a hospital bed once the licence has been revoked, because he or she has been deemed well enough to be discharged, that person will become a trespasser. The Trust has the option to remove the patient using reasonable force. Therefore if necessary security may be called to assist the patient to leave the premises. If required legal action can be taken to recover the bed under the law of trespass and a claim of possession made via the Court.
6 DEFINITIONS

6.1 Glossary of Terms Used

**Adults**: Persons aged 18 years and over being cared for in any environment, including critical care

**Discharge**: This refers to the process of patients being sent home as they no longer require hospital care or the patient’s care is handed over to another organisation or home setting i.e. to a residential or nursing home. Discharge can be categorised as:

**Simple Discharge**: Patients with simple discharge needs account for up to 80% of all discharges from hospital and include patients who:

- Will usually be discharged to their own home
- Have simple on-going care needs that do not require complex planning and delivery.
- Have care packages which remain unchanged
- Have no further care requirements

**Complex Discharge**: Relates to patients who will be discharged from hospital and have complex on-going health and/or social care needs. The discharge will require detailed assessment and planning by multi agency teams.

**Acute Care**: Whilst the principles apply to all patients, the legislation only applies to patients in receipt of acute care. Acute care is “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” (Delayed Discharges (England) Regulations, 2003).

**Intermediate Care**: Care provided after the acute care phase. This is usually provided in a care facility outside hospital. Given the re-ablement agenda this tier of care should be provided to promote rehabilitation and independence.

**Continuing Health Care**: NHS continuing healthcare is the name given to package of care that is arranged and funded solely by the NHS for individuals who are not in hospital but have complex on-going healthcare needs.

**EDD**: Expected date of discharge.
**End of life:** When a palliative care patient requires end of life care and their preferred place of care is home, nursing home or hospice and it has been identified that they will need care support on discharge.

**Medically fit for discharge:** When a clinical decision has been made that the patient is ready for discharge and a multidisciplinary team decision has also deemed the patient ready and safe for discharge.

**Multi-Disciplinary Team (MDT):** A team of at least two appropriate professionals who work collaboratively to assess the patient’s health and social care discharge needs.

**Neonates:** Neonatal patients are those patients from birth to the age of 4 weeks.

**Paediatrics:** Persons under the age of 18 years.

**Ticket Home: (Appendix 10)** A patient held document given to the patient their Expected Date of Discharge as well as some key information on their discharge home.

**Your Stay in Hospital:** A patient information leaflet outlining some of the pathways and moves they might encounter whilst in hospital.

### 7 DISSEMINATION ARRANGEMENTS

All staff will be made aware of the revised policy in the Trust weekly communication bulletin and will be raised with the Senior Nurse, Midwives and AHP Leaders Group. It will be communicated and stored via the policies section of the Trust’s intranet site. Requests for this policy in an alternative language or format will be considered and obtained whenever possible.

Training on discharge requirements will be provided as part of local induction for medical and nursing staff. It will also be included in the Preceptorship programme for newly registered nursing staff.

### 8 MONITORING

**8.1 Key Performance Indicators**

Successful discharge is a fundamental part of the patient journey and has a significant impact on both patient outcome and experience. There are many complexities involved as emphasised by the Department of Health (2010) in their seminal document ‘Ready to Go’ which clearly set out standards for best practice in discharge. It is essential the discharge
and going home policy is monitored and accurately evaluated to ensure its continued effectiveness against best practice standards.

Compliance will be monitored via:

- Audit against agreed discharge standards and record keeping requirements to ensure continued effectiveness.
- Weekly timeliness of provision of discharge letters
- Untoward incidents
- Out of hours discharges

