Policy Document Control Sheet

County Durham and Darlington NHS Foundation Trust

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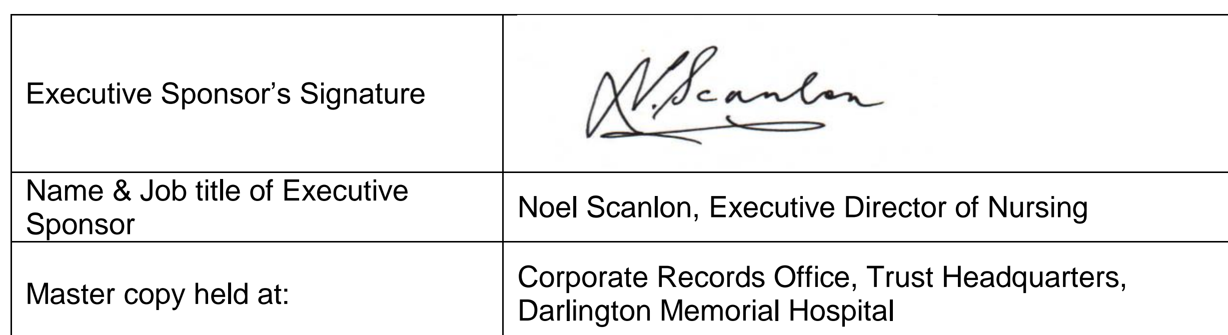

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1 INTRODUCTION

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 Foundation Trust (CDDFT) 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.

The consequences of a patient[1] who is ready for discharge remaining in a hospital bed might include:

- Exposure to an unnecessary risk of hospital acquired infection;
- Physical decline and loss of mobility / muscle use[2];
- Frustration and distress to the patient and relatives due to uncertainty during any wait for a preferred choice to become available;
- Increased patient dependence, as the hospital environment is not designed to meet the needs of people who are medically fit for discharge[3];
- Severely ill patients being unable to access services due to beds being occupied by patients who are medically fit for discharge.

2 PURPOSE

This policy is intended to assist all staff, working across all sites with County Durham and Darlington Foundation Trust (CDDFT), 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 patients and/or carer to ensure a smooth transition from hospital care, to their discharge destination.

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[1] The term 'patient' is used throughout this policy to refer to the individual receiving treatment

[2] Kortebein, P. et al (2008). *Functional impact of 10 days of bed rest in healthy older adults.* J Gerontol A Biol Sci Med Sci. 31(10):1076-81.

[3] Monk, A. et al. 2006. *Towards a practical framework for managing the risks of selecting technology to support independent living.* Applied Ergonomics, Vol. 37(5)

- Patients, where able, will be involved in any discussion in preparation for discharge and any associated choice. Continuity of care should be maintained if a patient transfers from one care setting to another.
- Patients will be discharged from CDDFT acute setting when no further acute medical intervention is required. Factsheet A, Letter A and Letter B from the Supporting Patients' Choices to Avoid Long Hospital Stay Policy, Appendix 12, is designed to facilitate this process.

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 temporary/permanent residence.

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.

This policy/procedure also applies to persons who, although not employed by The Trust, have authorised access to the Internet through the computers owned or managed by The Trust. This includes staff working for any affiliated organisations and includes County Durham and Darlington NHS Services (CDD NHS Services)

4 Duties

4.1 All staff:

All staff are responsible for:

a) Ensuring that the discharge plan in the patient record, documents the individual members of the multi-professional team involved in care, dates of referrals, actions to be taken and outlines agreed discharge criteria. The plan is a record of communication between the patient, family, carers and multi-professional team.

b) Keeping the patient and family or friends (if applicable) informed of the proposed length of hospital stay, and where possible, 24 hours' notice of the actual date of discharge will be given to the patient and carers where appropriate in order to allow preparatory arrangements to be made.

The ward multi-disciplinary team should work collaboratively with the patient and their carers to plan care, agree who is responsible for specific actions and make decisions on the process and timing of discharge.

Using the 'Safer' initiative principles, each ward must hold a minimum of a 2 daily "Board Rounds" where nursing and medical staff, allied health professionals and other professionals have a responsibility for attending. This meeting compliments the discharge planning process, discussing each patient and focuses on improved communication, timely decision making and reducing delays and barriers to discharge.

- 'Home first' principle should be the focus of all discharge planning, together with the use of Criteria Led Discharge;
- Teams Around Patients (TAPs) in home/community care settings;
- Discharge to assess pathways where appropriate,
- Optimising the use of discharge lounges.

All discharges should, where possible, be planned to take place before 11:00 and 14:00 (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 (Staff Nurse, Team Around Patients Leads (TAPs) to discuss any remaining concerns they may have. These concerns, if left unanswered, may result in a further unnecessary admission.

All patients must have an estimated discharge date set and documented within 24 hours of admission. This date should appear on the ward's NerveCentre screen. Patients identified at each Board Round for Criteria Lead Discharge should be also be included on NerveCentre.

4.2 Integrated Quality Assurance Committee (IQAC)

The IQAC 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.

4.3 The Consultant and Medical Team

The Consultant and medical team:

- Identify the '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 Multidisciplinary Team (MDT).
- Deciding and documenting when a patient is medically fit for discharge and for setting criteria that allows the patient to be discharged by a non-consultant to avoid unnecessary delay.
- Prescribe take home medication 24 hours prior to the EDD.
- Medical staff are responsible for completing the discharge summary and prescription, which will accompany the patient on discharge and a copy will be sent directly to the GP within 24 hours of discharge.
- 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 electronic letter as soon as possible.

4.4 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 or meetings, regular audit forums and the development of any resultant service improvement.

4.5 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 'Choice Policy' (**see Appendices 11, 12 & 13**) as well as managing the patient and families/ carers expectations.

4.6 Ward/Department Nurses

The nurse in charge of each ward is responsible for the overall co-ordination of effective discharge planning.

The Registered Nurse is:

- Responsible for assessing the patient's health and social care needs at pre-admission clinic, on admission or within 24 hours of admission and must complete the admission assessment document identifying the discharge needs for that patient.
- Encouraging and supporting the self-management of patients e.g. self-administration of insulin or anticoagulant
- Accountable for co-coordinating the discharge plan for each patient they are responsible for on a shift by shift basis (The Registered Nurse is referred to as the nurse throughout this policy).
- Responsible for ensuring that the Nerve Centre is kept up to date to ensure the Hospital Site Co-coordinator is aware of all *actual and potential discharges for that day*. Where appropriate the Discharge Lounge staff will be informed as soon as possible on the day of the discharge and will arrange to collect patients from the ward.
- Responsible for ensuring that the prescription is dispensed prior to discharge and that the medications are explained to the patient and understood by them.
- Ensures 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.

4.7 Discharge Management Team

The Discharge management Team (DMT). The main role for the Discharge Management Nurse is to provide education and training and manage complex discharges.

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 across the health and social care community, fostering and facilitating multi-professional interagency working and education in respect of adult complex, intermediate care, delayed discharge management and the continuing care process.
- act as an expert resource on Adult Complex Discharge and Delayed Transfers of Care, to support the provision if accessible, accurate and relevant information to managerial, medical and nursing staff within the Trust as well as to the Local Authority staff (social workers).

4.8 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.
- Attend the board rounds to ensure co-ordinated plans are in place
- Supporting and educating patients /carers in preparation for discharge
- Providing current contact names and numbers in case of difficulties
- 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.
- Ensure that the patient receives equipment aids and that the patient and carers are safe and competent to use them.
- Liaise with community-based counterparts and partner agencies as required.