8.2 Compliance and Effectiveness Monitoring

<table>
<thead>
<tr>
<th>Monitoring Criterion</th>
<th>Who will perform the monitoring?</th>
<th>What are you monitoring?</th>
<th>When will the monitoring be performed?</th>
<th>How are you going to monitor?</th>
<th>What will happen if any shortfalls are identified?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ward Managers</td>
<td>Quality matters metrics (QMM) – audit records, patient feedback (Ward managers) Out of hours discharges (OHD) - DMT Timeliness of discharge letter provision to GPs Untoward incidents – Matrons Turnaround times of work received into pharmacy - Pharmacy</td>
<td>QMM – as per schedule – minimum annual OHD – Record and review as occur Weekly monitor of timeliness of EDLs – Target 24 hours IR1 – Record of discharge associated untoward incidents as occur</td>
<td>Audit the discharge process using Quality Matters Metrics on every ward to ensure that the audit sample covers the different patient groups and check compliance of: • Discharge planning • Discharge/going home checklist • Completeness of discharge letters Weekly count of number and percentage of discharge letters completed and issued to GP practices within 24 hours. Record out of hours discharges and any discharge related untoward incidents</td>
<td>Designated Service leads, Matrons and medical staff will be responsible for developing and implementing an</td>
</tr>
</tbody>
</table>
| Where will the results of the monitoring be reported? | Quality and Healthcare Governance Committee  
Care Group Governance meetings  
Care Group Governance meetings  
Staff meetings |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How will the resulting action plan be progressed and monitored?</td>
<td>Action plans will be developed within the Care Groups and monitored via the Quality and Healthcare Governance Committee and Safety Committee</td>
</tr>
<tr>
<td>How will learning take place?</td>
<td>Outcomes will be shared via: Trust wide Matrons Meetings, Nurse Leader Away Days &amp; Care Group Governance Meetings. Any Trust wide key messages will be disseminated by the Quality and Healthcare Governance Committee and NHSLA Steering Group meetings</td>
</tr>
</tbody>
</table>

### 9 References


Achieving Timely ‘Simple’ Discharge from Hospital, DOH (2004) [www.dh.gov.uk](http://www.dh.gov.uk)


Ready to Go, Planning the discharge and the transfer of patients from Hospital and Intermediate Care [http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_116675.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_116675.pdf)


NHS and Community Care Act (1990), Office for Public Sector Information

The National Framework for NHS Continuing Health Care and NHS-funded Nursing Care, November 2012 (Revised) Department of Health 2013

Getting it right for people with dementia, DoH July 2003

National Audit of Dementia Round 2, Royal College of Psychiatrists 2012

Improving Supportive and Palliative Care for Adults with Cancer, DoH 2004

10 ASSOCIATED DOCUMENTATION

Policy for Policies
Trust Medicines Policy
Safeguarding Adults and Children
Escalation policy
Postnatal Planning and Discharge Guidance
Admission to Neonatal Unit
Information sharing Policy
Infection Prevention and Control Policies
Major Incident & Emergency Response Plan
# Appendix 1

## Useful Names and Telephone Numbers

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital / Ward Sister</td>
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</tr>
<tr>
<td>Discharge Management Co-ordinator</td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>Patient Advice and Liaison Service</td>
<td></td>
</tr>
</tbody>
</table>
**Simple Discharge Process (all)**

<table>
<thead>
<tr>
<th>Pre-admission: Elective patients. The nurses/midwives in the pre-admission/ante-natal clinic commence the relevant assessment and plan of care which includes preparation for going home prior to admission.</th>
</tr>
</thead>
</table>

| On Admission: Non-Elective patients – the nurse/midwife allocated to care for the patient will commence relevant planning and preparation for going home within 24 hours of admission with the patient. |

| On Admission: An Estimated Date of Discharge is confirmed by the medical team & recorded by the allocated nurse/midwife within 24 hours of admission using the ticket home. |

| During the episode of care: The nurse/midwife will co-ordinate planning for home & continuously review the EDD and arrangements. This will include input from patient carer/relatives, on consent of the patient, and will be recorded as part of the discharge plan. The discharge management team is available to support this process. Any changes required to the EDD will be communicated to the patient, their carers and other healthcare professionals involved in the patient’s care. Any changes will be recorded as part of the discharge plan. |

| The day prior to going home: Medical staff (or designated nurse in agreed areas i.e. days surgery) complete the Discharge Letter (section 3.4), send medication requests to pharmacy, confirm transport arrangements with the patient, family & carers and any follow-up arrangements and services required for going home. The status will be recorded as part of the discharge plan. |

<table>
<thead>
<tr>
<th>Information provided to the GP or receiving healthcare professional completed as per the discharge plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Electronic Discharge Letter from the medical team (nursing in selected areas i.e. day case). – within 24 hours. In some community hospitals type and fax discharge letters to relevant GP within 24 hours.</td>
</tr>
<tr>
<td>• Nurse to nurse handover information if appropriate i.e. to district nursing service, nursing care home or other provider.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information provided to the patient by the nurse at the point of going home and recorded as provided as part of the discharge plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Copy of the final discharge letter</td>
</tr>
<tr>
<td>• Copy of their going home information</td>
</tr>
<tr>
<td>• Medication Information (if appropriate)</td>
</tr>
</tbody>
</table>
Appendix 3

Discharge Process for patients with on-going health and/or social care needs (Adult)

Continuing Healthcare (CHC)

Consider whether the patient qualifies for NHS Continuing Healthcare before referral to Social Services. Use the CHC Checklist to screen and identify those patients who require a referral for funding consideration.

‘Yes’ Checklist – forward to the relevant CHC office. A referral to Social Services is not required. ‘No’ Checklist – forward to the relevant Social Services with the referral form.

Fast track for immediate CHC funding – patients with a rapidly deteriorating condition, which may be entering a terminal phase

Referral to Social Services

Referrals can be made on admission for assessment by other professions for the best care options to support patients to go home (not necessary to wait for a clinical decision of medically fit). Referrals made from the Trust will be accepted as formal notification and is required even if the patient is already in receipt of social care services. On referral adequate information should be provided.

County Durham: - Social Care Direct (0845 8505010) either by telephone or fax (0191 3835752) Darlington: - 01325 745600 or fax (01325 489030)

Contact is made with the Ward within 24 hours (1 working day) to liaise with ward staff, discharge management team/designated officer and relevant professionals:

a) Active (open) cases – the designated Social Worker will make contact
b) New cases – Intermediate Care Services will make contact

Provision of Aids & Equipment

Discharge Management Team will liaise with MDT (nursing staff, Occupational Therapist and Physiotherapist) to determine patient need for equipment i.e. pressure relieving aids, mattresses and beds. OT is also responsible for the provision of specific equipment i.e. hoist/rails etc. Hospital OT therapists provide equipment essential for safe transition to home. Social Service Department OT can visit as soon as possible and assess for minor and major adaptations. These recommendations will not delay arrangements for going home.

Discharge Management Nurse/OT orders the equipment. Use Handy Van Schemes if quick access to minor aids, equipment and adaptations is required.

A member of the team will liaise with the district nurse to inform them of the need for the equipment.

On delivery the District Nurse will ensure the equipment is working and safe to use.
Appendix 4

DISCHARGE FROM THE EMERGENCY DEPARTMENT

Patient medically fit for discharge from Emergency Department

Emergency Department staff must ensure discharge is safe and inform the relatives and/or care home that the patient is returning

All patients should only return to their home after 22.00 hrs if

- The risk of late complications is deemed negligible
- Suitable supervision arrangements have been organised i.e.
  - Family/carer
  - Charitable agency
  - Care home

A set of observations as per EWS protocol must be carried out and score calculated if there is any delay in discharge from the Emergency Department and documented on the Symphony system.

- Actions must be carried out as per the aggregate EWS

Patients should be observed (as per the EWS policy) on discharge for:

- The assessment of acute illness and the detection of clinical deterioration
- The initiation of a timely and competent clinical response.
- Depending on the EWS, this will determine the frequency of observations and the urgency of clinical review.

Emergency Department staff must ensure that appropriate information (written and verbal) is relayed to the relatives and/or care home team

- Where patients are entering or returning to residential or nursing home care, the home staff must have all necessary information to adequately care for the patient.
- All appropriate ED appointments/follow ups are provided.
Proforma Letter Confirming the Need for a Care Home Placement (Patient)

Dear (Patient)

I am writing to confirm that the multidisciplinary team has now completed their assessments of your needs. It is considered that you are medically fit for discharge, your medical condition cannot be further improved by in-patient rehabilitation, and placement in a care home is considered the best way to meet your needs.