4.9 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.

4.10 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.
- Escalate any specific outstanding issues regarding the discharge process.

5 DISCHARGES 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 for patients waiting for transport or they require an ambulance they should be transferred to the discharge lounge if appropriate. (There are additional requirements for discharges from the Emergency Department see Appendix 4)

An Estimated date of discharge (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 patients.

'Your hospital stay' document should be given to all patients on admission to ensure that they and their family are aware of the processes that will be followed as part of their stay in hospital

During the planning process individual needs of the patient should be identified to expedite any referrals to the Discharge Management Team. If a patient's discharge is identified as likely to be complex, a referral via nerve centre should always be made to the 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 20.00hrs 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 will be issued to the patient's general practitioner for receipt within 24hrs of the patient going home.

  This letter must be checked through with the patient before they leave the hospital to ensure they understand the next steps, any medication changes and what treatments and investigations they have had.

5. 1 Discharge process out of hours

The processes described above must be followed in the same way as the in-hours service. Vulnerable children and adults should not be discharged out of hours. The nurse has a duty of care to ensure adequate and safe discharge arrangements are in place and must inform the GP or the Social Services emergency duty team if appropriate the following day
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 Patient Flow Team (PFT) and given to the Discharge Management Team.

Examples of unplanned arrangements out of hours' may occur include:

- Self-discharge
- Ambulance transport issues

The reasons for <u>all</u> out of hours discharge should be clearly documented 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.

5.2 Communication and Involvement (Choice Policy)

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 '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 with their permission so that patients home environment is appropriately prepared for going home.

Patients should not be expected to make decisions about their long-term future while in hospital; home care, reablement or intermediate care or other supportive options should be explored first, where that is appropriate to their needs.

All possible efforts should be made to support people to return to their homes instead of residential placements, with options around home care packages and housing adaptations considered where identified needs can be safely met.

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 Nurse etc.

For those patients who are unable to communicate in English, then a translation service is available from Everyday Language SolutionPOL/PD/0054 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 Everyday Language Solutionsho can be contacted via the hospital switchboard. Interpreting services and appropriate communication aids are available if required. Refer to POL/PD/0054 Interpreting and Translation Service

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

5.3 Mental Capacity

Many patients will want to involve others to support them, such as family or friends, carers or others. Where the patient has capacity to make their own decisions regarding discharge plans, this should be respected as their individual decision to make an informed choice.

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 then a best interest decision making meeting shall be undertaken in accordance with the Mental Capacity Act 2005 (including the Deprivation of Liberty Amendment 2009). This will need to include social Care, nursing/medical/therapy staff, the discharge team, carers, family and the patient if able. If the patient is un befriended or has no family to support this decision the tTrust should seek to appoint an Independent Mental Capacity Advocate to support the individual in decision making where necessary.

5.3.1 Independent Mental Capacity Advocate (IMCA):

Where the patient is assessed as not having the capacity to make the discharge decision for themselves and where there is no-one appropriate other than paid carers to consult with, the patient has a statutory right to the support of an IMCA in circumstances where long term care decisions are being made. A referral to the IMCA service **must** be made. Where the local authority is placing the patient then it will usually refer the patient to an IMCA but where the NHS is responsible for the placement then the ward should make the referral

5.3.2 Best Interest meeting

For patients who've been assessed as lacking capacity to make decisions about their care needs, or place of discharge, a Best Interest Meeting will need to take place. This will need to include Social Care (they are the decision maker for accommodation/ placement), nursing/ medical/ therapy staff (as appropriate), Discharge Team, other carers from the community, family, friends/ IMCA and the patient if able. If the patient has a LPA for Health & Welfare, the named attorney must be involved, and is the decision maker, not the social worker. There is a Statutory Best Interest Checklist (Form MCA 2) to support decisions and documentation available on the intranet.

5.4 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 1. 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, voluntary services 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.

5.5 Complex discharge

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

Complex discharges may also include patients deemed vulnerable who may be less able than others to voice their wishes and any concerns.

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

- Patients with complex on-going health and social care needs who are being discharged home with a package of care e.g. the frail, elderly, those who live alone or those with mental ill health / dementia
- Discharge to another care setting e.g. nursing home
- Patients who lack capacity to make a decision about their long term care needs (including some patients with Learning Disabilities)
- Patients with mental ill health
- End of life care, for those not wishing to die in hospital
- Patents who are homeless
- Those in prison
- Children, or young people who may be at risk of harm or have suffered harm
- Adults where there is a safeguarding concern. (refer to Safeguarding adult's policy).
- Patients with capacity who are medically fit for discharge but are refusing to leave the hospital.

Once a patient has been identified as having complex needs a plan of care and capacity must be identified.

- They should be referred, as soon possible after admission, as a complex patient on NerveCentre to trigger the Discharge Management Team.
- 'Home first principle' should be followed as a target and address the associated risks wherever possible
- Any patients who have rehab potential should not have a CHC checklist completed until they have completed their rehabilitation and a clear vision of what there care needs are.

5.6 Referrals to Social Services

- Referrals to Social Services made from CDDFT will be accepted as formal notification of the need for an assessment for care support, even if the patient is already in receipt of social care services. Response time generally within 2 working days.
- Referrals to Social Services can be made for assessment about the best care options on discharge where it is identified they will have ongoing care needs (it is not necessary to wait for a clinical decision of medically fit).
- 'Home first' and 'discharge to assess' will always be considered as part of the triage and assessment process.
- Placement will only be considered when needs cannot be safely be met at home and the risks managed.

NB The patient's consent must be obtained and they must be fully and directly involved in the decision making process.

5.7 Discharge Requiring Continuing Healthcare including fastracking

A full assessment for NHS CHC should only be undertaken where the longer-term needs of the individual are clear. In the majority of cases, these assessments should be conducted outside of hospital within a reasonable time frame and should not be a reason for delaying discharge to care outside of hospital. However, if the individual has a 'rapidly deteriorating condition which may be entering a terminal phase' the NHS CHC Fast Track Pathway should be considered.

In accordance with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care the CCGs and their partner organisations should ensure appropriate processes and pathways exist for individuals who may have a need for NHS Continuing Healthcare, for example:

a) rather than completing a Checklist in hospital a decision is made to provide interim NHS-funded services to support the individual after discharge. In such a case, before the interim NHS-funded services come to an end, screening, if required, for NHS Continuing Healthcare should take place through use of the Checklist and, where appropriate, the full MDT process using the DST (i.e. an assessment of eligibility); or

b) a 'negative' Checklist is completed in an acute hospital (i.e. the person does not have a need for NHS Continuing Healthcare) in which case, where appropriate, an Assessment Notice may be issued to the local authority; or

c) a 'positive' Checklist is completed in an acute hospital and interim NHS-funded services are put in place to support the individual after discharge until

it is either determined that they no longer require a full assessment (because a further Checklist has been completed which is now negative) or a full assessment of eligibility for NHS Continuing Healthcare is completed; or

d) a ‘positive’ Checklist is completed in acute hospital and (exceptionally and for clear reasons) a full assessment of eligibility for NHS Continuing Healthcare takes place before discharge. In a small number of circumstances it may be decided to go directly to a full assessment within the acute hospital, without the need for a Checklist. If the full assessment does not result in eligibility for NHS Continuing Healthcare then, where appropriate, an Assessment Notice may be issued to the local authority; or,

e) where the individual has an existing package or placement which all relevant parties agree can still safely and appropriately meet their needs without any changes, then they should be discharged back to this placement and/or package under existing funding arrangements. In such circumstances any screening for NHS Continuing Healthcare, if required, should take place within six weeks of the individual returning to the place from which they were admitted to hospital. If this screening results in a full assessment of eligibility and the individual is found eligible for NHS Continuing Healthcare through this particular assessment, then re-imbursement will apply back to the date of discharge.