As explained previously, in accordance with the Policy ‘Managing discharge from Hospital to Care Homes’ you will be expected to find a vacancy in a home of your choice within the next 5 days. A copy of this policy can be made available to you on request. As availability in the home of your choice may take some time to arrange, a home must also be selected for an interim placement, until a room is available in one of the homes of your choice.

If you experience difficulties in finding a vacancy in a care home of your choice, please discuss this with a member of the nursing team responsible for your care (this may be a hospital Discharge Coordinator) within the hospital or your Social Worker as soon as possible to ensure that your transfer is achieved within the expected time scale.

We recognise that this decision is a major one and that you will require support and advice to guide you through the process of finding a suitable care home.

You will find the names and contact points for key people who can assist you on the back of this letter.

If you would like to discuss the content of this letter or have any queries or concerns about the discharge process, please do not hesitate to contact either myself, through the hospital switchboard or the Social Worker assigned to you.

Yours sincerely,
Proforma Letter Confirming the Need for a Care Home Placement (Relative / Carer/ Advocate)

Dear

I am writing to confirm that the multidisciplinary team have now completed their assessment and have agreed that …………………………………………………. is medically fit for discharge, their medical condition cannot be further improved by in-patient rehabilitation, and placement in a care home is considered the best way to meet their needs.

As explained previously, in accordance with the Policy ‘Managing discharge from Hospital to care homes’ you will be expected to find a vacancy in a home of your choice within the next 5 days. A copy of this policy can be made available to you on request. As availability in the home of your choice may take some time to arrange, a home must also be selected for an interim placement, until a room is available in one of the homes of your choice.

We recognise that this decision is a major one and that you will require support and advice to guide you through the process of finding a suitable care home. To help you with this, regular contact can be maintained with the nursing team (this may be the discharge coordinator) or your Social Worker.

You will find the names and contact points for key people who can assist you on the back of this letter.

If you would like to discuss the content of this letter or have any queries or concerns about the discharge process, please do not hesitate to contact either myself, through the hospital switchboard or the Social Worker assigned to your relative.

Yours sincerely,
Managing Discharge from Hospital to Care Home

MDT decide patient is ready for discharge

Within 24 hours of MDT decision inform patient / carer in writing advising them 5 days from receipt to arrange a placement (letter Proforma Appendix 5a and 5b)

No suitable placement identified within 5 days

Discharge Co-ordinator arranges meeting with patient / relative and MDT within 24 hours of expiry of first deadline. The MDT will ensure that all appropriate actions have taken place before the meeting is arranged

A further time period up to a maximum of 2 days granted, from the date of the meeting, to arrange a placement (issue Post 5 day action letter)

Still no suitable placement identified or placement agreed within the extended period

Date of second meeting. Meeting to take place within 24 hours of the expiry of the extended period

Patient informed that the Trust will take legal action to discharge.

Meeting of Trust and Social Care and Health to consider legal action to facilitate discharge

Patient Discharged
Discharge for Paediatric patients with complex care needs

Complex Paediatric preparations for going home may fall into 4 main categories

**Group 1: Change in need for an expected time period e.g. following Orthopaedics surgery**

Contact Home and Hospital teaching service

Complete referral form and give to ward based teaching staff

Contact Paediatric physiotherapist / OT and wheelchair services to provide any aids and equipment

Inform Children’s Community Nurses of discharge

Inform CCNS at least 24 hours prior to discharge where possible to discuss care needs

**Group 2: Children with known complex and continuing health care needs**

Community Paediatrician, Continuing Care Nurse & relevant specialist nurse informed of admission and expected discharge date.

Continuing Care Nurse and relevant Specialist Nurse informed of actual date to go home

Supplies and aids co-ordinated by continuing care nurses. Home care package recommenced as appropriate
Before any complex discharge is effected the Child’s Named Consultant, Named Nurse, Ward Manager (or deputy) and specialist services should be confident the transition is timely and safe.
Discharge Medication Guidance

Appendix 8

Normal Pharmacy opening hours

- The discharge prescription should be written by either the medical staff or ward pharmacist (as appropriate) the day before the estimated date of discharge.
- Prior to sending to Pharmacy, the ward pharmacist/technician (if available) or medical staff in conjunction with the nursing staff must perform a check of what medicines are already available to the patient.
- This will include checking for availability of patients’ own medicines (either on the ward or at home), medicines issued as part of the POMMs (dispensing for discharge scheme) service and over-labeled packs. The prescription must be endorsed accordingly for items not requiring a supply. If any items are required, the prescription will need to be sent to Pharmacy for dispensing.
- Where there have been no changes to any of the regular medication (i.e. no dose or frequency changes, no discontinuations) it may be acceptable to use the iSoft function ‘Admission medication unchanged. Any other medication prescribed has been started during this admission’. This may be used where new medication intended for long or short term use has been added to the patients usual treatment regimen, but no other changes have been made. This enables a supply of the new medication and provides clarity to the GP that no other changes have been made. Further details of the new medication should be made in the letter.
- The statement will not be used when medication has been discontinued. If a medication has been discontinued the full list of medications being taken must be prescribed and the medication that has been discontinued must be stated in pharmaceutical information.
- The statement will also not be used if the patient requires a further supply of an unchanged medicine. If a further supply of an unchanged medicine is required then the complete list of patients medications will be listed.
- For patients on compliance aids, the discharging ward may instead have to liaise with the patients’ nominated community pharmacy and GP to re-start supply of the compliance aid. In most cases, community pharmacies and GPs will require at least 24 hours notice to re-initiate supply.

http://intranet/Directorates/CCG/ALTC/Pharmacy/Shared%20Documents/Guidelines/How%20to%20ensure%20continuity%20of%20medicines%20when%20transferring%20patients.pdf

- Where compliance aids are being filled by a community pharmacist, and FP10 for the required items will need printing and sending to the community pharmacist (see How to guide: arrangement of multi-compartment compliance aids at point of discharge’)

- It is important that all patients understand the rationale for the treatment they are taking and any changes to their medication while in hospital must be fully explained.

- Patients should receive written drug information, which includes side-effects to watch out for. This may include patient information leaflets (manufacturers or in-house approved leaflets) or patient reminder charts. Where patient reminder charts are issued, as a minimum they should be:
  - electronically produced, not hand-written
  - include date of issue
  - name of person preparing the chart

- It is good practice that reminder charts are checked by a second practitioner prior to issuing to the patient.

Self-Discharge

- Patients may choose to self-discharge against medical advice. When this occurs, the patient will need to be made aware that they may have to wait until a Doctor or pharmacist is available to prepare the prescription and get any medication required dispensed from Pharmacy. If a patient is not prepared to wait then the medication may be prepared for the patient or their representative to collect later. If the patient does not agree to this then no discharge medication will be issued.

Discharge Medication Outside of Pharmacy Opening Hours-of-Hours (Acute sites)

Between 4pm and 5pm Mon – Fri:

- The Patient Flow Sister should contact the duty pharmacist-in-charge and explain that there is/are discharge prescription(s) that are required to be dispensed due to bed pressures. The Pharmacy department will make every effort to dispense these prescriptions as a matter of urgency.

After 5pm Mon – Fri / After 1pm Sat / All day Sun:
The Patient Flow Sister or Senior Nurse on the ward should assess the patient’s medication requirements.

- Does the patient have a supply of medication in their locker that is suitable for discharge?
  - The Trust operates a dispensing for discharge scheme on many wards where inpatient supply of medication is pre-labelled ready for discharge.
- Does the patient have a supply of their own medication at home?
Most patients will have a supply of their regular medication at home. If the medication has not changed since admission they will probably have a supply at home. Supply should only be considered for items that have been newly prescribed.

- For patients being discharged direct to community hospitals or other Trusts: Does the receiving ward keep the required medication as normal stock?