First step = Completion of the CHC checklist to initiate the assessment process.

- A trained nurse who knows the patient must complete the CHC screening checklist.
- The checklist should be completed when the patient’s needs on discharge are clear
- The patient should be involved in the completion of the checklist and offered the opportunity to have a representative 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 assessment, a referral to Social Services can be made if there is a need identified for ongoing care.

If the outcome of the screening checklist is that the patient meets the criteria for CHC assessment i.e. it is a YES Checklist; a copy must be forwarded to the CHC office to initiate a full assessment of the patient. Until funding is approved, discharge arrangements cannot take place. This does not necessarily mean that the patient needs to remain in hospital until this formal agreement (assessment of the funding) takes place.

Patients referred for Continuing Health Care (CHC) funding with a completed and appropriate checklist will subsequently be referred to Social Services by the CHC team. 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 process for CHC is summarised in the flow chart in Appendix 2.

5.8 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, care home or hospice and an appropriate clinician considers that a person has a primary health need and

- When expectation is either for continual sustained or rapid deterioration
- where person is identified as being end of life stages of a terminal illness

For patients who are near the end of their life and who wish to be discharged home for their remaining days, the NHS Continuing Healthcare Fast Track Tool must be completed.

This document is the process for financial authorisation for urgent care and should be completed by relevant staff together with the appropriate consent. It is the responsibility of the CHC team to arrange the care package/placement.

If planning to go home the allocated nurse should contact the District Nursing Team and GP and liaise with the MDT (including CHC, Macmillan Carers, social services and Marie Curie) to support coordination and meet the needs of these patients.

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

5.9 Community nursing

Patients requiring community nursing following discharge must be referred not less than 48 hours prior to discharge. This applies to patients returning 'home' or to residential care i.e. not a nursing home bed as the nurses employed by the home to carry out regular nursing tasks. Always ensure there is a 7 day supply of dressings etc. to facilitate a safe and effective discharge and the nurse handover sheet is completed and forwarded to the service.

5.10 Managing the discharge process in a timely way

Patients should be involved in all decisions about their care, as per the NHS Constitution, and should be provided with high quality support and information in order to participate, where possible. In the context of a discharge decision, the information relevant to the decision will include an understanding of their care needs on discharge, the process and outcome of the assessment of needs, offers of care and options available.

The process of offering choice of care provider and/or discharge destination will be followed in a fair and consistent way and there will be an audit trail of choices offered to people.

Interactions with patients will acknowledge and offer support to address any concerns.

If a patient is not willing to accept any of the available, appropriate alternatives, then it may be that they are discharged, after having had appropriate warning of the risks and consequences of doing so as identified in the Supporting Patients'

Choice to Avoid Long Hospital Stay. This option would only be pursued following the offer and rejection of available, appropriate options of care and appropriate safeguards and risk assessments. For patients who may lack capacity to make their own discharge decisions , see 5.2.

If a patient is medically fit for discharge, it is not suitable that they remain in hospital due to the negative impact this can have on their health outcomes.

- Patients do not have the right to remain in hospital longer than required

- Except where a patient with the relevant capacity has made an informed decision to discharge himself/herself against the advice of health or social care professionals, the discharge process must not put the patient or their carers at risk of harm or that could breach their right to respect for private life. It should not create a situation whereby the independence of the carer or the sustainability of their caring role is jeopardised.

- The process and timelines within this policy should be clearly communicated to the patient so that by the time a patient is medically fit for discharge they are aware of and understand the discharge process, the decisions and actions that they may need to undertake and the support they will receive.

- If a patient's preferred care placement or package on discharge is not available when they become medically fit for discharge, an available alternative which is appropriate to their health and care needs will be offered on an interim basis, whilst they await availability of their preferred choice.

5.11 Funding Arrangements

This policy applies equally to people regardless of the funding arrangements and the nature of their on-going care.

Those self-funding care will be offered the same level of advice, guidance and assistance regarding choice as those who are fully or partly funded by their local authority or NHS Continuing Healthcare (CHC), although it is likely that some of the content will need to differ.

5.12 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 discharges 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.
- Referral to Care Home Selection supported by Social Worker.

Remaining in an acute bed is not an appropriate option if the patients' in-patient care is complete, and they are medically fit for discharge. All stakeholders must 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:

- The patient waiting to be discharged is in an inappropriate care setting for their health, social and pastoral needs.
- Prevents other patients being admitted to hospital and obtaining treatment in a timely fashion
- Potential for increased patient wait times, cancellations and delays for patients scheduled for elective admissions.

5.13 Decision to discharge agreed

When the multidisciplinary assessment of the patient indicates that the individual is medically fit for discharge and relevant decisions such as Best Interest decisions or CHC decisions have been taken into account, 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 12 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, if referral necessary. This will include details of the patient's care 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 in the Locality area in which they work.

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 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. Distance from family is not a determinant
- The case 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.

5.14 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:

- The Ward Manager will arrange a meeting to coincide with the Supporting Patients' Choice 7 day process; if the patient has not been discharged by day 5 an MDT will be arranged to agree the next steps. The MDT will ensure that all appropriate actions have been taken before the meeting is arranged and the Supporting Patients Choices, Letter B, to include detail of the meeting outcomes, will be given to the patient after the meeting.

- The social worker/case worker will be invited to attend.

- The Matron/Senior Nurse for Discharge/Clinical Service Manager for the area will be in attendance to chair the meeting. If the patient is in a community hospital, a GP may wish to attend.

- Any therapy specialists will be invited to attend/input.

- The invitation will advise on the role of Patient Experience Team 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

Details of this discussion will be confirmed with the patient and/or carer by using the Supporting Choices Policy Letter B; a copy will be retained in the patient's health records.

5.15 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 Ward Manager/Matron will arrange a further MDT meeting with the patient/relative/carer to discuss their discharge plans within 2 working days of the expiry of the 7 day deadline.

The Ward Manager/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 Ward Manager/Matron/Clinical Service Manager will confirm the discussion in writing, using Letter B, 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)
- Senior Nurse Integrated Discharge

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.

5.16 Transport

When starting the discharge planning process, nursing 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 an anesthetic
- 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, the ward staff 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.

5.17 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. The Duty to Refer (October 2018) must be followed.

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.).

5.18 Nurse/Therapy/Criteria Led Discharge

Where there is 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.

5.19 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 to be administered. 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 must be counselled 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 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.

5.20 Feeding systems in community (Dietetics)

For patients who have been identified as requiring home enteral feeding post hospital discharge; 4 working days' notice must be given to the dietician to organise pre discharge training with patient/carers and set up the system for home - if this has been instigated during this hospital stay. Where patients are being transferred to Nursing or Care homes or other hospitals where staff are

identified as competent users of feeding systems then 2 working days' notice is needed. For complex patients with established home enteral feeding regimens this is not required.

Please ensure that all patients are discharged home with a 7 day supply of; enteral feed, enteral syringes and giving sets (if pump fed). If the patient is fed via a nasogastric tube they should be supplied with pH paper. If the patient is pump fed, a pump and a stand should be provided for discharge. Pumps and stands will be supplied by the Dietician.

5.21 Discharge Letter

A discharge letter must be completed using iSoft and 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 should 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

5.22 Patient Information

To ensure safe transition home the patient must be provided with all relevant information prior to them leaving the hospital.

The nurse will check that the patient has understood the following

- What has happened
- What will happen next
- The medication prescribed to them or any that has changed, the purpose, possible side effects
- Information at the point of discharge, this should include:

- Final discharge letter if requested by the patient
- Medication information
- Other relevant information such as
  - Post-operative advice sheets, warfarin booklets or infection control advice,
  - Specific wound chart, SALT guidelines, feeding regimes, medication regimes,
  - DNACPR
  - 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.

5.23 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 to be carried out and documented on any transfer.

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.

Patients taking warfarin must have their medication chart emailed to relevant anticoagulation clinic as per "PROC/MM/0015: Oral anticoagulation with warfarin - adult patient management guidelines (including bleeding with NOACs)".

5.24 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, ward nurse or discharge lounge staff (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.

5.25 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.

5.26 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 and all the relevant facts are recorded in the patient record.

Any request by a patient to discharge themselves should be taken seriously. A self-discharge form (Appendix 9) will be completed, signed by the patient and retained in the patient record. If the patient is unwilling to provide a signature, this must be clearly documented in the patient record. Further guidance and the required document to be completed can be found in Appendix 9.

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.

In instances where the patient lacks capacity steps should be taken in the patients best interests.

If it is considered the patient has a mental health disorder which is contributing to their decision to self-discharge or by self-discharging they may come to harm the medical team must be involved

5.27 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.

5.28 Training

The Discharge Management Team has responsibility for updating nursing staff on use of any new documentation and changes in the discharge policy. Instruction on discharge process and planning will be provided by the discharge management team

5.29 Patient Who Refuse Discharge

On rare occasions a person with capacity 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 on-going 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.

A patient who may require residential or nursing home care or other community care facilities, should be supported using the supporting patients' choices to avoid delayed discharge.This policy supports people's timely, effective discharge from an NHS inpatient setting, to a setting which meets their individual needs and is their preferred choice amongst available options. All staff should ensure that they adhere to the process set out within the policy which provides a framework to ensure effective communication, expectations and timelines. This also supports existing guidance on effective discharge, such as the 2015 NICE guidance 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs' and is based on existing good practice.

5.30 Adult Safeguarding Concerns

If staff are concerned that, or it is disclosed that a Vulnerable Adult is at risk of, or may have suffered harm or abuse, ring Adult Social Care (refer to Safeguarding Vulnerable Adults/ Adults at Risk Policy). Where a Safeguarding alert has been raised, liaison with Social Care must take place before a patient a patient is discharged

6 DEFINITIONS

6.1 Glossary of Terms Used

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).

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

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.

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.

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:

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

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.

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.

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

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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

Monitoring Criterion	
Who will perform the monitoring?	Ward Managers Discharge Management team (DMT) Information department Matrons Pharmacy
What are you monitoring?	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
When will the monitoring be performed?	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
How are you going to monitor?	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
What will happen if any shortfalls are identified?	Designated Service leads, Matrons and medical staff will be responsible for developing and implementing an action plan to address shortfalls.

Where will the results of the monitoring be reported?	Quality and Healthcare Governance Committee Care Group Governance meetings Care Group Governance meetings Staff meetings
How will the resulting action plan be progressed and monitored?	Action plans will be developed within the Care Groups and monitored via the Quality and Healthcare Governance Committee and Safety Committee
How will learning take place?	Outcomes will be shared via: Trust wide Matrons Meetings, Nurse Leader Away Days & Care Group Governance Meetings. Any Trust wide key messages will be disseminated by the Quality and Healthcare Governance Committee.

9 ASSOCIATED DOCUMENTATION

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

References

Care Act 2014 DH 2014
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Safely Home: What happens when people leave hospital and care settings? Healthwatch England July 2015

Guide to reducing long hospital stays NHSI 2018
https://improvement.nhs.uk/resources/guide-reducing-long-hospital-stays/

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

Delayed transfers of care: a quick guide 2017
https://www.kingsfund.org.uk/publications/delayed-transfers-care-quick-guide

Ensuring the Effective Discharge of Older Patients from NHS acute hospitals HMSO (2003) Human Rights Act (2003), Office for Public Sector Information
http://www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1

National Assistance Act (1948), Office for Public Sector Information
http://www.opsi.gov.uk/revisedstatutes/acts/ukpga/1948/cukpga_19480029_en_1

NHS and Community Care Act (1990), Office for Public Sector Information http://www.opsi.gov.uk/acts/acts1990/ukpga_19900019_en_1January 2011

The National Framework for NHS Continuing Health Care and NHS-funded Nursing Care, October 2018 (Revised) Department of Health

Getting it right for people with dementia, DoH July 2003

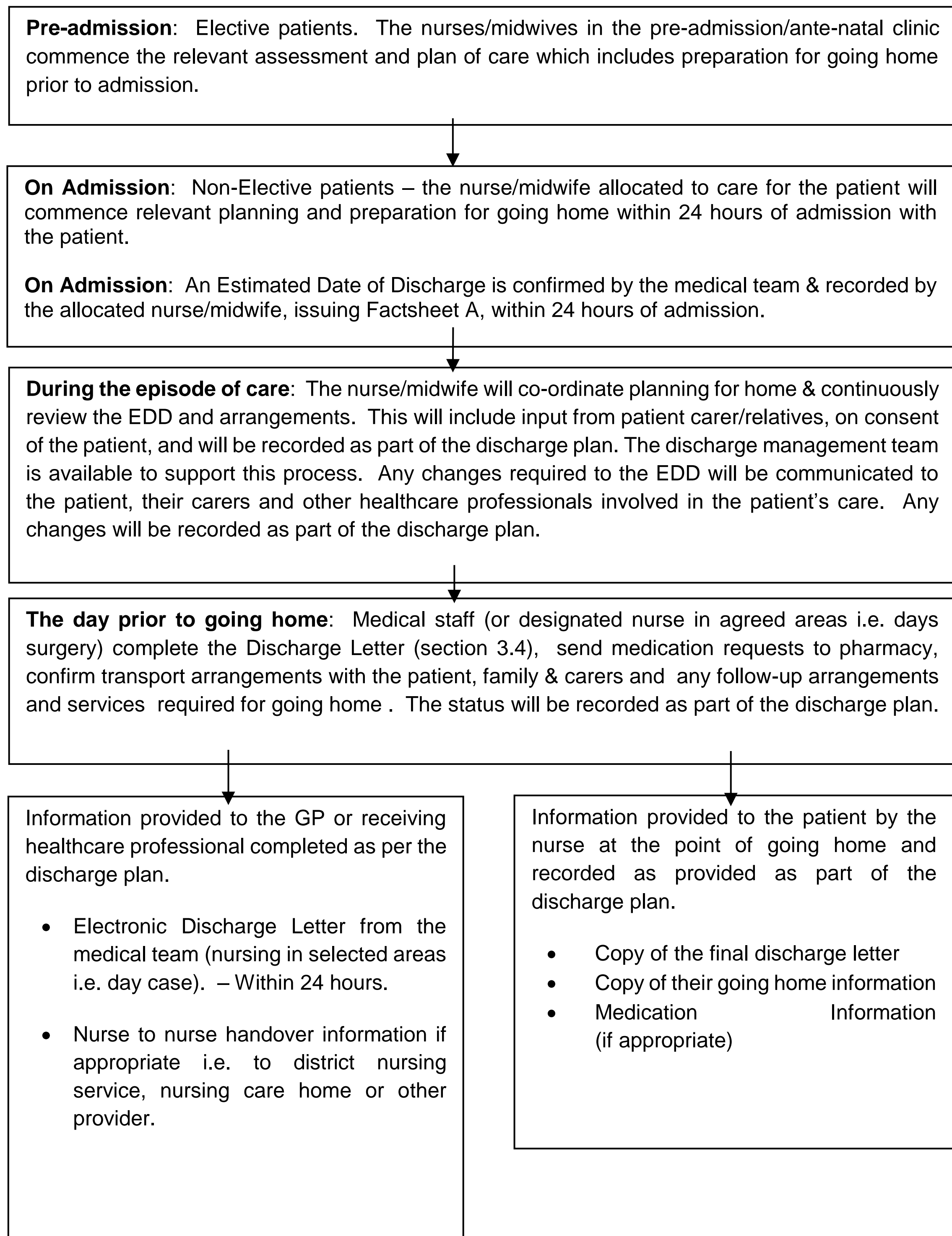
National Audit of Dementia Round 2, Royal College of Psychiatrists 2012

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

Homelessness – Duty to Refer October 2019 https://www.gov.uk/government/publications/homelessness-duty-to-refer

10 APPENDICES

10.1 Appendix 1 – Simple Discharge Process (all)



10.2 Appendix 2 - 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, as the CHC team will do this.

- Fast track for immediate CHC funding – patients with a rapidly deteriorating condition, which may be entering a terminal phase
- 'No' Checklist – retained in patients records

Referral to Social Services

Referrals can be made following 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 by telephone (0845 8505010) or Integrated Quality Assurance Committee Darlington: - 01325 745600

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

10.3 Appendix 3 - 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.
- Hospital 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. and liaise with Social Service Department OT to assess for minor and major adaptations.

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

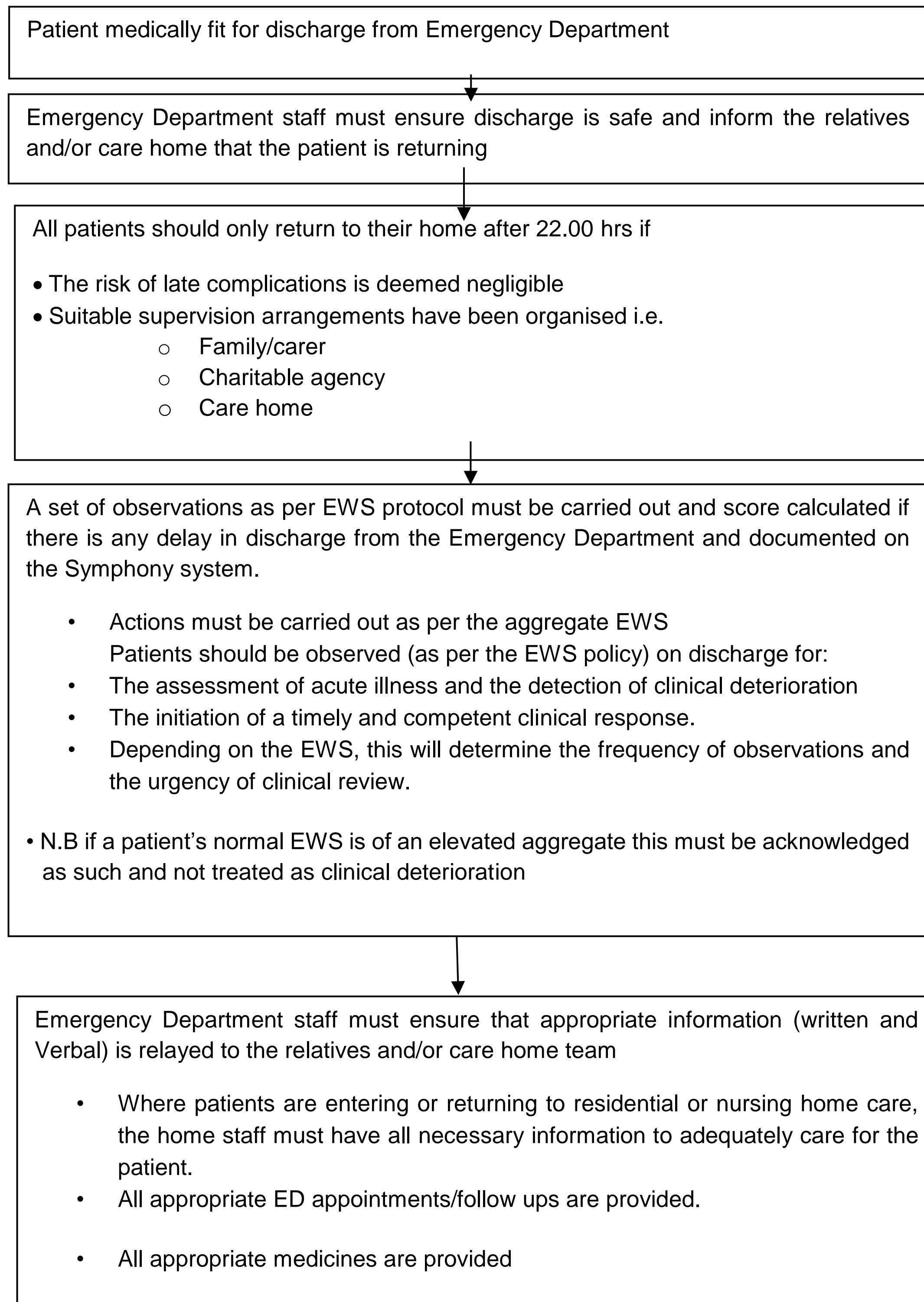
↓

DMT orders will be referred to the district nurse for. A member of the team will liaise with the ward to inform them of the need for the equipment.

↓

OT service will ensure appropriate followed up to ensure the equipment is working and safe to use

10.4 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.

- N.B if a patient's normal EWS is of an elevated aggregate this must be acknowledged as such and not treated as clinical deterioration

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.
- All appropriate medicines are provided

10.5a Appendix 5a - 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,

10.5b Appendix 5b - 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.

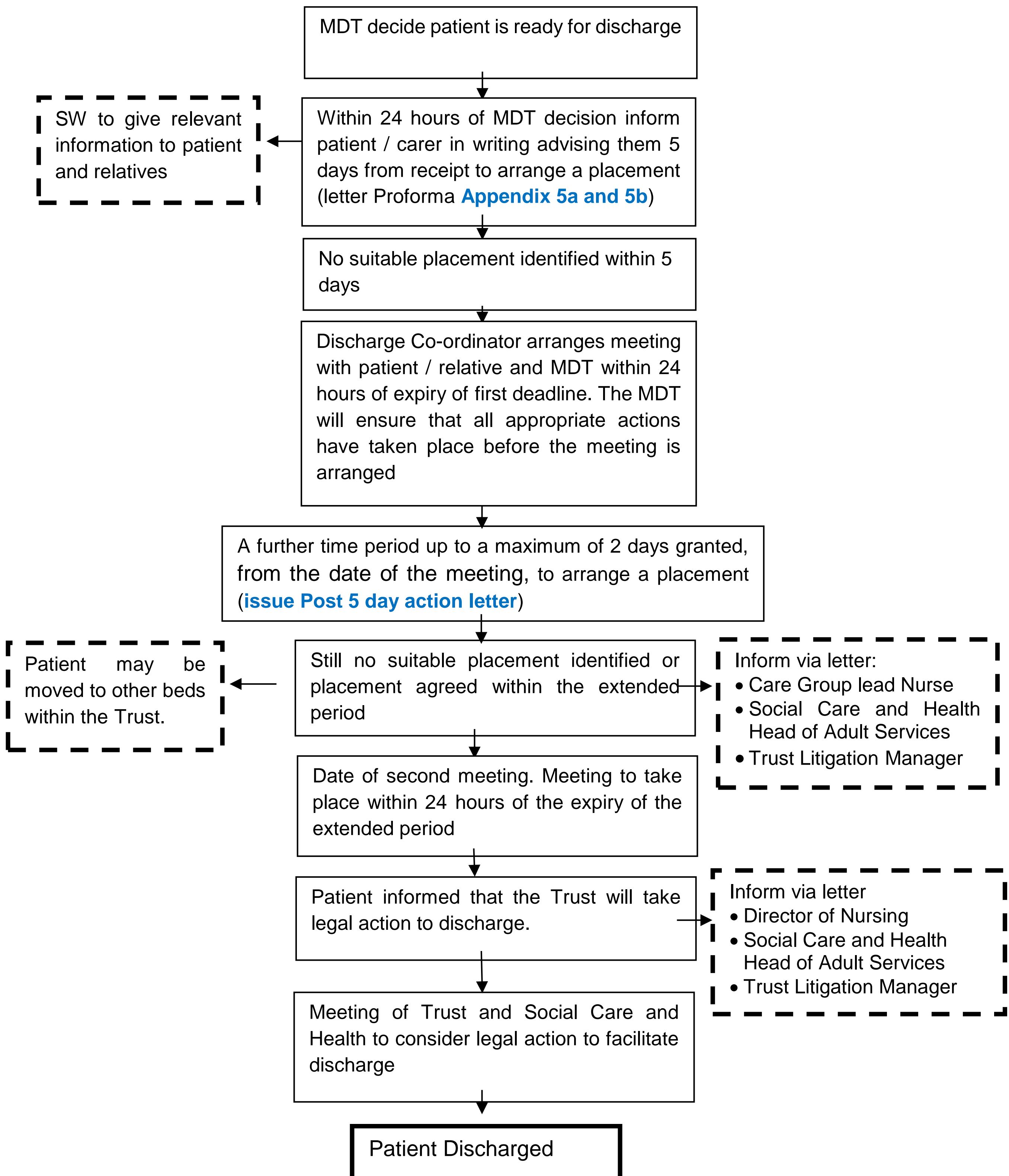
We recognise that this decision is a major one and that you will require support and advice to guide you through the process of finding a suitable care home. To help you with this, regular contact can be maintained with the nursing team (this may be the discharge coordinator) or your Social Worker.

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.

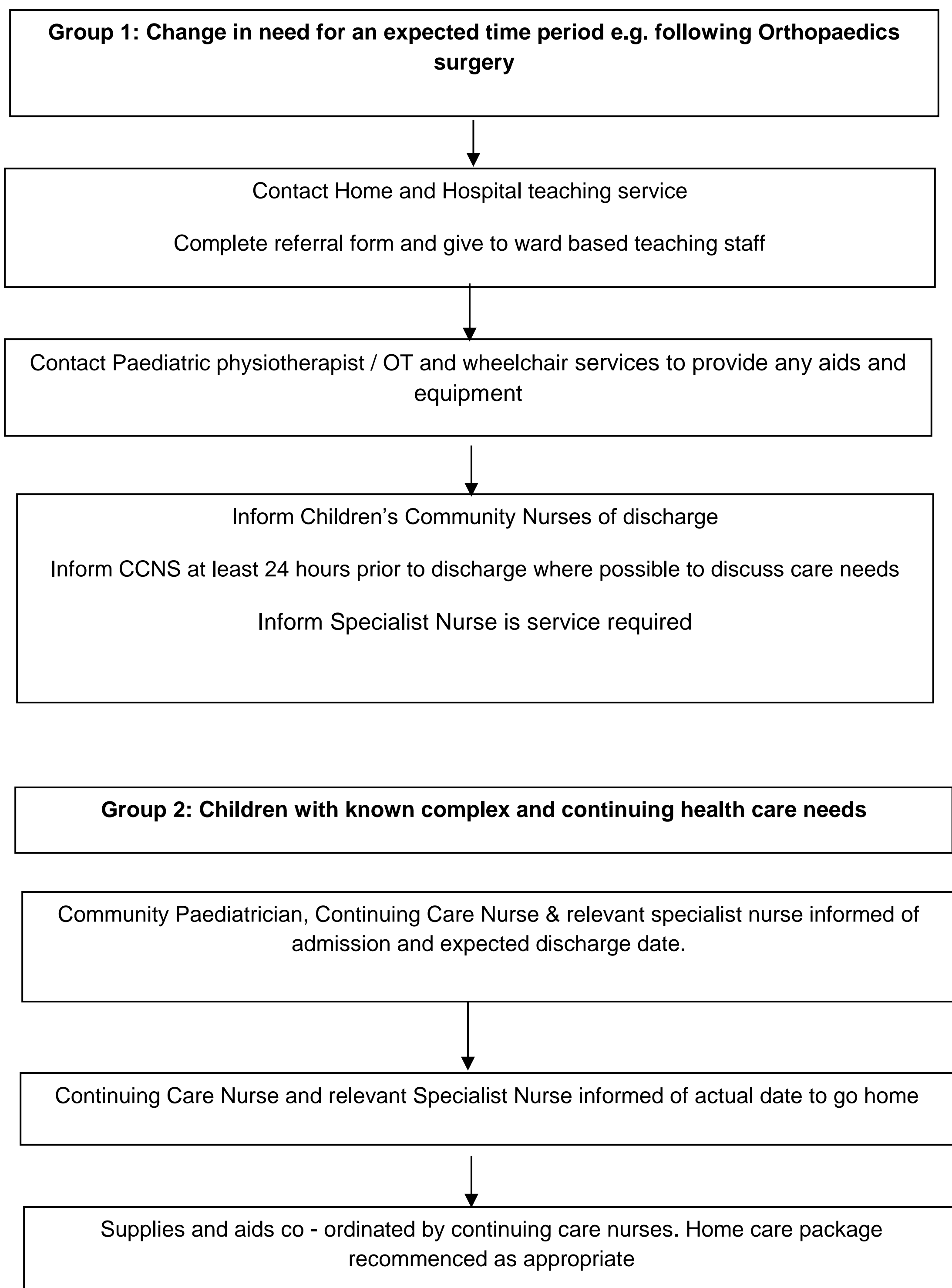
Yours sincerely,

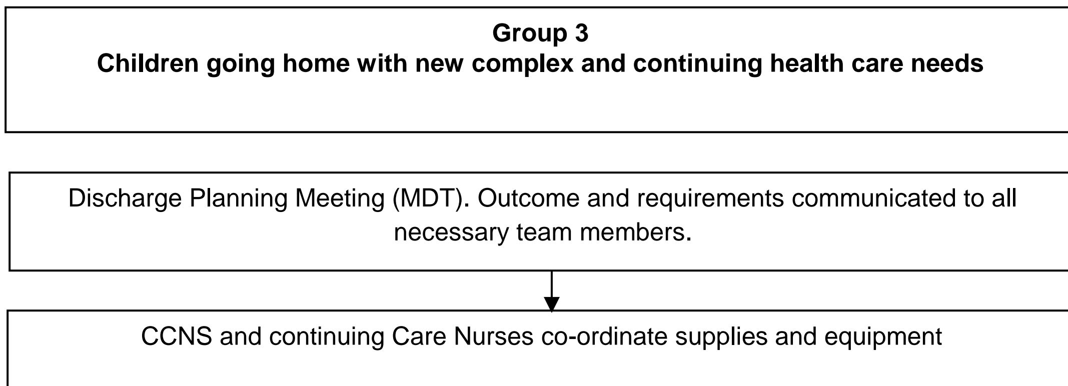
10.6 Appendix 6 - Managing Discharge from Hospital to Care Home

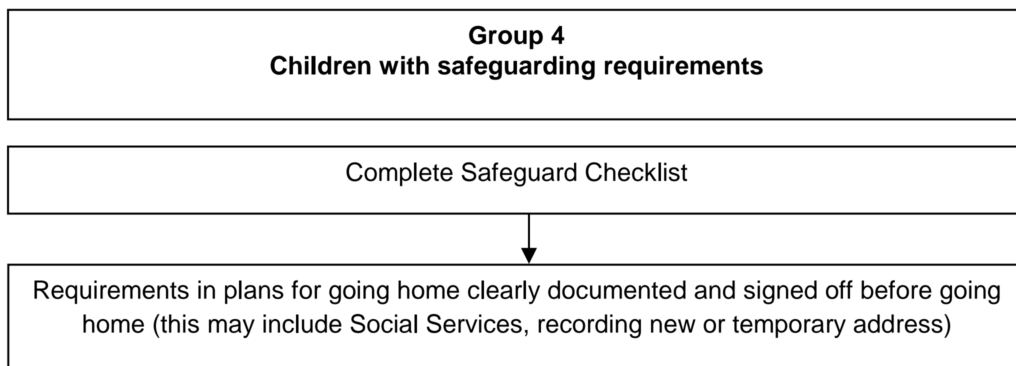


10.7 Appendix 7 - Discharge for Paediatric patients with complex care needs

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







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.

10.8 Appendix 8 - Discharge Medication Guidance

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-labelled 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 24hours notice to re-initiate supply.

  http://intranet/Directorates/CCG/ALTC/Pharmacy/Shared%20Documents/Guidelines/How%20to%20ensure%20continuity%20of%20medicines%20when%20transfering%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')

  http://intranet/Directorates/CCG/ALTC/Pharmacy/Shared%20Documents/Guidelines/How%20to%20Guide%20-%20Arrangement%20of%20multicompartment%20compliance%20aids%20at

%20point%20of%20discharge%20v1%200.pdf)

- 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 form 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-labeled 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%20transfering%20patients.pdf

- *Is there an over-labeled supply of the medication available within the hospital?*
  - Many wards within the hospital have a supply of medication that has already been labeled 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.

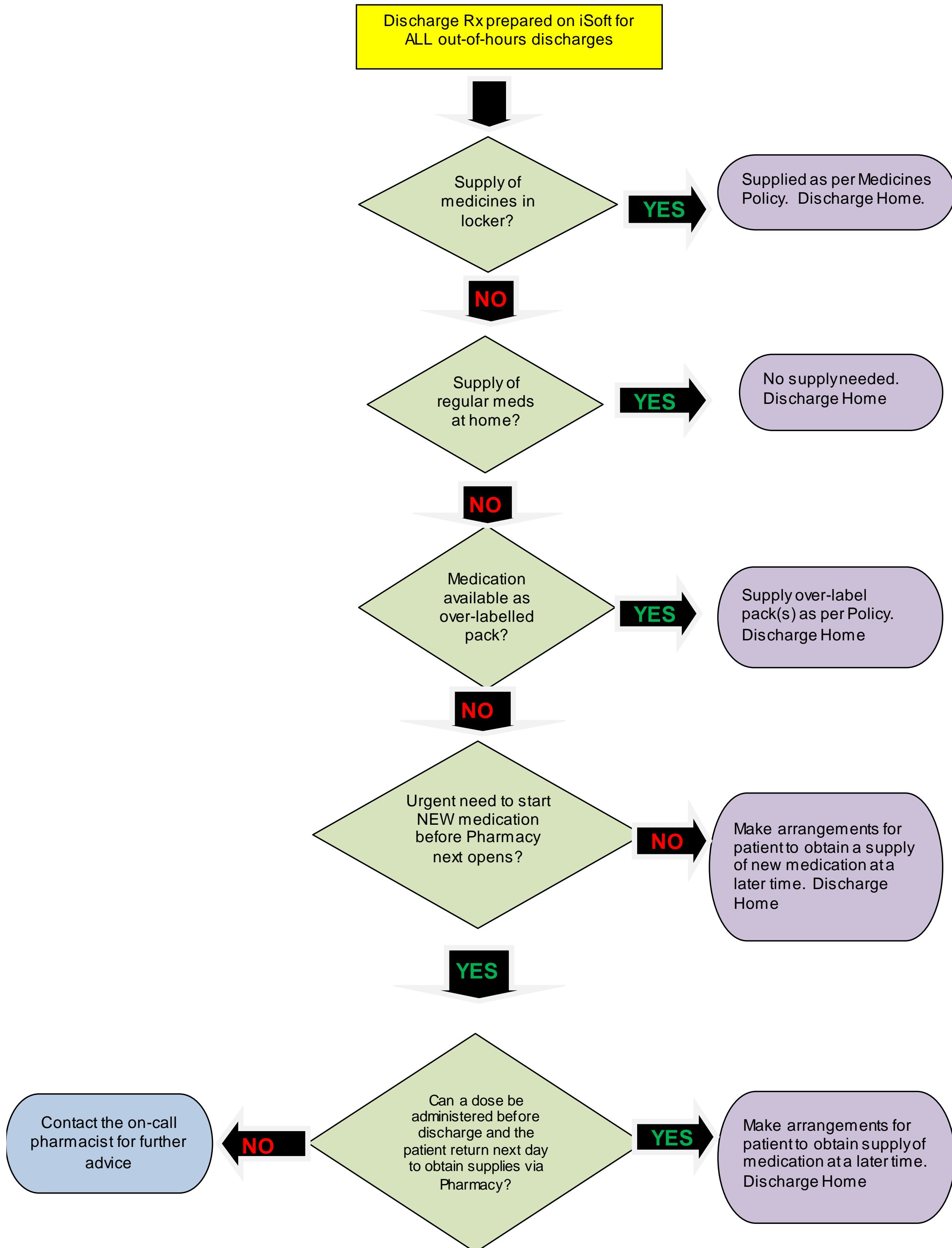
Has the patient access to a supply of all the medication they require?

Yes – discharge home

No – nursing and medical staff must **not** supply unlabelled or inappropriately labelled 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)



10.9 Appendix 9 – Self Discharge Form

Self Discharge Form

<table>
<tr><td colspan="2">Patient Name:</td></tr>
<tr><td colspan="2">Address:

Tel No.</td></tr>
<tr><td>DOB:</td><td>Unit No:</td></tr>
<tr><td>Hospital:</td><td>Ward:</td></tr>
<tr><td>Date of Admission:</td><td>Date of Self Discharge:</td></tr>
<tr><td colspan="2">GP:</td></tr>
<tr><td colspan="2">Advice Given to Patient:

</td></tr>
<tr><td colspan="2">Health Professional Details:

Name: ______________________ Signature: ____________________

Designation: _________________ Date: ________________________</td></tr>
<tr><td colspan="2">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: ________________________</td></tr>
</table>

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.

10.10 Appendix 10 – Factsheet: The Assessment and Discharge Process to a Care Home

We want to give you the support you need to get home as quickly as possible. Following a hospital admission, most patients are able to return home, sometimes with a care package or adaptations made to their home. However, some patients are unable to return home and need the added support only available in a care home.

We will involve you in all decisions about your care, treatment and discharge, and give you all the information and support you need to make the best decisions

What can you expect to happen?

- We will tell you when your treatment is due to end and when you would be considered well enough to leave hospital (this is called an estimated discharge date) – we aim to tell you this within 48 hours of you being admitted and will discuss with you if this changes.

- We will provide you with a named staff member who will support you throughout your time in hospital and make sure that things happen when they are supposed to. They will tell you how to access information, advice and support to help you make your discharge decision. This will include helping you to understand your care needs, the process of assessing your needs and the care options available to you.

- With your permission, we will request assessment(s) to find out what needs you have and the services you might need to be safely discharged from hospital. The assessments could be for social care, home assessment for any adaptations, eligibility for NHS continuing healthcare, etc.

- It may also be necessary to assess how any ongoing care will be funded, although in most circumstances to avoid any delay this will be carried out after you have been discharged. It is important to note that whilst NHS care is free to everyone, social care is not.

- Once you have received information about the discharge choices that are available to you, we request that you make a decision within 5 days. You may wish to arrange for yourself or a family member to meet with the care providers during this time. We will do our best to help make this possible for you and you will be able to speak with a nurse or social worker about these choices.

- If your preferred choice is not available when you are ready for discharge, you may be asked to find an alternative home or an alternative option could be arranged for you temporarily. It is not possible for you to wait in this hospital, once you no longer need hospital care.

- If you wish to make a complaint or appeal against any part of the discharge process then contact at any point the complaints department

If you would like a copy of this factsheet to be given to someone else or you have any questions, please speak to one of the nurses on your ward or any member of the team caring for you.

Please do not hesitate to ask questions about your discharge at any time during your hospital stay.

With best wishes for a speedy recovery,

[*insert NHS Trust Chief Executive signature*]

10.11 Appendix 11 - FACTSHEET A: The Assessment and Discharge Process

We want to give you the support you need to get home as quickly as possible. Following a hospital admission, most patients are able to return home, sometimes with a care package or adaptations made to their home. However, some patients are unable to return home and need the added support only available in a care home.

We will involve you in all decisions about your care, treatment and discharge, and give you all the information and support you need to make the best decisions

What can you expect to happen?

- We will tell you when your treatment is due to end and when you would be considered well enough to leave hospital (this is called an estimated discharge date) – we aim to tell you this within 48 hours of you being admitted and will discuss with you if this changes.

- We will provide you with a named staff member who will support you throughout your time in hospital and make sure that things happen when they are supposed to.

- We will tell you how to access information, advice and support to help you make your discharge decision. This will include helping you to understand your care needs, the process of assessing your needs and the care options available to you. This may be provided by your discharge coordinator, or they may ask a member of the Discharge Management Team to support with this.

- With your permission, we will request assessment(s) to find out what needs you have and the services you might need to be safely discharged from hospital. The assessments could be for social care, home assessment for any adaptations, eligibility for NHS continuing healthcare, etc.

- It may also be necessary to assess how any ongoing care will be funded, although in most circumstances to avoid any delay this will be carried out after you have been discharged. It is important to note that whilst NHS care is free to everyone, social care is not. Speak with your named staff member to find out what the time limits are for free care and what this might mean for you.

- Once you have received information about the discharge choices that are available to you, we request that you make a decision within 7 days. You may wish to arrange for yourself or a family member to meet with the care providers during this time. We will do our best to help make this possible for you and you will be able to speak with your discharge coordinator or the Discharge Management Team about these choices.

- If your preferred choice is not available when you are ready for discharge, an alternative option may be arranged for you temporarily. It is not possible for you to wait in this hospital, once you no longer need hospital care.

- If you wish to make a complaint or appeal against any part of the discharge process then contact at any point the Patient Experience Team on 0800 783 5774.

If you would like a copy of this factsheet to be given to someone else or you have any questions, please speak to one of the nurses on your ward or any member of the team caring for you.

Please do not hesitate to ask questions about your discharge at any time during your hospital stay.

With best wishes for a speedy recovery,

10.12a Appendix 12 – Choice Letter A

From
Email
Direct Line

Your ref:
Our Ref:

Address

Date

Dear

<u>Choice letter A</u>

Notification of hospital discharge

I am writing to confirm that your care team have completed their assessment and treatment and consider that your medical condition is now stable and you are medically fit for discharge.

We have previously provided you with all the information, advice and support concerning the choices currently available to you, and the option to involve your family, friends and carers to support you as required.

All necessary arrangements have since been put in place to facilitate your safe discharge from hospital with appropriate support available in the community.

Should you wish to discuss the content of this letter or have any further queries or concerns about the discharge process, please do not hesitate to contact one of the nurses on your Ward or any member of the team caring for you.

Yours sincerely

Signed by Senior Clinician

10.12b Appendix 12 - CHOICE LETTER B

From:
Email:

Direct Line:
Your ref:
Our ref:

Address

Date

Dear

Choice letter B

Discharge arrangements following formal meeting

Thank you for meeting with the care team to discuss your discharge arrangements from this hospital and ongoing care needs.

As previously stated, we want to help you leave hospital as soon as possible because you no longer need hospital care. Your medical condition is now stable and you are medically fit for discharge.

In addition we have a responsibility to ensure that the hospital has beds available on the wards for people who require acute treatment which can only be provided in hospital.

At the meeting we discussed the following actions to enable the discharge process to proceed:

-
-
-

The following discharge plan was agreed with a focus on the best outcome for you:

-
-
-

Or

We have noted the reasons why you are unwilling to engage with this process:

-
-
-

We will continue to work with you in order to agree a mutually acceptable solution. However, meanwhile the hospital will need to consult with our legal advisors about this situation and how we can facilitate your safe discharge from hospital as soon as possible. We have a responsibility to consider your health and wellbeing throughout this process. You also have the right to consider taking legal advice.

Should you wish to discuss the content of this letter or have any further queries or concerns, please do not hesitate to contact one of the nurses on your ward or any member of the team caring for you.

Yours sincerely

Signed by Senior Clinician

10.13 Appendix 14 - Equality Analysis / Impact Assessment

Full Assessment Form **v2/2011**

Division/Department:	Integrated Medical Specialties/Discharge Management
Title of policy, procedure, decision, project, function or service:	Discharge and Going Home Policy
Lead person responsible:	Senior Nurse Integrated Discharge
People involved with completing this:	**Norman Devlin/Sharon Proud**

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 patients' discharge.

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 ongoing destination.

What barriers are there to achieving these outcomes?

Delays in discharge process.

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?

No this is a comprehensive policy covering Trustwide discharge.

Step 2 – Collecting your information

What existing information / data do you have?

Previous Discharge Policy. OPEL and SAFER, #nextstephome

Who have you consulted with

Nursing, medical and other Allied Health Professionals across the Trust.

What are the gaps and how do you plan to collect what is missing?

None

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.

Disability

No impact or potential for impact on any group.

Religion or Belief

No impact or potential for impact on any group.

Sexual Orientation

No impact or potential for impact on any group.

Marriage and Civil Partnership

No impact or potential for impact on any group.

Pregnancy and Maternity

No impact or potential for impact on any group.

Gender Reassignment

No impact or potential for impact on any group.

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.