If the receiving ward stocks the required medication, there will be no requirement to supply on transfer. Where the patient takes a medication that is not stocked then it is the transferring wards responsibility to ensure supplies are transferred to ensure continuity of treatment. Supplies direct to other wards do not need to meet discharge labeling requirements in these circumstances, e.g. can transfer temporary stock supplies previously issued to the transfer ward for the patient. (See: How to guide: ensure continuity of medicines when transferring patients)

http://intranet/Directorates/CCG/ALTC/Pharmacy/Shared%20Documents/Guidelines/How%20to%20ensure%20continuity%20of%20medicines%20when%20transferring%20patients.pdf

- Is there an over-labelled supply of the medication available within the hospital?
  - Many wards within the hospital have a supply of medication that has already been labelled ready for dispensing by ward staff. A medication locator is available on the Pharmacy & Medicines Management intranet site – Pharmacy & Medicines Management > Medicines Management > Out of Hours Pharmacy Information.

Has the patient access to a supply of all the medication they require?

Yes – discharge home

No – nursing and medical staff must not supply unlabeled or inappropriately labeled medication from ward stock for patients to take home.

- Is there an urgent need to start any new medication BEFORE pharmacy next opens?
- Can the dose be administered on the ward prior to discharge and the patient asked to return to the ward the following day to collect the medication (Monday to Friday discharges)?
- After all the options above have been explored an FP10 prescription may be used. This option may only be considered after agreement has been gained from the patient/carer. This still requires an iSoft discharge prescription to be prepared so that there is an electronic record available.
- If none of these options appear to be reasonable or advice is required then contact the on-call Pharmacist. They will offer advice on the critical nature of the medications
required and whether the patient can be safely discharged home without an immediate supply of a medication. Arrangements must be put in place to ensure that a supply of the required medication is made as soon as possible and with minimal inconvenience to the patient.

- The Patient Flow Sister or Senior Nurse must clearly document, and explain to the patient, the arrangements put in place to facilitate their discharge.
OUT-OF-HOURS DISCHARGE MEDICATION (ACUTE)

Discharge Rx prepared on iSoft for ALL out-of-hours discharges

Supply of medicines in locker?  
YES  
Supplied as per Medicines Policy. Discharge Home.

NO

Supply of regular meds at home?  
YES  
No supply needed. Discharge Home

NO

Medication available as over-labelled pack?  
YES  
Supply over-label pack(s) as per Policy. Discharge Home

NO

Urgent need to start NEW medication before Pharmacy next opens?  
NO  
Make arrangements for patient to obtain a supply of new medication at a later time. Discharge Home

YES

Can a dose be administered before discharge and the patient return next day to obtain supplies via Pharmacy?  
NO  
Contact the on-call pharmacist for further advice

YES  
Make arrangements for patient to obtain supply of medication at a later time. Discharge Home
# Self Discharge Form

**Patient Name:**

**Address:**

**Tel No.**
- **DOB:**
- **Unit No.:**
- **Hospital:**
- **Ward:**
- **Date of Admission:**
- **Date of Self Discharge:**
- **GP:**

**Advice Given to Patient:**

**Health Professional Details:**
- **Name:** ____________________  **Signature:** ____________________
- **Designation:** ________________  **Date:** ______________________

**Patient Declaration:**
I confirm that the above advice has been given to me but still wish to take my own discharge against medical advice

**Name:** ____________________  **Signature:** ____________________  **Date:** ____________________

**NOTE** Where the patient has left the ward without informing staff, the patient and/or relative should be contacted and details of the information given recorded above. Where the patient/carer cannot be contacted, record details of the attempts made.
Your ticket home includes your expected date of discharge (EDD) this is the date that your clinical team feel you will be well enough to leave hospital. The date gives you and your family the opportunity to make any arrangements to ensure you are ready to leave hospital.

Your expected date of discharge is ________________

Please let the ward team know if you foresee any problems with your discharge from the ward. On the day of discharge we will aim for you to leave the ward by 11am, we will expect you to make your own travel arrangements. In exceptional circumstances hospital transport can be arranged.

What will I be given to take home?

Medicines- If you brought medications in to hospital with you these will be returned to you if it’s safe to do so. You will be given any new medications when you go home and the pharmacist or nurses on the ward will explain any instructions that you need to follow.

Discharge letter- This is a letter giving details of your hospital treatment and discharge medications, a copy will be sent directly to your GP and you will also be given a copy.

<table>
<thead>
<tr>
<th>Discharge checklist- before you leave the ward do you have?</th>
</tr>
</thead>
<tbody>
<tr>
<td>All your belongings and valuables</td>
</tr>
<tr>
<td>Any medication you have been prescribed along with instructions on how to take them</td>
</tr>
<tr>
<td>Your house keys or someone to meet you at home</td>
</tr>
<tr>
<td>Adequate clothes to travel home in</td>
</tr>
<tr>
<td>Any equipment or dressings you require</td>
</tr>
<tr>
<td>Your discharge letter</td>
</tr>
<tr>
<td>Any outpatient appointment details you require</td>
</tr>
<tr>
<td>Have you completed your ‘Friends and Family’ questionnaire?</td>
</tr>
</tbody>
</table>

Hospital Contact Numbers: University Hospital of North Durham- 0191 333 2333
Darlington Memorial Hospital - 01325 380 100
Bishop Auckland Hospital - 01388 455 000
Appendix 11

Equality Analysis / Impact Assessment

Full Assessment Form v2/2011

Division/Department: Corporate Nursing

Title of policy, procedure, decision, project, function or service: Discharge and Going Home Policy

Lead person responsible: Associate Director of Nursing: Effectiveness

People involved with completing this: Clinical Audit and Effectiveness Manager
Clinical Effectiveness Lead

Type of policy, procedure, decision, project, function or service:

- Existing
- New/proposed
- Changed ☒
Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

The policy provides a framework for CDDFT hospitals to ensure a safe and effective planned discharge process for patients going home.

Who is the policy, procedure, project, decision, function or service going to benefit and how?

Patients will receive a safe and effective planned discharge from a CDDFT hospital.

What outcomes do you want to achieve?

Staff will have a framework for discharge arrangements to ensure safe and timely transition of patients to their home.

What barriers are there to achieving these outcomes?

Delays in decisions to discharge patients
How will you put your policy, procedure, project, decision, function or service into practice

Policy will be disseminated Trust wide, available on the Trust intranet and essential training.

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

Yes – aligns to the Clinical Handover of Care on Transfer Policy

Step 2 – Collecting your information

What existing information / data do you have?

Previous Discharge and Transfer Policy. Emergency Pressures and Bed Escalation Policy is in place and staff awareness of the policy.

Who have you consulted with

Nursing, medical and other Allied Health Professionals across the Trust.
Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race
No impact or potential for impact on any group.

Sex/Gender
No impact or potential for impact on any group.

Age
No impact or potential for impact on any group.
<table>
<thead>
<tr>
<th><strong>Disability</strong></th>
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<tbody>
<tr>
<td>No impact or potential for impact on any group.</td>
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<table>
<thead>
<tr>
<th><strong>Religion or Belief</strong></th>
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<tr>
<td>No impact or potential for impact on any group.</td>
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<table>
<thead>
<tr>
<th><strong>Sexual Orientation</strong></th>
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<tbody>
<tr>
<td>No impact or potential for impact on any group.</td>
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<thead>
<tr>
<th><strong>Marriage and Civil Partnership</strong></th>
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<tbody>
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<td>No impact or potential for impact on any group.</td>
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<thead>
<tr>
<th><strong>Pregnancy and Maternity</strong></th>
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<tbody>
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<td>No impact or potential for impact on any group.</td>
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<tr>
<th><strong>Gender Reassignment</strong></th>
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<tr>
<td>No impact or potential for impact on any group.</td>
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</table>

**Other socially excluded groups or communities e.g. rural community, socially**
excluded, carers, areas of deprivation, low literacy skills

No impact or potential for impact on any group.

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

N/A

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act?

Yes ☐ No ☒
Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

The policy was previously integrated with the Discharge and Transfer Policy has been in existence since 2004.

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

N/A

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

See monitoring table in this policy for details.

Step 6 – Completion and central collation
Once completed this Equality Analysis form must be attached to any documentation to which it relates and must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk